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**Sudden Death Processing:
An Ethnographic Study of Emergency Care**

Patricia Scott

Ph.D. Thesis

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University of Durham

Department of Sociology and Social Policy



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INTRODUCTION

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Abstract

The following doctoral thesis provides an ethnographic account of sudden deathwork performed by emergency personnel. The study centres on three accident and emergency departments in the North East of England. Sudden death practices and perceptions are revealed using thick description from focus groups, narratives and informant accounts. Three emergency disciplines: accident and emergency nurses, police traffic officers and paramedics provide the backdrop to describing three sudden death trajectories, which take the dead body from a state of collapse to a mortuary. Particular attention is paid to the significance of status passage as a temporal dimension of deathwork with due consideration being given to the concept of body handling as 'dirty work'. A feminist concept of embodiment challenges the dominant discourse of the death processing industry in relation to beneficence and non-maleficence for those who are left behind to grieve. The theatrical representation of the body to relatives is discussed within a dramaturgical frame, questioning what is appropriate and achievable within the boundaries of an emergency care environment. An exploration of the roles of emergency personnel illuminates problems of dealing with a phenomenon, which annihilates the possibility of a sense of order and emotionally incapacitates emergency personnel. The procedural base to sudden death is presented through accounts of emergency personnel contact with human suffering and emotional pain with the intention to build a substantive theory of a sudden death milieu. Finally, Schutzian relevances highlight key concepts of significance within the data demonstrating how, despite an evidence-base to practice, some myths are highly influential in shaping the behaviours of emergency personnel throughout the sudden death event. It is hoped that insight gained may provide a catalyst to inform change where needed, in service provision and enhance interprofessional working relationships.

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Introduction

Levine (1988) describes an ideal death scenario in which

“...we imagine ourselves surrounded by loving friends, the room filled with serene quietude that comes from nothing more to say, all business finished; our eyes shining with love and with a whisper of profound wisdom as to the transiency of life, we settle back into the pillow, the last breath escaping like a vast ‘Ahh!’ as we depart gently into the light” (p.8).

In contrast, the accident and emergency sudden death scenario is stripped of ‘good death’ characteristics. It is reduced to a situation in which a socially rationed attempt to resuscitate, in the absence of loving friends involves a barrage of invasive procedures and measurements conducted within a resuscitation specific frame. The awareness and orientation of the patient is questionable and the chance of being pain-free is dubious. There is also limited opportunity to complete personal psychological business such as saying goodbye to relatives.

The following thesis contributes to the emerging sociology of sudden death focusing on the specific involvement of three emergency professions: accident and emergency nurses; police traffic officers; and paramedics. The primary location of the thesis is the accident and emergency department of three hospitals in the North East of England. The first is a major trauma centre, which serves the population of a large industrial coastal town and is a sub regional centre for burns treatment and plastic surgery, neurosurgery and maxillo-facial surgery. The other two accident and emergency departments also serve the population of large towns nearby but do not have the specialities of the former. Should their condition demand patients are directed to the definitive trauma centre for treatment.

Narrative accounts from emergency personnel highlighted the procedural base to sudden death practice. Reflexive biographical accounts from the researcher as ethnographer contributed to the data, illuminating many scenarios described. From these two perspectives the collapse to death career of the patient through various phases and locations en route to a mortuary was described resulting in a substantive account of a sudden death milieu. Disclosures from informants highlighted dilemmas, dualisms, metaphors and analogies operating within an emergency culture, exposing the uncertainties of working within a domain, which at times annihilates any possibility of maintaining sentimental order. Yet, order does exist as observed in the routinisation of procedures, though this sense of sentimental order as fragile reminders of the complexities of accident and emergency culture are prone to collapse.

Data were collected from the three emergency disciplines to support the thesis comprising: paramedics during their period of duty at three ambulance stations serving three accident and emergency departments and frequent reference will be made to their specific pre-hospital sudden death encounters. Similarly, accident and emergency nurses provided information on sudden death happenings from the same three accident and emergency departments. The Constabulary approached had one Traffic Division, which served the entire geographical area of the three hospitals. Three groups of traffic officers provided rich details of a range of sudden death activities occurring at various locations from the scene of the accident to the relative's home, hospital and to bring closure to the sequence, their mortuary encounters.

Part One provides an introduction in relation to how the research was executed by presenting key stages of methodology within the literature review and methods chapters. Consideration of an epistemological frame determined the design of the research justifying the ethnographic position on which the study was based leading to a rationale for the selection of the instrument, ethical considerations, and approaches to the analysis and presentation of the data.

Chapter One reviews the literature on the subject of sudden death providing insights into a number of touchstone texts from an otherwise fairly limited field of study. Death trajectories are introduced at this point providing an outline into the career of a once alive individual through initial contact with the emergency services ending with the deposition of the remains in a mortuary as 'cadaver'. Key texts describe and critique the ethnographic approach of previous authors to the study of this very specific aspect of social research. Few have tackled the subject of death, even less focused on sudden death as a sub discipline of thanatology. Deathwork, status passage, embodiment, dramaturgy and dirty work are discussed as sociological concepts, which impact on accident and emergency sudden death encounters.

Chapter Two focuses on the methodological aspects of the research explaining the various stages of research activity, which generated and analysed the data. An ethnographic approach was used within a grounded theory method, whereby the reflexive biography of the author is integrated into the text complemented by narratives reporting thick descriptions of sudden death encounters from nurse, traffic officer and paramedic informants. Ethical considerations are included which facilitated access to the semi-closed research fields of policing and emergency care. Nine focus groups gleaned extensive data, which was subsequently analysed using the NUDIST NVivo computerised data analysis package. Schutzian relevances enabled the discussion of a range of issues regarding how and why emergency personnel manage the sudden death event in the way they do.

Part Two locates sudden death as a visible, audible and temporal entity. Explanations are offered in relation to how the study of the subject may be enhanced by not only exploring sudden death as a specific subject for enquiry but also explaining how a wider range of dimensions may be revealed when the same subject is considered over a period of time. Thick descriptions of three trajectories examine problems associated with sudden deathwork in the pre-hospital phase, in the accident and emergency department and in the mortuary.

Chapter Three explains how sudden death as a visible and audible entity is located whilst paradoxically, much effort on the part of emergency personnel goes into concealment of the death from public gaze. Focusing on the temporal aspect, three trajectories are introduced within the patient to cadaver career of an individual to allow the reader to fully engage with a multiplicity of activities when emergency personnel handle the sudden death event: the Direct Trajectory; the One-stop Trajectory, and the Elaborate Trajectory.

Chapter Four focuses on the Direct Trajectory, that phase of activity, which takes the individual from a collapsed state to a funeral director's mortuary, which chiefly involves paramedics, general practitioner and relatives at the patient's home or in the immediate vicinity of the home. This phase of activity is characterised by early paramedic disengagement from the body of the deceased and departure from the scene enabling a transfer of interest to funeral industry personnel.

Chapter Five describes the One-stop Trajectory, which focuses on the dead on arrival scenario outside the accident and emergency department en route to a hospital mortuary. Death is verified in the ambulance and minimal interaction takes place between emergency personnel, prior to transportation of the body in the ambulance to the hospital mortuary.

Chapter Six explains in detail an extensive range of activity and interaction between emergency personnel during the sudden death career of an individual within the accident and emergency department. The Elaborate Trajectory is complex creating a high level of interaction between emergency personnel through an intricate procedural base, which centres on the representation of the dead body to the relatives.

Chapter Seven explains how the news of a death is delivered to relatives by emergency personnel, the reaction of the relative when receiving the news and dilemmas faced by emergency personnel in meeting the emotional and practical needs of the relatives.

Part Three takes the research into a series of discussions informed by attention to Schutz's notion of 'relevance'. Key dimensions emerging from the data are analysed and critiqued to form a wholesome account of the emergency care, sudden death milieu.

Chapter Eight presents role relevance within four themes: role resignation, uncertainty, obstruction, and routinisation. Resignation to perform a role is associated with a duty bound obligation to perform dirty work such as, body handling and delivering the news of a death to relatives, which would much rather be delegated to another. Role uncertainty concentrates on a lack of awareness among emergency personnel regarding each other's functions. Role obstruction involves not only difficult members of the public who prevent emergency personnel from 'doing their job' but also reveals how emergency personnel themselves obstruct one another, use delaying and avoidance tactics to disengage from one another. Role routinisation is explained as a feature of normalisation when preparation for the extreme circumstances associated with sudden death become an inherent part of daily working life, it becomes what emergency personnel 'do'.

Chapter Nine discusses legitimisation rhetoric in relation to emergency personnel perceptions of what is deemed an acceptable or unacceptable sudden death. Drawing on associated characteristics of youth, fame, and mode of death, personal attributions are awarded the death based on high and low social status of the dead person. The use of personal emotional analogy is a strong reminder of how easy it is for emergency personnel to engage with the death on a personal level and this discussion prepares a path to the following chapter.

Chapter Ten discusses how encounters with sudden death induce a strong emotional response in some emergency personnel who subsequently provide insights into their coping styles. The use of incongruous black humour, which infiltrates all three emergency disciplines, is discussed, as is the annoyance generated toward some individuals including among emergency personnel. Finally, some situations, and there

are some particularly traumatic events described here, lead to emotional exhaustion and staff have provided intimate details of those circumstances in which emotional exhaustion incapacitated them.

Chapter Eleven considers the transitional period between life and death in the manner by which emergency personnel disengage from the dead individual recognising it as 'cadaver'. Status passage within the death processing industry makes a dead person and declares the status of the dead person as such there is a time when the emergency personnel's role is no longer viable and the cadaver must be released to the pathology or funeral directing service. Consideration is given to binary oppositional forces of being biologically dead yet socially alive by questioning when it is that an individual as a person becomes cadaver as non-person so legitimising behavioural transition on the part of emergency personnel.

Chapter Twelve discusses spiritual relevance of emergency personnel in relation to how their behaviour may be influenced by religious and spiritual dimensions. Myths and rituals symbolic of religious and spiritual reverence are exposed for discussion. However, of most significance the issues of 'relationship' and 'embodiment' within human service provision is discussed and the notion that all three disciplines provide a humane embodied service is questioned.

Chapter Thirteen seeks to summarise and integrate the material into a substantive theory of sudden death. This chapter questions whether sudden death is similar today to Sudnow's descriptions from some thirty years ago and offers scope for further research into areas, which first, require clarification and second, create totally new avenues of inquiry. Practical measures are presented, which may help make the handling of the event a little less painful and perhaps more practical for relatives and emergency personnel.

Rationale

Initial thoughts about this study were generated during extensive practice as an accident and emergency staff nurse, and subsequently, departmental sister in another hospital handling the sudden death event on a regular basis. Working alongside other emergency personnel specifically, police traffic officers and paramedics affirmed the notion that despite contrasting disciplines and hence organisational cultures, the practices of the three professions converged at the point of managing a sudden death. Practices converged when a patient was brought into and died in the department (D.I.D.), also when a patient was brought in dead (B.I.D.), and finally when the practical concerns of relatives and colleagues required to be managed.

The rationale for exploring the subject is to understand more clearly the nature of sudden death encounters to arrive at a more responsive service, which considers better, the needs and wishes of the relatives. This is to be achieved by deconstructing some of the observed and reported practices and interactions unique to emergency personnel in the pre-hospital phase, leading up to the arrival of the patient, their subsequent death if not already dead, and the immediate post-death phase en route to, and within a mortuary. This approach aims to contextualise the sudden death event and to question whether sudden death practices have altered since the groundbreaking medical sociology of Sudnow (1967) the death trajectories revealed by Glaser and Strauss (1968) and the more recent cardiopulmonary resuscitation trajectories explored by Timmermans (1999). Additionally exploring the sudden death interface between paramedics, accident and emergency nurses and police traffic officers may reveal strategies to enable emergency personnel to manage the event and heighten personal awareness of their own involvement in such a scenario.

At various stages throughout the discussion it will become clear that despite the development of an evidence base to emergency care, some practices are based on myth perpetuated by organisational norms manifested within the relevant discipline.

Some practices are understood solely within the context of the relevant discipline. For example, it is interesting to consider the rationale for the action of a nurse opening a window in the resuscitation room following death of a patient, related to the freeing of the deceased's spirit. Many nurses engage in this practice despite acknowledging the irrationality or purely symbolic nature of the act. Closer examination of the emergency personnel interface will reveal how some practices are not mutually understood among the emergency professions. For example, on occasion a vigil is maintained by police officers outside or in the immediate vicinity of the resuscitation room. Nurses do not necessarily understand why police officers do this and police presence can lead to a perceived hostility by nurses. It may be that in waiting for impending news of patient outcome or in preserving a chain of continuity required for forensic evidence, police officers quite simply do not have anywhere else to wait. From a paramedic context, deceased adult patients are likely to be verified as 'brought in dead' (B.I.D.) in the ambulance, and the body transported to the mortuary in the same ambulance that brought them to the doors of the accident and emergency department. Yet the body of an infant following sudden infant death would be brought into the department for a pseudo-resuscitation display.

Some police officers perceive nurses as obstructive when they decline to reveal confidential patient information to police officers in the course of their enquiries. In response, some nurses are known to use avoidance tactics to maintain the requirements of the confidentiality clause of their Code of Conduct (UKCC, 2002). Police officers are not necessarily aware of or acknowledge the existence of the clause. On occasion certain individuals reveal selective information to officers, which effectively results in the officer leaving the department. There is variation in the amount and timing of the information given to police officers. Practices exist within all three disciplines that are yet to be explained and which may offer a route to a more harmonious multi-agency approach to the management of the sudden death scenario.

PART ONE

PART ONE

METHOD

Part One is divided into two distinct chapters consisting of the literature review and the methods section. The literature review contextualises subsequent material using literature already available on the subject specifically, death trajectories, status passage and literature central to deathwork and death processing. Concepts of embodiment, the ‘polluting body’, dramaturgy and theatrical representation of the body and the notion of body handling as ‘dirty work’ are central characteristics of sudden deathwork. Finally, a section related to emotional labour considers key literature on emotional incapacitation in service roles, which has direct applicability to emergency personnel encounters with sudden death. The chapter relating to the method considers an epistemological frame, which determined the design of the research, justifies the ethnographic position on which the thesis is based, and provides a rationale for the selection of the research instrument, approach to data analysis, presentation of the data and ethical considerations.



CHAPTER ONE

Introduction

The following chapter introduces the theoretical underpinning to the thesis critiquing a range of seminal texts, essential for developing insights into the material to follow. Death literature is a developing field and with the creation of two new British journals during the last decade and a national conference inviting an eclectic range of speakers and topics devoted exclusively to the sociology of death and dying has placed death theory on the sociology agenda. Death trajectories are introduced in this chapter, providing insights into the career of a once live person through initial contact with the emergency services and ending with deposition of the remains in a mortuary under the new status of 'cadaver'. Of equal importance to presenting the literature on the field of death is the method by which previous researchers cited in the literature review 'investigated the phenomenon. Investigation of the subject using a grounded theory approach within the Chicago tradition was thoroughly explained by Glaser and Strauss (1967) and this method was adopted for the purpose of this research, providing a sound rationale to guide the execution of the sudden death research.

LITERATURE REVIEW

Analysis of death literature commences with a discussion of seminal texts (Sudnow, 1967; Glaser and Strauss, 1965; 1968; 1971; Strauss and Glaser, 1970), which describe a temporal sequence to the death event, drawing on status passage related to death trajectories (Timmermans, 1996; 1998; 1999a). Sudnow's (1967) sociology of death in the hospital setting and Glaser and Strauss' (1968) temporal death trajectories underpin the theoretical frame. These two texts provide a touchstone to the groundbreaking material already written on the subject. Timmermans (1999a) provided a sudden death resuscitation specific framework, which focused on the social value of resuscitation candidates within a 'techno-scientific script' for comparison with the earlier texts. The discussion on the social rationing of resuscitation based on the patient's perceived social value moves the literature review into a more contemporary era.

A plethora of texts are published, the titles of which are testimony to the use of metaphor in death literature as expressed in the 'scars', 'gifts', and 'sacred spaces', which are 'wrapped in mourning' (Lendrum and Syme, 1992; Sayre-Adams and Wright, 2000; Wertheimer, 2001). Mode of death was addressed specifically in Lukas and Seiden's (1990) work on death by suicide. Stress responses of the emergency disciplines to high stress producing incidents were reported by Palmer (1983), Newton (1989), Mitchell and Bray (1990) Hetherington (1994), Noe (1996) and, Hetherington et al (1997).

A range of literature was published which has great bearing on the overall concept of sudden death. Hughes' (1971) 'dirty work', facilitated understanding of the professional's involvement in handling the perceived 'polluting body'. Goffman (1959), Burke (1969), Turner and Edgley (1976) and, Bradbury (1993; 1996; 1999) explored the concept of dramaturgy which assists in explaining death related rituals and the transformational process prior to representation of the dead body to grieving

relatives. Hallam et al (1999) explained binary oppositional groupings in relation to how death processes facilitate a socially acceptable process of disengagement or closure from the once live person. Grosz (1994), Hallam et al (1999), Scott and Morgan (1993), and Turner (1991; 1992) explained concepts of embodiment and this literature is most useful in understanding the mechanism of professional and personal engagement and disengagement with a given phenomenon such as sudden death. Cathcart (1990) highlighted ways in which police officers could offer a human, caring service by providing choices to relatives regarding important decisions in relation to the deceased. Schroeder (1992) and Howard (1994) urged nurses and police officers respectively, to consider the professional relationship with the public and remain engaged with the experience in order to provide an effective service and Maeve (1998) explained how nurses arrive at moral meanings regarding suffering and death among patients. Mitchell (1996) questioned police coping methods when dealing with the relatives of a sudden death outlining three factors: emotional hardiness through habituation, impact of training, and expression of 'black' or 'gallows' humour. Narratives obtained from individuals who had experienced the sudden death of a close relative revealed how they felt and offered comments on how individuals should be approached, cared for and managed throughout the sudden death experience (Cathcart, 1990; Diamond and Watson, 1990; Jones and Buttery, 1981).

Green (1989) highlighted specific religious rituals related to a range of religions to be respected by emergency personnel when supporting relatives following death of a loved one, though McGuinness (1986) claimed there was a distinct lack of awareness of the needs of a multi-cultural society among emergency personnel. Spiritual dimensions of care and service delivery were explored within a nursing context (Reed, 1986; Ross, 1994; Dyson et al, 1997; Kellehear, 2000 and, Narayasamy, 1999) with specific reference to the capacity of agnostic/atheist nurses to provide spiritual care (Burnard, 1988). Murray and Zenter (1989) offered a definition of spirituality which extends "...beyond religious affiliation to include awe, reverence and meaning and purpose..." (p.259). Various elements were considered to provide a vehicle to the delivery of spiritual care such as the giving and receiving of love and forgiveness

(Ross, 1994), trust and mutuality which provides hope and strength (Stoll, 1979) and, honesty and genuineness as enacted in touch, listening and, committed presence (Mayerhoff, 1971). Carroll (2001) offered a phenomenological heuristic approach whereby hospice nurses revealed personal beliefs as they told their individual stories of caring for dying cancer patients. McSherry (1998) and Taylor et al (1995) explained how the 'meaning of life' is inextricably linked with religion and spirituality and how such meaning is expressed through ritual whilst Highfield (1992) suggested that nurses could be more effective in a spiritual domain if they were to bracket personal beliefs. Seale (1998) reported on the liminality of death related discourse within Western culture whereby a transformative process permits the death to be perceived as an opportunity for personal growth. In contrast, Critchley (1997) reported on death within a nihilistic discourse whereby the death of an individual was considered 'the end', resulting in 'death, decay and nothingness'. Whatever the belief frame of the professional, spirituality was forwarded as the cornerstone of holistic care and recommended as the fourth domain of nursing practice (Carson, 1989).

'Emotional labour' as a coping mechanism within service-based professions was reported on by Hochschild (1983) and discussed later by Van Maanen and Kunda (1989) and also Ashforth and Humphrey (1993). Hochschild (1983) provided an explanation of deep or surface acting required in service based occupations in responding to role expectation and this is significant to the manner by which emergency personnel deal with the sudden death incident. Wright (1991) provided insight into the emotional incapacitation reported by carers when handling the sudden death event in accident and emergency. Sudden death narratives revealed a range of intense expressions of feeling from relatives who shared their thoughts some time after the sudden death event, and from emergency nurses who on occasion found difficulty in coping with the expression of raw emotion from relatives. Huyler (2000) offered valuable reflections of his hospital encounters with sudden death as an emergency physician and May and Kelly (1998) explained how a sense of professional identity emerges following professional encounters with dying patients. Berk et al (1989) reported on measurable physical and emotional changes follow mirthful

laughter and Meyer (1997) described how humour was a powerful element in uniting and dividing employees. Specifically, 'black humour' or 'gallows humour' acts as a stress response facilitating the prevention of burnout among emergency personnel (Coser, 1959; Keller, 1990; Rosenberg, 1991). James Beattie first linked stress to laughter in 1776 (Rothbart, 1996) detailing six areas: incongruity, intensity, sympathy, fear, socialisation and, world politics, which provided a starting point within this thesis to examine humour as expressed by emergency personnel when dealing with sudden death. Further, Nerhardt (1996) enlarged on the necessary ingredient of 'incongruity' as a critical component of funniness and the analysis of laughter within Chapter Ten.

Walter (1993) claimed that a wealth of data on the subject of death had been largely ignored within sociology and with it a major perspective on our cultural values. Specifically, the British 'way' of death equalled a sociological vacuum. Naylor (1989) addressed a totally neglected area of sociology since Gorer (1955) who had provided the only major sociological work on death in Britain. Other sociological texts have dismissed death in one sentence, such as Young and Wilmott (1957) 'Family and Kinship in East London'. Walter advocates the development of mortality studies through an increase in theoretical publications containing a clear focus on specific aspects of modern death. He suggests that a sociology which excludes robust reference to thanatology in comparison to other heavily researched elements of society such as gender, ethnicity, class, and age, is damaging to the discipline. Walter observed that the volume of literature on feminism and women's studies is dramatically more extensive than studies about death and draws on the analogy that 51% of society is female yet 100% of society will die, so the demand for a discipline within sociology exclusively devoted to studying death is justified.

"... a sociology that has largely ignored human mortality may well need its concepts and theories radically revising. Whither then – a sociology of death, or a mortal sociology?" (Walter, 1993:290).

A critical juncture in the publication of death literature occurred during the mid-nineteen seventies when attention turned to the reporting of widespread transformative bereavement counselling services and stress assessment scenarios for those involved in deathwork. During the 1960s and the 1990s a range of critical texts challenged perceived active grieving processes within the field of bereavement psychology (Kubler-Ross, 1982); developed the sociology of cross-cultural death experiences (Krupp and Kligfield, 1962; Green, 1989) and, considered bereavement as being linked to the concept of 'loss' (Bowlby, 1981; Penson, 1990). Additionally, an array of texts focused on emotional help and support as a specific aspect of loss of a parent (Kohon, 1999), spouse (Fanslow, 1983), child or sibling (Rosenblatt, 2000), or community as in the case of counselling disaster victims (Hodgkinson and Stewart, 1991).

Martin and Doka (2000) explored gender styles of grief response highlighting male and female stereotypical coping patterns; whilst Ellis (1993) documented her personal grief narrative following the tragic death of her older brother in an aeroplane crash at sea. Kleinman (1993) critiqued Ellis's (1993) narrative suggesting that the 'feminist' Carolyn collides with Carolyn the 'good girl' in the following statement. "I helped my mother make up a list of pall bearers. There were rules. "They should be his best friends," she [Carolyn's mother] says. "It can't be relatives. They have to be men. There should be six of them." This is not the time to argue for women pall-bearers. This is for my mother" (p.719).

In an attempt to bring order to the perceived emotionally disrupting concept of 'grief' various models of grief response were proposed (Kastenbaum, 1974; Bowlby, 1981; Kubler-Ross, 1982), which challenged Freud's (1917) 'active grief' proposition that the grief experience requires much hard work, which focuses on gradual detachment from the deceased and reinvestment in life and living (Strachey et al, 1975). In contrast, Kubler-Ross (1982) begins her analysis of the first stages of grieving by explaining the psychological mechanisms of denial and isolation, anger, bargaining, depression, and final acceptance. However, it is difficult to establish whether grief is

an active process or constitutes a series of passive phases through which the bereaved individual drifts. This distinction resulted from a comparison of the grief reaction to depression, and provided one of the most important studies of human behaviour to date challenging Freudian approaches to the recognition of dysfunctional grief and subsequent upsurge in grief counselling roles in the nineties. The previous value-laden model consisting of temporally distinct bereavement phases was to be replaced gradually by a post-modern eclectic philosophy of a temporally undefined nature whereby 'it is O.K. to feel the things that you are feeling' because 'all of your feelings are valid'.

Death trajectories

Sociological research on death in the hospital setting can be dated back to the work of David Sudnow (1967). In his book 'Passing On: The Social Organisation of Dying', Sudnow claimed that death was a major topic among anthropologists, physicians, artists, and men of literature, indeed literary descriptions of death scenes were considered to exceed those of professional academics in detail and sophistication. However hardly any attention had been given to the empirical investigation of settings of death and dying in contemporary Western society. Ethnographies of death within the social organisation of the hospital did not exist and the provision of an ethnography was Sudnow's contribution. In his study the central theoretical perspective suggested that categories of hospital life such as life, illness, patient, dying, death were manifested in the practices of hospital personnel as they went about their "...daily routinized interactions within an organisational milieu..." (p.8). Rather than entering the hospital to investigate the broad subject of death and dying he searched in a more focused way for the procedural basis of events to establish what death and dying were. Concentrating on those socially infused activities central to the death event (i.e. inspection, examination, disposition, announcing, pronouncing, discharging, wrapping, etc.) a parent activity emerged, which he referred to as "making a dead or dying person". Sudnow's work centred on the production of death and dying and also through his discussion on 'death talk' focused on the production of

a bereaved person. The sociological structure of death was observable in such activities as seeing death, announcing death, and suspecting death, which provided a basis for a description of death as a sociological concept.

Sudnow declared that social status determined resuscitation outcome and suggested that an individual suffering a critical heart attack should keep well dressed and have clean breath since he postulated the emergency personnel's interpretation of patient characteristics affected decision making over life and death. Sudnow highlighted those individuals whose moral character was considered to be reproachable that is, the suicide victim, the drug addict, or the known wife beater in contrast to morally acceptable characters for whom resuscitative effort and life/death decisions may be more justified.

By comparing the observed practices of two hospitals in the United States referred to as 'County' and 'Cohen', Sudnow as non-participant observer, sought to get close to occasions of death and dying. He located death and dying as organisationally relevant events, observed their handling by hospital personnel within the social world of the hospital and ward, and directly witnessed approximately 200 to 250 deaths. The co-operation of individuals who might be considered 'informants' were useful in supplying Sudnow with information about the circumstances of their work, technical matters, feelings about the institution and the practices of others and information on events which he may have missed. The occurrence of death in hospital was frequent with on average, about three deaths each day in the whole of County Hospital, making around 1000 per year. With such frequency in mind it was acknowledged that death had become a routine daily event, which was visible in a series of processes, including the institutionalised processing of a dead body; the process of transporting a body to the mortuary; and the production of death packages for the purpose of documenting a death.

Of significance to this thesis is the ceremonial structuring of 'death talk' as distinct from other forms of social interaction. The sequence of death pronouncing

conversation invariably contains an initial introduction from the doctor or nurse, followed by an assessment of the relative's knowledge of the seriousness of the event. These are followed by confirmation of death, reference to the medical history of the deceased, then a period of silence prior to a reaction. Though the sequencing and intensity of the dialogue varies, what is certain is that a reaction of some sort will take place. Sudnow (1967) referred to the institutionalisation of 'talk' whereby conversational transition moved death talk to a social talk context with the effect of inducing emotional realignment in the relative. The initial disturbance subsided in order to deal with pragmatic concerns (e.g. signing the autopsy permit, arranging the disposal of the body, and obtaining personal belongings). This study will discuss death and social talk in the emergency care setting and reveal that conversational transition contributes not only to the emotional realignment of the relatives but also for the emergency personnel. It offers an opportunity for emergency personnel to 'draw a breath' from those aspects of care that incapacitate the carer (Wright, 1991).

Thirty-three years since its formulation Sudnow's major contribution to medical sociology is somewhat dated. Organisational change within health care and in particular emergency care (Leckey et al, 2000) has impacted on the practices of health personnel to such an extent that some practices are no longer visible. Emergence of the paramedic role has radically altered practice in the pre-hospital setting, whilst accident and emergency nurses and doctors have streamlined resuscitation room activities. International and national benchmark standards have resulted in the production of protocols, which have impacted on resuscitation. Specifically, Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS) and Paediatric Advanced Life Support (PALS) protocols have streamlined the resuscitation of life threatening conditions and have rapidly become the globally recognised resuscitation system. Research has more clearly defined the extent of multi-system trauma that would permit continuation of life (Royal College of Surgeons of England, 1988) providing new definitions and capabilities for the sustenance of life in extreme conditions. Sophisticated knowledge of physiology and methods for measuring body core temperature have radically extended the

resuscitation trajectory of hypothermic patients who now receive lengthened life support, which correlates with a slow rise in body core temperature to prevent hypovolaemic fluid shift. Trauma victims receive swifter paramedic response times and pre-hospital emergency stabilisation at the scene prior to hospital transport, in some cases using an emergency air ambulance service. Mobile intensive cardiac care units administer immediate thrombolytic therapy and reduced 'call to needle' times have had a critical impact on mortality rates.

New technologies related to pulse oximetry, central venous pressure lines and cardiac monitoring provide accurate and immediate feedback of core measurements. As a result of technological advancement Bauman (1992) argued that resuscitative effort had lost its specularity and ceased to impress reducing the discriminating power of emergency personnel whilst an emphasis on social worth as a discriminator has been replaced with values relating to issues such as organ donation. Refined techniques in brain stem death testing provide a basis for definitive pronouncement of death in intensive care units though three areas of confusion exist. First, there is a need for the criteria of death to be related to concepts of death to appreciate the relationship between biological death and the departure of the soul from the body. However, the impossibility of ascertaining the anatomical locus of the soul means that physical and spiritual death cannot be guaranteed to occur together. Second, there is a need to determine whether death is an event or an insidious process. Third, the physiological end needs to be established in relation to whole brain death, persistent vegetative state, and death of the brainstem (Pallis and Harley, 1996).

Greater professional autonomy is expanding the boundaries of practice among emergency personnel. Recently the United Kingdom Central Council for Nursing, Midwifery and Health Visiting argued a case to the Home Office for a clearer and quicker death certification system in selected circumstances, which enables the nurse to deal with the aftermath (UKCC, 2001). The emergence of the paramedic role has radically altered pre-hospital resuscitation and led to a more empowered professional approach. Similarly a police traffic officer may perform synchronised cardiac

defibrillation on a collapsed individual at the scene. With organisational change in mind death and dying procedures have radically altered so, taking informal laws into account, it is highly probable that death is dissimilar to Sudnow's 1967 U.S. interpretation. Death and dying then is not what it used to be.

Whilst Sudnow's classic ethnography was in the process of publication Glaser and Strauss were similarly, investigating social concepts within a theory generating framework documented in the important text 'The discovery of grounded theory'. This inductive process led to a range of death related studies (Glaser and Strauss, 1965; 1967; 1968; 1971; Strauss and Glaser, 1970). Glaser and Strauss (1968) proposed that dying is a time sensitive phenomenon and introduced the notion of a death trajectory. When working with a dying patient staff organise their activities around the anticipated time that the patient will take to die and in instances where the patient actually dies earlier or later than expected 'untimely death' will upset work schedules. Temporal order in death generates a series of events focusing on: accepting there is nothing more to do, the death then occurs, followed by the formal pronouncement of death, then the announcement of death to the family. At each stage of the temporal order of death the staff continually readjust and co-ordinate their activities in recognition of and in response to approaching death or recovery and at this critical juncture the person is recognised and treated like a dying person. Differences in certainty and time were considered to yield four types of death expectation. First, there is certain death at a known time. Second, certain death is apparent but at an unknown time. Third, death is uncertain but there is a known time when certain death may be established. Finally, there is uncertain death expectation at an unknown time because it is not possible to establish whether death will or will not occur and if death does happen it is not possible to predict when.

Glaser and Strauss asserted that a distinct patterning of mood and sentiment existed on each ward which was central to the ward milieu. Disruption of ward work by unexpected 'happenings' resulted in the shattering of 'sentimental order' as observed in for example, the patient who dies unexpectedly. Shattered sentimental order is

related to the absence of 'nothing more to do care' in which comfort care rather than recovery orientated care is given by relatives and staff. Relatives feel especially cheated of the 'death watch', the 'last look', or 'comfort care'. The distinction drawn between the mobilising and immobilising impact of emergency on the sentimental order of the ward remains relevant. It can be assumed that emergency wards are ready, willing and able to cope with any emergency scenario, yet occasionally an emergency response may turn into a crisis when for example, equipment is not at hand or a member of the resuscitation team is not present. In Glaser and Strauss's study coping in emergency turned into reactionary crisis management and this is certainly a feature of more contemporary practice though standardised protocols have to some extent, strengthened the procedural basis of events within the resuscitation room. Timmermans (1996; 1998; 1999) provides a closer examination of the impact of the 'technoscientific script' later in the literature review.

The "slow dying trajectory" is observed in longer stay wards and elderly care where a social value is placed on the patient whereby a proportion of patients are regarded as socially dead even though biologically alive (a discussion of social value in relation to legitimate sudden death is explored in Chapter Eleven). Extra staff effort was arranged for patients who became 'critical' leading to relocation closer to the nurses' station for intense observation and involvement in care. Few heroics or last-ditch attempts to save their life were implemented, the patient having 'earned their right to die' and staff expressed how they would for example "Miss the old fellow" after death. Deaths were justified and staff and family expressed a sense of low value of the quality of life in respect of the contribution to society using phrases like "He was so old", "He'd lived a long life", or "Its better that he died, he's better off". Post mortem 'scenes' with grieving families characteristic of other types of death trajectory were absent and sometimes the family would not appear at all, the patient having been almost forgotten. In all, the organisation of work emphasised comfort care and custodial routine and was complemented by a sentimental order, emphasising patience and inevitability.

Within the quick dying trajectory, three hospital careers existed: the expected quick death, the patient who was expected to die but actually died unexpectedly quicker than anticipated and, the patient who was not expected to die at all but did die. The quick dying trajectory was observed to be of five types. On initial definition of imminent death staff may have attempted to save the patient but may have redefined the trajectory in response to the hopelessness of the case to one of 'nothing more to do care'. Second, staff may have continued to revive the patient 'heroically' until death occurred. Third, the staff may have redefined the trajectory of a responding patient with a previously hopeless trajectory resulting in a life saved and such an assumption formed the basis of the Major Trauma Outcome Study U.K. (MTOS UK) (Royal College of Surgeons of England, 1988). These three patient careers assumed that the patient would have lived whilst two other careers assumed that the patient would not survive. In the fourth case the staff may have assumed that the patient would not live and comfort care was provided till the patient died with no heroic effort. The fifth scenario concerned a split second event involving either saving, or comfort care where the patient was considered to be 'going fast' and there was little opportunity to do anything.

In the quick dying trajectory the 'educated guess' was sometimes deemed appropriate in shaping immediate treatment decisions. The 'pointed trajectory' allowed the staff to mobilise itself in advance of heightened death risk with all relevant resuscitation equipment prepared and accessible in readiness for the patient's possible death trajectory. The 'danger period' trajectory was observed when it was touch and go as to whether the patient would 'pull through'. The 'crisis trajectory' was defined when the patient's symptoms suggested a crisis developing which required that staff closely observe and monitor the patient until the crisis subsided, the patient being re-defined to a survival trajectory. In the 'will probably die trajectory' a steady downhill slide into death was observed in which the inevitability of death meant that staff made little effort to save and typically this involved accident victims, suicides, physical crises such as renal, diabetic or heart patients. The 'swift expected trajectory' commonly affected the cancer patient who had previously experienced the 'entry re-entry'

hospital career and this patient may have been redefined to a possible quick trajectory. Finally the 'save-loss trajectory' was possible in all the aforementioned careers but where a patient may have been revived sufficiently for staff to feel that the patient had been saved some patients subsequently plummeted into another quick death trajectory. Diagnosis "ad mortem" or near to death would occur when the patient was considered not 'worth' having a chance of survival and these patients were usually manoeuvred into another room to die and this practice continues in the UK emergency care context. The expected quick death trajectory determines staff decisions to relocate a dying patient to another less frequently used clinical room for the purpose of administering 'nothing more to do' care. A nurse attends the needs of the dying patient and family in a neutralised location, free from the trappings of resuscitation equipment whilst relocation allows tidying and restocking of the resuscitation room to commence in readiness for the inevitable arrival of the next patient.

The unexpected quick trajectory brought an element of surprise to the staff in two distinct ways. The 'emergency' response was considered to be mobilising and the team was ready for action. Alternatively, the team could be immobilised into a 'crisis' situation where equipment was not at hand and the team was not synchronised in their actions and ward sentimental order then became chaotic. In these situations relatives needed to be managed in such a way as to cope with their surprise too and similarly, the patients in the vicinity may have needed assistance in coping with their surprise. A collective ward 'armamentarium of defenses' was visible in the bolstering of the team members, which helped keep morale high. Despite the existence of an 'armamentarium of defenses' to the death event which results in preparation for yet more deaths, Glaser and Strauss's claim that the slow dying trajectory patient has a more intense emotional impact on nursing and medical staff than quicker dying trajectory patient is perhaps a little understated. Their statement is disputable given that one nurse informant in the present study recalled the sudden death of a young mother and her baby in a road traffic accident of some fifteen years or more ago. When probed further she offered information on five other incidents from even further back in her career which continued to have a significant personal emotional impact

and which seemed to be ingrained in her mind. These recollections reveal that many of the quick trajectory deaths result in significant emotional engagement for staff involved and some images never leave them.

The end of the dying trajectory posed three general problems, the location of death, care provision within the careers of the staff, and the management of the family. The critical juncture in the last stage of the death trajectory determined whether the patient went into hospital, went home to die or the patient died wherever the patient happened to be such as, in unexpected quick death. Staff typically shifted the type of care provision from curative, to palliative, to terminal when the nothing more to do phase had been reached. Glaser and Strauss referred to the 'entrapment' experienced by the principal carer who sustained the bedside vigil until death, the death itself being perceived by relatives and close friends as a special occasion evoking special values, dilemmas and bedside ceremony for those involved. Three stages within the patient's final hours emerged in the hospital setting: the deathwatch; the death scene; and death itself. The deathwatch was described as 'empty' time, the lull before the storm and a great deal of staff activity was observed in contrast to the minimal activity within the empty temporal space, whilst waiting for death to arrive. The deathwatch ended at the point of passing on and a number of problems were observed with potential impact on sentimental order but in particular, nurses were reported to have found the death scene upsetting.

Once death occurred the work of the hospital was not finished and various measures were taken for body disposal, so ending the career of the remains. Closure of the patient's story involved preannouncement of impending death, announcement of the actual death, with some brief temporalised resume of the hospital career and dying trajectory. A private location for the announcement of death to the relatives was crucial in avoiding any disruption of sentimental order by intense reactions. Glaser and Strauss claimed that emergency wards were adept at coping with these potentially explosive situations by using half-truths about the live/dead status of the relative in order to buy time and this notion is borne out in Chapter Seven when traffic officers

report a similar tactic with distressed relatives. Coping with delivering the death message to relatives and the possibility of disclosure of the live/dead status of the deceased continues to cause dilemmas among nurses. Strategies exist which help to alleviate the need to disclose half-truths by arranging for a police officer to go to the relatives home and bring them to the hospital. However, on occasion emergency personnel do continue to stumble at the point of disclosure and the manner of such disclosure will be revealed later in the thesis.

The closure of the patient's story is somewhat difficult in the absence of any concrete information on autopsy results. It was not until the outcome of the Allitt Enquiry (HMSO 1991, Recommendation 2) in which a nurse murdered nine babies in a paediatric unit that it was recommended that Coroners send copies of post-mortem reports to any consultant who had been involved in the patient's care prior to death. Unless particularly unusual the case would not be discussed at any great length. In one of the accident and emergency departments studied for the sudden death research the case of a hangman's fracture dislocation of the neck following a road traffic accident generated much interest. Significant time was devoted to looking at the radiographs of the distorted cervical spine and as such the patient's case was included in the informal teaching within the department.

The last look would take place in a number of locations: the hospital ward; or the mortuary and was more likely to occur on quick dying wards. Usually last looks were not permitted at the death scene due to the risk of interference, yet relatives were considered likely to have needed to come to terms with the 'mystic gap' between life and death that brought future torment. A relationship existed between the relative's last look and the presentability of the body in terms of disfigurement. Interim repairs and patching up would take place and the body would sometimes be removed to a neutralising location, one that is not as highly charged as the resuscitation room. Chapter Six provides a thick description of the staffs' involvement in the closure phase of sudden death and emphasises in particular the use of dramaturgy highlighting the problems encountered by emergency personnel as they try to represent the body of

the deceased to relatives. The last look brought an additional threat to maintaining composure in the last touch, again aimed at closing the mystic gap between life and death and sometimes staff 'ushers' who would dislodge the relative from the body of the deceased forcefully closed the gap. Other relatives were more sedate, involving gentle touch, kisses, stroking of hair and general assurance of 'everything in its right place'. Emergency personnel have since recognised that forceful disengagement of relatives from the body of the deceased detrimental to the relative's recovery and measures are now taken to permit access to the body for as long as the relative wishes to stay. The nursing staff also encourage relatives to return at any time during the day or night should they feel the need to be with their loved one. This is particularly so for the parents of sudden infant death. Indeed the empathy that one nurse expressed was particularly striking when she described how in the event of her own child's death she would not want to let go of her child in the knowledge that the body would be placed in a mortuary refrigerator. A further potential emotional peak occurred with the hand over of personal effects to relatives.

'Anguish' (Strauss and Glaser, 1970) is a case history, which tells a story about a lingering dying trajectory with accompanying theoretical commentary. The single social unit for study was the patient, Mrs. Abel, which explained in detail the temporal span or interlude in social life, on this occasion Mrs. Abel's death career due to cancer. Theoretical propositions explained in Glaser and Strauss's *Awareness of Dying* (1965) were developed and secured the case for analysing personal change as a permanent feature of human biographies generating a substantive theory of a lingering dying trajectory. The lingering dying trajectory involved a long-term course of dying on a surgical ward in a U.S. hospital and two features were prominent: long duration and slow, steady downward transition. A perceived course of dying generates questions from staff of how fast the patient will die and as it is often difficult to predict, staff is inclined to redefine the trajectory.

Mrs. Abel, the central character was a middle-aged married woman who had a primary breast cancer and was dying of adenocarcinoma complicated by intense pain. Weeks

before her death she had experienced virtual isolation increasing with her overall decline. She had reached a point of pain, physical degeneration and social isolation, which indicated that comfort care until death was not an option. A last-ditch attempt to save her resulted in a fatal surgical operation, which masqueraded as a measure for 'symptom control'.

Four stories were claimed to exist within Mrs. Abel's dying career. First, her life-story as it is integrated in particular into her lingering trajectory. Second, the interactions of the hospital staff were documented during her slow decline. Third, the stories of two student nurses and how they cared for this perceived, disagreeable woman. Fourth, the culmination of the text 'Awareness of Dying' Glaser and Strauss (1968) created a story in itself by focusing on one key trajectory. On reviewing the construction of the case study, which was built around the comments of the student nurses, Strauss and Glaser suggested that the reader need not accept everything in the entire account as accurate however, the internal consistency was sufficient to suggest a relatively accurate rendition of the chronology of events. Within the lingering trajectory there are 'work related' temporal features involving feeding, bathing, turning and medicating, and the behaviour of the people and the timing of these activities are crucial. What was observed was the collapse of temporal management as Mrs. Abel deteriorated physically and also became increasingly psychologically demanding to the staff. Strauss and Glaser also suggested that nurses preferred to focus care and attention on recovering and less troublesome dying patients.

The classic text, 'The Unpopular Patient' (Stockwell, 1972) served to identify categories of behaviour nurses use toward unpopular patients. The chief aim of the study was to determine whether there were some patients whom the nursing team enjoyed caring for more than others and if that was the case, to ascertain whether there was a measurable difference by using rating and ranking scales. Observable differences in nurse interactions with the most and least popular patients were reported, unpopularity being mostly related to personality factors and physical defects, longer stays in hospital and foreigners, those factors that might affect prejudice and

stigma. The behaviour of giving least attention to those in the mid-group, bedfast patient who was neither popular nor unpopular with nursing staff, was not anticipated. Stockwell highlighted the impact of popular/unpopular within the patient/nurse power base in that pressures are brought to bear on individuals who do not comply with their defined role. First the nurse would encourage individuals to conform, then if not productive in generating compliance, would attempt to ostracise the individual. Role definers in any given situation have the power to exercise rewarding and punishing sanctions and conversely, those individuals with power have most authority to define roles. In considering the transition to client-centred care and the assumed negotiable interaction between nurse and client, it is appropriate to question whether the previous dominant discourse is perpetuated and the term client-centred reduced to mere rhetoric.

In Mrs. Abel's case identification with patients was at its strongest perhaps when young nurses and physicians reacted with immense involvement to the deaths of young terminal patients. Personal analogy also featured in the case of a young doctor who identified similarities with Mrs. Abel's death to that of his own mother. Personalised conceptions of deathwork may run counter to the dying situation and Mrs. Abel's expressed conception of time of death were at variance with the staff's though in the end she wished to die on the operating table. An important element in the patient's trajectory is that it must be recognised that the person is actually dying, the dying person must act like a dying person and, the staff must perceive the patient as a dying person. The culmination of which leads to the recognition that there is nothing more to do. In Mrs. Abel's case routine 'nothing more to do' work was denied to the staff when her life ended in the peri-operative period.

Strauss and Glaser described the unfolding of routine tactics, which are used when patients have 'normal pain', "The doctor does this, the doctor does that; the nurses do this, and the nurses do that" (p.39). The type of tactic probably does not vary much from patient to patient. For example, rather than be woken up during the night or at

weekends the doctor would write in advance a whole range of medications that would be used should Mrs. Abel require them, a repeated habit became a routine.

Accountability to superiors was met at two levels. First, rules were adhered to on the basis that the action was of benefit to the patient. Second, deviation from the rules was tolerated in the belief that the patient would also benefit with an additional benefit to the staff. To explain further, there are rules as they are written in the rulebook and there are rules as they are practised 'on the street'. Care of the patient calls for "...a minimum of hard-and-fast rules and a maximum of innovation" (p.10), which was tolerated to get the care done. Incidental communications in the course of clinical contact forms much of what most physicians and nurses would term 'good terminal care' and falls into the non-accountable range of activity to be rarely reported. Also the very acceptance of a non-accountable range of activity rendered Mrs. Abel increasingly isolated toward her death in the period immediately following surgery.

A critical juncture emerged whereby along with the nurses' preoccupation with Mrs. Abel's pain, an additional element arose in relation to how to give comfort care to this terminal patient when the staff had gradually withdrawn interest. Intricate balance between two trajectories was at stake: a dying trajectory and a pain trajectory. Balance was complicated by a perceived pain trajectory in which the staff's expectation of the pain level generally experienced on that ward was at variance with Mrs. Abel's expressed pain level. The nurses did not anticipate the level of pain nor were they ready to believe that she had as much pain as she claimed. This belief led to subversive activities involving repeated requests for tablets when not in intense pain in order to stock pile medicine. Ideological arrogance on the part of the nurses' dismissive approach to Mrs. Abel's expressions of pain induced a situation whereby she legitimated her pain by overemphasising it. Attempts to legitimate her pain reinforced the staff's impression that the woman was over-demanding.

In conclusion, 'Anguish' relates the story of inappropriate care conditions within a US context pre-hospice era. It should be questioned whether contemporary palliative care approaches continue to generate the same patient care experiences and dilemmas. Also, in the light of contemporary pain management approaches, it is arguable whether Mrs. Abel fitted the criteria of 'unpopular patient' (Stockwell, 1972) and if nurses continue to prefer working with the more highly valued patient. Many palliative and terminal care patients die in their place of choice although there remain cases in which preferred place for terminal care is not guaranteed due to organisational constraints (Haveman et al, 2000) so some terminal and palliative care patients may inappropriately face death in hospital. The philosophy of the hospice setting, which accommodates the needs of all terminal care categories, including those with non-cancer conditions, address those aspects of care that can not be addressed when a terminal patient is inappropriately admitted to a surgical ward.

During the lingering trajectory all relationships with and around Mrs. Abel had become attenuated or had utterly collapsed. Closed awareness of the dying trajectory moved into open awareness when staff began to acknowledge the 'nothing more to do' phase of Mrs. Abel's dying trajectory but by that time it was too little, too late. Growing intolerance of the staff to her complaints of pain, ritualistic demands and excessive need for attention actually shaped her dying trajectory. Gradual withdrawal was contrary to the nurses usual practice of delivering care at the bedside, keeping patients informed, comfortable, assisting them in settling personal affairs, and 'being there' during their final hours. The sentimental order in the ward was in disarray because the nurses, doctors and the chaplain failed to communicate between each other and with Mrs. Abel and this continued post-death in the absence of discussion about the case.

In the hospice setting the dominant discourse of medical paternalism is discouraged and a culture of openness, and client-centred holistic care delivery forms the foundation of palliative care work. A mechanistic and dominant discourse of medical paternalism led to deficiencies in care provision for Mrs. Abel, "Here on this floor we

have a group of doctors with a particular philosophy of giving pain medication” (p.43). The holistic framework is manifested in the way staff organise their activities which has transformed since the nineteen seventies from a task orientated model to a primary care, or team nursing approach of the nineteen eighties and nineteen nineties. Presently ‘integrated care pathways’ are emerging as a way of organising care delivery to encompass the range of holistic needs within a multi-professional frame. Care definitions must have been different in this U.S. private care surgical context. It seems somewhat strange that a patient could not have her hair washed when attention to hygiene and body image is an essential element of nursing care. It is also disturbing to learn that Mrs. Abel’s request to have this need met was expressed as ‘pestering’ (p.114).

Of significant concern is the ethically dubious bargaining behaviour of the hospital in putting Mrs. Abel forward as a research patient in order to qualify for pain controlling treatment. The notion of a ‘repayment for agreeing to be a research patient’ is indicative of a payback system rather than a commitment to provide unconditional care, and begs ethical questions regarding the selection and training of personnel. “The first step to insure compatible hospital careers for dying patients is the training of nurses and physicians in psychological and sociological understanding of dying patients and of themselves in relation to the dying patients” (p.175). This should be integrated into knowledge of how the hospital organisation impacts on the professional care of dying patients. Pain control is much more sophisticated now and the intense pain that Mrs. Abel encountered is more likely to be minimised through the accurate assessment and specialist practice of a nurse-led pain management service. Patient controlled analgesia is likely to be the preferred pain management approach for Mrs. Abel had she been alive today.

Status Passage

Status passage forms an integral dimension of the sudden death thesis, which is essentially a phenomenological, temporally sensitive, cross discipline study to arrive

at a description of what sudden death is. Glaser and Strauss (1971) studied status passage within social structure and how such passage may entail movement into a different part of a social structure. It is essentially a study in social mobility though it is claimed to be applicable to a range of substantive areas. Status passage may involve loss or gain of privilege, influence or power, and a changed identity of self, as well as changed behaviour. Within the occupational arena status passage is distinctly observable and freely discussed as individuals move into new occupational positions. Every social structure requires that individuals move through it, along social positions, so status is a 'resting place for individuals'. However, no matter how long an individual retains a status position there is an assumed stage for departure. Strauss (1969) claimed that a temporal dimension is implicit in all kinds of status, "No one is assigned, nor may he resume, a position status for ever. Always there is a clause, whether hidden or openly acknowledged, whereby man may be dispossessed or may dispossess himself of the status" (p.124). Clear rules governing the timing of status passage are initiated by either the holder of the position or another agency, and there are prescribed sequences of steps, which the individual must go through in order to accomplish the passage. Ritual accompanies certain phases of the changes.

The properties of a passage are fairly regularised, scheduled, and prescribed. Additionally, status passage may be desirable, inevitable, reversible, and repeatable. Further, the individual may experience status passage alone, collectively, or in aggregate with others. Awareness of the status passage is not necessarily present as is communication with others who are experiencing status passage and some may volunteer to adopt a status for others, or it may be imposed. The degree of control an individual has may affect choice to engage in status passage whilst legitimation by an authorised agent is a necessary feature of status passage. Legitimators of timing declare passage transition and in sudden death it is conventionally a doctor who declares the patient dead. Death pronouncement is designated to a doctor to provide legitimation of status passage following an informed decision prior to declaration of the observed transition from alive to dead though it is now accepted practice that nurses may verify that a death has occurred but not to certify the death (UKCC, 2001).

Six principal properties are claimed to feature in status passage: reversibility, temporality, shape, desirability, circumstantiality, and multiplicity. Reversibility is a feature of status passage in that the direction of the passage is usually inevitable, despite efforts by either the passagee or an agent to stop the process. In the sudden death context passage from life to death is in many cases inevitable yet attempts to reverse this inevitability are made by CPR intervention. Further, it is a feigned display of reversal as emergency personnel enact the conditions of CPR in a previously established irreversible situation for instance following a cot death. It is argued that inevitability requires that there be institutions and organisations to manage, direct, and control the death passage. Further, in 'false reversal' the organisation "...must be prepared to handle the knotty social and psychological problems of passagees and their families and friends when the desirable, but false, reversal leads to unrealistic hopes" (Glaser and Strauss, 1971:16).

Temporality of status passage concerns the schedule of transition, and the regularity, prescribed stages, speed and pace of transition. Temporality operates within a climate of ceremony and ritual, which if initiated inappropriately early or late, may risk disruption of sentimental order and the shape of status passage is determined by combining direction and temporality or its movement over time. In sudden death it is the course of the patient's life/death career from a live person experiencing a life-threatening event to a changed status as a scientifically useful, objectified cadaver in the mortuary, or a spiritual dimension in the minds of family and friends. The involuntary nature of status passage centres on the motivation of those involved which quite naturally impact on the shape and timing of the passage. When passagee and agent mutually desire status passage, co-operation is the dominant feature and in the sudden death context it is mutually assumed that the patient would prefer to survive and the hospital will appropriately intervene to enable that result. Circumstantiality refers to single or collective conditions of status passage regarding whether a single individual or a group of individuals participate in transition. Glaser and Strauss argue that variable structural conditions related to passage mean that an individual can enter status passage in solo, collectively or in aggregate. In the sudden death context, a

person may die individually (solo), may die (collectively) as a member of a cohort perhaps during a major incident in which many deaths occurred at the same time, or may die (aggregate) individually within an overall sequence of deaths possessing similar characteristics such as suicide or an e-coli outbreak.

Multiple status passages involve transitional status of more than one individual, though some status passages are independent of each other as they compete for time and energy and lead to prioritising which elements are important and which are ranked in order of lower importance. For example, in the sudden death scenario a dying individual may be a husband, a son, a father, an uncle and a nephew. Changing status as death ensues involves the prioritising of which individuals should be present at the death. Concurrently, the wife, parents, siblings, and more distant relatives experience status passage as grievors. There is a need to decide who is to be present at the death, who will receive the death message, who will organise the post-death activities of arranging and receiving a funeral director and notifying other relatives and friends. In sudden death it is not possible to be so selective. Because the event is so unexpected, multiple status passage is of little consequence to the deceased however, who is present at the death is of enormous significance to the grieving relatives. Additionally, multiple status passage is of significance to emergency personnel because the presence of certain family members or friends can help or hinder deathwork.

It was not until the 1990s that any substantial critique of Sudnow's work was published. Timmermans's (1998a) critique of Sudnow's (1967) classic study 'Passing On' was recognised as one of the most powerful sociological formulations to account for social inequality in the process of dying. Despite three decades of development Timmermans claimed that the health care system did not weaken but instead fostered social inequality in death and dying based on observed resuscitations and interviews with health care workers. Death, the "great equalizer" has become inextricably linked with the patient's perceived social value in that low social worth is more likely to induce minimal resuscitative effort. Sudnow had previously argued that certain

groups of people were more likely to be treated as “socially dead” depending on their social characteristics of age, moral character or capacity for interesting clinical teaching. Most disturbing was the observation that social death becomes a predictor for biological death during resuscitative attempts annihilating initiatives such as advance directives, which were supposed to empower patients (Timmermans, 1999).

The noticeable omission of social rationing from legal, medical and ethical resuscitation literature reinforces the implementation of universally employed resuscitation protocols supported by resuscitation theory (Cummins et al, 1991) specifically, Basic Life Support (BLS), Advanced Life Support (ALS), and Advanced Trauma Life Support (ATLS). Protocols ensure that resuscitation is based on formal probabilistic reasoning that individuals suffering specific percentages of body system trauma will die and conversely, will survive such as that specified in the Major Trauma Outcome Study (UK) (Royal College of Surgeons of England, 1988). Systematically applied algorithms form the procedural base to resuscitation the most obvious example being the administration of intravenous medication combined with defibrillation loops so that clinical data inputs (e.g. blood pressure, pulse and respiration measurement) link with therapeutic decision outputs dependent on the response of the patient. A resuscitation loop consisting of the sequenced administration of oxygen, cardiac massage, defibrillation and drugs is repeated in response to the patient’s respiratory and cardiac output. Protocols are to be followed until an end point is reached and social factors should be irrelevant.

Timmermans was disturbed by Sudnow’s conclusion that social death became a predictor for biological death during resuscitation explaining how the sociological literature of the sixties suggested that health care workers alternated between aggressive resuscitation and preparation for impending death based on the patient’s social value. However, advances in the resuscitation procedure and legislative requirements to resuscitate individuals if medically indicated negate Sudnow’s postulation.

Sudnow explained how dying became an institutionally routine and meaningful event for the hospital staff whereby appropriate 'impersonality' existed among staff who favoured social death preceding biological death. Timmermans's critique indicates that the widespread use of resuscitation technologies help health care providers make sense of resuscitating individuals who have little chance of survival and the potential to become severely disabled and they cope by not trying to revive certain individuals. In addition, as gatekeepers between life and death, staff have the opportunity to execute the "pervasive but subtle moral code of the wider society". Clinical potential does not tend to determine survival so much as social viability. It is only when a patient transcends anonymity and gains a sense of personhood that aggressive resuscitation is initiated. Timmermans further disputes Sudnow's postulation that health care providers "obtain 'experience', avoid dirty work, and maximize the possibility that the intern will manage some sleep" (p.170). Resuscitation decisions are made within a climate of increasing external regulation, cost-effective medicine, physician autonomy, peer review, and medical malpractice suits all of which have to some extent redefined the limits of resuscitative effort.

Timmermans (1996) explored the relationship between multiple identities and resuscitation technology by questioning the double dynamic of resuscitation scripts, which can either save lives or save multiple identities. Certain identities are pre-written in resuscitation scripts and if an individual is followed through the resuscitation process it is possible to observe a double identity transformation. Resuscitation technology is claimed to facilitate certain medical identities, and render other identities irrelevant. When outcome is known the process is reversed so that previously irrelevant identities are reinstated. The idea that individuals possess multiple identities is the cornerstone of symbolic interactionism (Goffman, 1959) in that identities relate to various spheres of life such as occupation or family. Timmermans refers to Klapps's (1969) three basic variables of the concept 'identity'. First, identity concerns what a person thinks about him or herself introspectively. Second, it concerns what others attribute to the individual and constitutes the social identity. Third, concerning the validation of feelings which an individual shared with

others to affirm “the real me”. The essence of Timmermans’s dynamic resuscitation scripts centre on social identities (i.e. those identities which others attribute to an individual).

Technology sustains, creates, disregards and even abolishes certain identities and CPR technologies and protocols provide the scripts for identity attribution. The relationship among those involved, the spaces in which they move, the ways they interact, and the values they adhere to are all pre-inscribed. This pre-inscription occurs, not only at operational level but is integrated at the design level into the policy-making machinery of organisations through codes, policies and sanction. “Tight coupling” of medical devices and victim results in the insertion of the victim as ‘patient’ into the medical system, initially by a by-standing rescuer then by a paramedic. Tight coupling is reinforced most in the behaviour of the staff in the emergency department. Protocols determine the correct execution of the life-saving script, so the implementation of the CPR script crystallises values in a similar way to how the black box affirms adherence to correct procedures on an aircraft. Universality of resuscitation is achieved through standardisation of protocols at local level (Timmermans and Berg, 1997) and the strongest moral point of the resuscitation script is that it presumes the overriding value that a human life is worth saving and worth saving quickly.

Disappearance of multiple identities into the margins of the resuscitation script occurs when the inscription is not transcribed. Marginalisation of multiple identities may be due to an extensive range of factors, which reduce the effectiveness of the resuscitation protocol perhaps due to not reaching the victim quickly enough, choosing not to become a rescuer, or venous collapse on attempted insertion of an intravenous cannula. Two further categories of marginality exist. Individuals who position themselves outside of the script such as suicidal people, may consider resuscitation to be a violation. Further, there are people who should be included in the resuscitation script but who are excluded because medical decisions render them ineligible. The moral strength of the resuscitation script indicates how unwelcome

CPR and 'Do not resuscitate' (DNR) orders are violated. Eight of Timmermans's 112 observed cases provided testimony to this assumption in that in only two cases out of eight did the emergency department personnel become aware of the patient's wishes before resuscitation commenced. The force of the resuscitation script performed by emergency personnel dominated personal preference and the default mechanism became operational in six cases and was reinforced by spatial displacement of the body turning into identity displacement.

Timmermans (1998) reported on how resuscitative efforts are the "quintessential examples of a medicalised and technological death" (p.144) and questioned whether advanced resuscitation technologies and dignified death can co-exist in the case of sudden death. He claimed that the less medical technology is used to extend the dying process the more humane the death becomes. Resuscitation is claimed to possess default character, an internal momentum, which acts on a de-contextualised body (Timmermans, 1998; 1999). The expectations of the public and also emergency personnel reinforce resuscitative behaviours even though the patient's physical condition is non-viable so that in Western culture "it is illegal to die". The example of Sudden Infant Death Syndrome (SIDS) is provided whereby an instructor posed the question of SIDS resuscitation to a hesitant paramedic "Mike, in the SIDS case you ALWAYS resuscitate. Even if the baby is stiff as a board". Resuscitative effort is being used to help make sense of a senseless death and despite the futility of the act. Unfortunately, typical resuscitations involve patient transportation from the place of collapse to an emergency department where "...white-coated professionals with only superficial knowledge of the patient will follow standardised protocols" (Timmermans, 1998:144-145). Criticism focused on the denial, medicalisation, professionalisation and bureaucratisation centred on the use of technology, which would be justified if lives were saved. In the majority of cases the patient dies an unnecessarily 'drawn out, inhumane techno-death'.

Timmermans's (1998) analysis was twofold: whether technology is to blame for the way individuals die suddenly and; whether the omnipresence of resuscitative efforts

renders sudden dying meaningless. The dominant resuscitation theory (Cummins et al, 1991) advocated that the quicker the implementation of the 'chain of survival', the better the chance of survival. The chain of survival begins with the raising of the alarm and immediate resuscitation at the scene of the collapse and ends in the emergency department. However, if there is a weakness in the chain due to delay or incompetence it is virtually impossible to recover, and this possibility of failure is internalised within the emergency culture in that some personnel may be less willing to aggressively resuscitate when ideal conditions have not been met. The process of dying takes on one of three meanings. First, resuscitative effort provides a temporal reprieve due to a liminal link between life and death which means that relatives may come to terms with the death more readily than if the death was immediate. Liminality between life and death provides relatives with a hope for recovery. Second, resuscitation technologies embody modernist approaches that the dying process is reversible and that it is possible to have control over the inevitability of the end of life. Third, the sustained theatre, which resuscitation provides suggests that everything medically possible had been done and such medically confirmed explanations and descriptions may ease the relatives' grief. Collectively then, resuscitative effort is understood as a biomedical ritual to facilitate status passage.

Timmermans considered a combination of sudden death elements: clinical, biological, social, and legal factors within four resuscitation trajectories, legal, elite, temporary stabilisation, and stabilisation. First, the 'legal death trajectory' concerns the presumed low social viability of most patients as perceived by emergency personnel. Absence of clinical signs of life accompanied by significant time lapse since arrival in the resuscitation room, are central features of this trajectory. The structure of the emergency system in the U.S. requires that paramedics follow standing orders to resuscitate and transport patients to an emergency department where the attending physician is required to declare the patient dead but only following full resuscitation. To perform any less resuscitative effort could be construed as abandonment, jeopardise insurance and subject the physician and/or hospital to a malpractice suit. In this trajectory the patient usually has no cardiac output and is not breathing otherwise

referred to as 'pulseless non-breathers', 'goners', or 'flatliners' and therefore is considered to be biologically dead. The patient in the legal trajectory may be elderly, suffer serious illness and is awarded low social viability and the staff feel defeated in advance particularly when the low social viability is complicated by additional negative elements. Closure of the trajectory involves preparation for an official death declaration. Sufficient negative evidence regarding biomedical indicators, social characteristics, circumstantial indicators and medical history enable the decision to discontinue resuscitative effort. Timmermans (1999) suggests that the legal protections to guarantee universal life-saving effort in the United States creates new criteria that need to be met prior to death declaration rather than qualitatively enhanced lifesaving. A new temporal interval is identified between receiving the biologically dead patient with assumed low social viability into the department, which focuses on the time required to exhaust the resuscitative protocol.

Second, the 'elite death trajectory' concerns the high social viability of the patient and recognition of biological death, which induces an aggressive resuscitative effort despite a sometimes quite lengthy collapse to resuscitation interval. The typical example would concern sudden infant death syndrome where the infant may have been dead for hours, or the arrival of a prominent person within the community. Resuscitative effort is at its peak compared to other trajectories and this could create tensions in the case of patients arriving with advanced directives not to resuscitate. The staff was described as evasive when approached about the subject and felt it highly likely that the directive would be dismissed unless written substantive evidence could be provided during resuscitation. Spiritual and emotional aftercare for the grieving relatives is likely to be more intensive. Closure for the elite death trajectory is more likely to be a joint decision from the emergency team following a review of events.

Third, the temporary stabilisation trajectory resembles a roller coaster in that the patient is considered of high or low social viability, yet some degree of clinical viability is apparent. Recovery from cardiac arrest is likely to lead to further relapse

and it is not unusual for a patient in this trajectory to have repeated resuscitation loops with periods of stabilisation between each arrest. In effect, the patient is on a slow-dying trajectory and staff anticipate further collapse and/or neurological dysfunction should the continuation of resuscitation prolong the trajectory. Sufficient uncertainty regarding the pre-hospital resuscitative effort may exist in this patient who compels the team to continue and the paramedic may discover a pulse in the patient despite a lengthy emergency call to arrival interval. The patient is usually transferred to intensive care but the staff feel the patient is too unstable to risk moving. The staff's reluctance to revive patients from this trajectory is accompanied by a fear that the patient will join the ranks of the low social viability group of neurologically dysfunctional patient or persistent vegetative state due to a low oxygen uptake. As disability is considered to be associated with dependence and helplessness, long-term disability seems worse than biological death and the dominant resuscitation theory suggests that rescuers believe that the prospect of long-term physical, but particularly mental, disability is reason enough to slow a lifesaving attempt.

Fourth, the stabilisation trajectory is the most viable of the four trajectories in that the patient has either a high or low social viability. Essentially the patient experiences a swift transportation time and has a sound clinical presentation at the scene of the collapse and on arrival to the emergency department. The circumstances become more fortunate with the young to middle-aged individual who has received immediate bystander cardio-pulmonary resuscitation (CPR) where such preliminary measures offer a more successful resuscitative outcome. Timmermans describes the team as undergoing a similar chaotic process of information gathering, centralising and sharing the resuscitation process but with few patients actually benefiting from this trajectory. In the case of redefining a resuscitative attempt to a low viability Timmermans observed a technician perform single-handed CPR, which would not otherwise be permitted. Indeed an action of this sort is likely to attract a severe reprimand in UK hospitals. An operational definition of viability is almost exclusively grounded in current biomedical observations and responses to medications and blood and technical analysis of the patient's condition.

Advanced directives introducing an element of patient autonomy in a sudden death scenario have actually served only to disempower the patient by inducing medical paternalism. Failure to produce a written advanced directive at the point of resuscitation has shortened the course of resuscitative effort for patients within the low social viability category (i.e. those considered to be socially dead). Paradoxically the absence of an advanced directive for the patient in the high social viability category means it is likely that staff would continue to resuscitate despite a request to the contrary. Health care workers will uphold the request documented in an advanced directive only when the content concurs with the level of social viability awarded by the staff, so the advanced directive does not rise above the professional judgement of the staff. Of significance is Timmermans's observation of eight resuscitations in which patients had written advance directives. When an advance directive instructs "no heroic measures" staff interpreted this as continue CPR but with hold intubation, drugs, and defibrillation. Should the advance directive state "no CPR" the resuscitation should cease completely. In accident and emergency departments in the UK few advance directives are produced, few may be written and there is no guarantee that if they are written and produced whether they would be complied with. In Timmermans's study, the advance directives only became apparent when well into the lifesaving attempts. This issue highlights a very potential area subject for research within a U.K. context.

Scenarios of social and biological death may present in one of five ways (Timmermans, 1999). First, stabilisation or survival presents when the patient is neither socially or biologically dead the patient survives and social viability is not an issue for the staff during resuscitative effort. Second, death on arrival is observed when the patient's social and biological death coincides. Third, temporary stabilisation occurs when the patient's social death coincides with biological viability. Fourth, retroactive social death occurs when the patient's social death follows their biological death. Fifth, proactive social death presents when the patient's social death precedes biological death.

Social inequality and sudden death are inextricably linked to the staff perception of viability. As gatekeepers to resuscitative effort the staff exercise selection measures based on perceived social viability, clinical parameters and circumstances surrounding the arrest. Additionally, staff re-appropriate advanced directives, legal imperatives to resuscitate, and biomedical protocols based on the assumed social viability. Selective passive euthanasia and excessive resuscitative effort is the unintended consequence of universal resuscitation techniques. Timmermans draws attention to Bauman's (1992) phrase, "All too often, and certainly much too often for moral comfort and political placidity, the audacious dream of killing death turns into the practice of killing people" (p.160). Despite the development of new technologies social rationing during resuscitation has not diminished since Sudnow's observations of death practices in the sixties. Bauman however, does not argue that resuscitative effort is not determined by the patient's presumed social worth any longer but argues that social discrimination has shifted from "primitive" technologies to more advanced medical technologies such as organ donation and "electronic computerized gadgetry".

Timmermans's contribution is responsive to Glaser and Strauss's (1971) suggestion that "...anyone who wishes to develop a substantive analysis about any phenomenon that might be fruitfully conceived of as a status passage can considerably tighten up, as well as make more "dense", his systematic formulation by guiding his research with a sensitivity to the kinds of properties listed..." (p.9). To explain, if one thinks about a phenomenon in terms of its specific properties through the passage of time then it may be possible to specify why the various rituals and ceremonies take place in the way they do. Timmermans explored the phenomenon of CPR within a time sensitive frame highlighting the manner in which individuals are processed through the CPR experience. However, not only did Timmermans's frame the phenomenon temporally but did so within four trajectories. To do otherwise would achieve an incomplete analysis, which merely exposes a 'freeze-frame' of a single activity providing limited information. The complex permutations of each activity and the interrelated properties, coupled with a dense reporting of incidents, which deviate from the usual template of activity provide a more complete analysis of the phenomenon as it led to

comparative analysis of more than one trajectory. By centring the activity within a temporal frame, which considered status passage, illuminated relevances regarding high or low social value influencing subsequent resuscitation outcome. Such a strategy has been adopted within the sudden death thesis.

Death trajectories have been presented with reference to a temporal dimension and focused chiefly on Sudnow's social organisation of dying complemented by a range of Glaser and Strauss's death related literature within a theory generating ethnographic approach. Timmermans offered an interesting and important challenge to the earlier work of medicalised hospital death critiquing such issues as social value, advanced directives, and witnessed resuscitation and declaring that resuscitative effort possesses a default characteristic. In Chapters Four, Five, and Six emergency care related sudden death trajectories are presented using thick description to probe the very focused field of sudden death encounters in the accident and emergency setting. Prior to this it is considered necessary to explore various specific aspects of deathwork, which have an impact on the way emergency personnel manage the event.

Deathwork

Introduction

A range of literature of significance to the thesis concerns various aspects of deathwork, which facilitates understanding of the complexities of the subject. Deathwork consists of activities, which are performed by death workers in the death processing industries of pathology, forensics, medicine and clergy. Gorer (1955:50) published his seminal text on the 'pornography of death' highlighting how 'death' in the post-Victorian era was perceived as inherently abhorrent and how death could not be discussed or referred to openly. The taboo nature of the concept 'death' derives its status from the potentially polluting nature of the decaying cadaver. It is interesting to note how the concept has become universalised so that all death work may be considered 'dirty work' and how such a conceptualisation may be perpetuated by personal and social constructs related to the embodiment of death as dirty and uncontrollable. Various techniques are employed by death workers to make safe the polluting body, using dramaturgical techniques to theatrically represent the body to relatives. For the relatives and indeed the dead person the choice to have such procedures performed is limited due to the default mechanism on the part of death processing personnel and there is also an emotional price to pay for those who engage in such dirty work. The use of emotional labour and potential for incapacitation is explained using key literature sources.

The activity of death workers in the death-processing industry is of significance to the post-sudden death phase of activity displayed by emergency personnel. Similar to morticians and funeral workers emergency personnel become involved in 'dirty work' (Hughes, 1964; 1981; Howarth, 1992), which would often rather be avoided but which is an essential part of the daily activities that constitute work. Such dirty work is carried out in a range of locations, in the home of the deceased, in the accident and emergency resuscitation room, or in the hospital mortuary. Preparation of the body of the deceased prior to its theatrical presentation to relatives involves attention to detail

regarding the location, cleaning the body, tidying the body, applying cosmetics, so as to represent the death in a manner, which is considered acceptable to the remaining relatives (Goffman, 1959; Smale, 1985). Ownership and assumed ownership of the body is discussed in more detail to explain the manner by which personnel in the death processing industry assume the right to conduct such post-death procedures of embalming, despite the fact that the body is to be buried or cremated only a few days later. Emergency personnel also participate in preparation and theatrical representation of the body to relatives and such behaviours demonstrate meaning. Post-sudden death procedures and rituals literally mean that sudden death speaks for itself (Naylor, 1989). The funeral and pathology industry then, provides a rich source of transferable data to help understand sudden death practices by emergency personnel because they too enact very similar behaviours.

Prior (1987) examined the nature of the mortuary as a socio-medical-institution and the discourse of pathology, which operates within it. The meaning of the word 'mortuary' revealed how despite a range of possible meanings none of them fully grasp the unique nature of the phenomenon: a building in which bodies are stored; a place belonging to the dead; or, anything associated with death. The mortuary is considered to be a site where investigative and explanatory power of the state is exercised over social beings. Prior asserted that as a site for discovery and explanation, two sets of forces converge in the mortuary setting. First, the state's increasing concern with the minute detail of its subjects manifested in 'a silent system of surveillance'. Second, the development of clinical medicine characterised by the clinical gaze and an emphasis on reconstructing the social and pathological investigation of an individual's existence, particularly concerning the immediate period prior to death. A sketch plan of a Belfast mortuary identifies additional functions to those cited by the then Ministry of Health (MOH.20, 1963) which are: keeping bodies until burial can be arranged; investigation of cause of death by a pathologist; and, viewing or identification of bodies by relatives and friends. First, documentary evidence on the social identity of the cadaver is kept in an office, and second, a spiritual dimension is accommodated in the use of a chapel where religious

ceremonies take place. A Register of all cadavers to and from the mortuary is a fundamental requisite, "Within the storage area there should be a space for each body, isolated, marked, and recorded in the written documents around which the mortuary circulates. Such disciplinary space has as many sections as there are bodies to be distributed, and upon these physical spaces are grafted the therapeutic and administrative practices through which the system operates" (Prior, 1987:358). Not only does the cadaver require to be identified but the body storing spaces also require to be identified and marked accordingly and such objectification is another item in the mortuary system that results in the body being referred to as 'it'.

Prior describes how the construction of the Belfast mortuary aimed to segregate death from public gaze. Its location is to remain unreferenced, secret, and unknown, indeed emergency personnel affirm the existence of a pathological discourse in relation to the use of the term 'mortuary' by the use of alternative words such as 'Chapel of Rest' or 'Rose Cottage' when referring to the mortuary. The building was isolated from other hospital buildings, which signifies the separation of functions to be performed within it. Even the modern mortuary is located at the back of a hospital just as it was located outside the city walls as the cemetery used to be. The entrance should be screened to avoid the risk of upsetting patients and to deter the 'inevitable curious onlooker' (Knight, 1984) and this issue is significant when discussing the comments of the paramedics at the point of contact with the mortuary. Specifically, the entrance for the cadaver is located in a different place to the entrance which relatives and friends would go through, deliberately arranged to make it impossible for relatives to enter the place where the bodies are.

Embodiment

According to Bourdieu (1977) aspects of the 'body', which are considered essential to its nature are reflections of ideologies that are exposed through discourse and social practices (Hallam et al, 1999). The cognitive construction of 'body' is important in understanding dramaturgy and ritual in sudden death because it helps to explain the way in which members of social categories such as 'funeral director', 'emergency

personnel', 'grieving relative', are positioned in relation to the body of the deceased. Social, political and economic systems determine how an individual acts on assumptions, which are determined either within or on the body. Death creates distance from the body as such "It is in death that the object-like nature of the body becomes most visible. Rather than the smoothly managed object which, as adults with social and economic resources at our disposal, we can dress and position in socially advantageous ways, our dead body lies totally beyond our control, shamefully breaching the boundaries over which, since our early childhood we learn to maintain vigilant control" (p.205). The funeral director is positioned to re-construct the identity of the body, which the body at one time had, followed by discrete distancing from the represented body, and concealing details of the mechanism by which the body was reconstructed. On reconstructing the body as the person it once was the undertaker must conceal the violence inflicted on the flesh in the effort to reconstruct. Similarly, emergency personnel conceal evidence of violent resuscitative effort prior to relatives seeing the body. Defibrillation pads, intra-venous cannulae, and endo-tracheal tubes are removed and blood is washed away. Surgical incisions, which rapidly exposed the heart for open chest cardiac massage, are covered with a large white post-operative pad. Intra-venous cut-down incisions which were made to then suture a vein onto the surface of the skin of the forearm providing immediate access for re-hydration and drug administration are also covered with a post-operative pad, or bandage.

Turner (1991; 1992) challenged the Cartesian division of mind and body associated with dualism, reductionism, and positivism, which resulted in a disembodied sociology. The omission to integrate the notion of 'body' created academic division as the two realms, body and mind were addressed within two distinct disciplines: natural science including medicine; and cultural sciences or humanities including the mind. Turner claimed that sociology suffered at the hands of such division by neglecting the importance of common-sense discussion of the human body within aspects of social life concerning health and illness, religion, death. The significant absence of the body from sociology generated problems in the construction of sociological perspectives. The sociology of the body acknowledges the essentially

social nature of human embodiment, social representation and discourse of the body, a social history of the body, society and culture. Scott and Morgan (1993) questioned first, why there was an apparent absence of sociological interest in the body until very recently offering the following explanation. Where bodily matters have prior been the concern of social anthropology the rivalry between the two disciplines has perpetuated bodily absence. Second, why has a recent upsurge in embodiment interest emerged across a wide spectrum of disciplines? It is forwarded that feminist theory and critique accounts for much as do Foucauldian explanations of body positioning and power. Additionally, the detachment and removal of the body as a solid separate object positions modernity as the driver. This is particularly observable in the medicalisation of health and hence death.

At an individual level it is argued that people have control over their own bodies, in the sense of 'embodiment' yet until two decades ago this had not been addressed within an anthropological phenomenological frame regarding the experiences of the 'lived body'. Frank (1991) rejects Turner's societal model, which approaches the problem of the body from the society down to the individual. Instead Frank advocates an orientation toward the body's problems, to explain how the body is a problem to itself, as such the body possesses action problems rather than societal problems. Highlighting an example of medical dominance over the female body, Frank discusses Fisher's (1986) gender based patriarchal view of the trajectory of a woman's body. "What counts is to protect a woman's fertility during child-bearing years, to regard birth itself as dangerous and requiring professional intervention, and finally to view an older woman's sexual organs as disease producing and best removed" (p.214). No matter how women see themselves in medicine, they are not central to the decision-making process that process is controlled and is controlled by men. The transferable concept here is found in the embodiment of death whereby the death processing industry controls body disposal and rituals surrounding disposal reinforced by the power of the state and the church.

The body 'polluting'

Shilling (1997) claimed that it is in the context of the body's inevitable death that its full social importance is understood. Shilling refers to Peter Berger's (1967) argument that humans are a species whose notion of embodiment force them to act, and to invest themselves and their actions with meaning in order to survive. Individuals construct their world and give meaning to those constructions. Death is managed through shared meaning systems, which minimise the threat which death brings to societies 'self-building' and world-building' activities. Social institutions have firmly established interpretations of the world and rules for body management, behaviour and appearance and this is particularly so in uniformed service based professions. Such body rules prevent the leakage of conflicting realities to the rest of the world for fear of jeopardising social order. Death challenges the taken-for-granted 'business as usual' attitude in society becoming an existential problem in that it inevitably leads to fears regarding mortality, decay and decomposition. It is dreaded and stigmatised in terms of society's embodied identity. Gidden's (1984) 'ontological security' is threatened requiring that death be attended to, managed, controlled. The death processing industry is adept at recreating ontological security or 'normalising' the situation through representing the body as it was before death. There has been a societal withdrawal from inevitable death manifested in death procedures of embalming, cosmetic application, rather than a meaningful attempt to deal with death. To display death otherwise is considered distasteful and socially unacceptable.

Douglas (1970) argued that 'bodily order' is maintained by its symbolic properties including its orifices, pollution and waste. Social and physical categories sustain a continual exchange of bipolar meanings that amount to the body politic (i.e. sacred and profane, purity and danger, risk and taboo, order and chaos). Douglas's example of 'dirt' explained how the structuring of ideas around a concept is vulnerable at its margins (Williams and Bendelow, 1998) and pressure is exerted at socially and ritually proscribed boundaries to retain bodily order. Grosz (1994) explained how bodily orifices and marginal matter are potent symbols of power and danger, pollution

and taboo. The body provides a metaphor for social order and social disorder. Whilst the body is inherently ordered, bodily seepage represents dirt, disgust and horror and the impossibility of clean, pure and proper. Demarcation of body boundaries are threatened by the ability of the body to exude bodily fluids e.g. blood, milk, urine, faeces, vomit, sweat and tears. Escaping fluids traverse the boundaries of the body re-ordering the bodily fluids as 'out of place', threatening the margins of the body politic. Dirt and pollution is directly related to order and disorder. To counteract the body 'polluting' society generates higher social controls to make safe threatened bodily order. It is at the margins of the body politic that emergency personnel and the death processing industries operate and such procedures are made using the dramaturgical process of theatrical representation of the body to the relatives.

Dramaturgy

Dramaturgy refers to the process of representation, the manner in which individuals make presentations of self to others (Goffman, 1959). Dramaturgical sociology has its roots in Simmel's (1950) concept of 'sociation' concerning the crystallised interactions among people (Denzin and Lincoln, 1998). Multiple relations between individuals in constant interaction with one another constituted society and Simmel's unit of analysis was defined by an individual's relationship to others through a 'relational feature' such as marginality, conflict, and subordination. Direct observation of a phenomenon placed Simmel in an excellent vantage point. Denzin and Lincoln (1998) claimed however, that "Observers need close access to their settings and subjects to enhance direct insight and understanding but their failure to be admitted to the center of action gives them a role that fosters scrutiny of those at the centre as well as those on the outside" (p.91). Goffman also studied how people act in front of others and how individuals formed relationships and carried off personal constructs of self in the presence of others. During encounters with sudden death both relatives and deathworkers attempt to maintain orderliness in their behaviour despite the sometimes extraordinary set of circumstances which are to be faced. The observed become a performing team whilst the observers become an audience (Bradbury, 1990)

for whom a theatrical representation of the body and hence social values concerning death are acted out. Williams (1894) lyrically described such representation in his dealings with the death of a young girl whilst working as a physician in a Dublin hospital in the following extract from his verse:

“...Before the sun had risen
Through the lark-loved morning air,
Her young soul left her prison,
Undefined by sin or care.
I stood before the couch in tears,
Where pale and calm she slept,
And, though I’ve gazed on death for years,
I blush not that I wept.
I checked with effort pity’s sighs,
And left the matron there,
To close the curtains of her eyes,
And bind her golden hair.” (p.222)

Turner and Edgley (1976) discuss the dramaturgy of death in an analysis of the American funeral and in doing so trace the origins of dramaturgy to the work of Kenneth Burke (1969). Dramaturgical metaphor was considered to be the best mechanism to reveal human social life and Burke assumed that investigators should begin by analysing theories of action rather than theories of knowledge. Burke (1969) defined five principles for the investigation of dramatisation: act, scene, agent, agency, and purpose. The act must be named to make it identifiable in terms of what took place. The scene provides the background in which the act occurred. The agent is the person or people who participate in the act, whilst the agency refers to the instruments or ‘props’ used in performing the act. Finally, the purpose of the act may be defined and redefined depending on how the act is interpreted. On investigating fifteen mortuaries in three United States cities, Turner and Edgley (1976) used the

dramaturgical metaphor to understand relationships and interactions that feature in the American funeral.

Funeral directors are considered to be actors who stage a performance to an audience comprising bereaved family and friends. The dramaturgical display is one of competence, sincerity, dignity, respect and concern. There is only one opportunity to make maximum impact, as it is not possible to repeat the funeral act in the event of a mistake. Favourable impressions are to be generated among the audience for the funeral home to retain its marketable credibility as a quality assured service provider. An extensive range of activity occurs backstage, strategically hidden from the audience. Information about the activities is shielded from the audience because it would be incongruous with the desired effect. Such information is deliberately withheld so as not to contradict, alter, qualify, or destroy the impression fostered front stage and various territorial enforcers signify the boundaries such as doors, curtains, locks, and 'employee only' signs. As in Prior's mortuary, spatial boundaries segregate medical pathology from bereavement and grief. Medicalisation of the pathology area reinforces the boundary line to the relatives in a similar way as the resuscitation room is assumed to be 'out of bounds' to relatives despite the expressed desire of many to be at the relative's side at the moment of death. Nevertheless, relatives rarely cross the boundary line unless invited to do so. Such boundaries prevent relatives from accessing the distasteful elements of death work which involves body washing, shaving, disinfecting, slicing, piercing, creaming, powdering, waxing, stitching, painting, manicuring, dressing, and positioning. It is Turner and Edgley's view that relatives would prefer not to learn about the activities and choose an acceptable ignorance in relation to the 'mysteries' of the body preparation room.

It is only in the last year that the Department of Health has been called to account by relatives who collectively demanded information regarding the extensive retention of body parts from cadavers for research and teaching purposes (Department of Health, 2001). Such accountability exposed a culture of patriarchal arrogance and oblivion among medical staff regarding a failure to obtain informed consent for post-mortem

and also for retention purposes. This UK wide controversy resulted in co-operation between pathologists and relatives' groups to develop a leaflet 'Guidelines for the retention of tissues and organs at post-mortem examination' (Royal College of Pathologists, 2000), which seeks to empower relatives regarding this specific aspect of back room activity. One further example where oblivion in grief was shattered was through the exposure in national newspapers of the 'Bodies in the Chapel' furore, which subsequently called for the resignation of the Chief Executive of Bedford Hospital Trust (Donnelly, 2001). Despite the apparent lack of respect and dignity shown to the dead by the publication of photographs in the national press of eight bodies lying alongside one another on the mortuary chapel floor the quality assurance body the 'Commission for Health Improvement' found no evidence to suggest a general lack of respect for individuals at the hospital. It is from such instances of unanticipated exposure of mismanaged death worker practices that medical pathology, bereavement and grief collide to form a public mistrust of the death processing industry. Some months later the Chief Executive declared that a refrigerated mortuary body storage cabin, commissioned on a temporary basis to cope with mortuary overflow had a jammed door so as a temporary measure a decision was made to place the bodies on the mortuary chapel floor.

The identification, observation and restoration of the cadaver are the remit of mortuary staff and the mortuary system creates its own sentimental order. Once post-mortem is complete it is the role of the technician to restore the body to as near natural presentation as possible within the confines of surgical procedures. Effort is made to create a 'restful pose' in preparation for relatives' viewing the body. Attention to lighting, decoration and the application of blusher is the concern of the technician aimed at the continuation of sentimental order (Glaser and Strauss, 1965) because spontaneous outbursts from relatives are considered a nuisance. The use of the glass partition for viewing purposes as recommended by the Ministry of Health (MOH:20 1963) has been challenged in recent years because relatives increasingly wish to touch, hold and cradle the body, especially if the body is an infant or child (Wright,

1991). These changes in practice perhaps signify a rearrangement of the bond, which exists between the living and the dead.

Using Geertz's (1973) 'thick description' Ellis (1993) gives voice to her own emotional experiences recalling how her brother's body was represented in the funeral home. "I stand close to him as the director opens it. I am not afraid of you. I love you. There he is. Is it him? I have to be sure. I know it is. I dare hope and know it is impossible that they have made a mistake. But it doesn't look like him. His face is swollen and his nose, from being broken, is flatter and much bigger than usual. And that dead colour doesn't help either. The huge gash on his forehead glares at me from underneath multi-layers of pasty make-up. I swallow, and it is MY head hitting the front seat as we crash. He is shrouded in polyester, dead clothes complete with clip-on tie, an outfit that would have horrified him. I want to dress him in his own clothes. But, my Mom has proudly announced she told the funeral director to put him in a new blue suit. No one else is going to see him. What difference does it make anyway?" (p.720).

Techniques to neutralise and account for unpleasant aspects of their vocation parallel those employed by other professions when dealing with 'dirty work' (Hughes, 1964). Using an ethnographic approach, Howarth critically evaluated 'bodywork' and ceremonial practice within the much denigrated and maligned funeral industry in the East End of London, and the dramaturgical metaphor (Goffman, 1959) to interpret the theatrical aftermath of death. Focusing on the interplay between funeral workers and customers and the roles each take in the rituals, which precede and follow upon death, death work was heavily influenced by an interpretation of popular beliefs regarding maintenance of the correct social and physical distance from death. Of significance is the workers relationship with the dead body, the housing of the cadaver and the acceptance of responsibility for funeral organisation. Similarly, such a relationship is manifested in the willingness of the emergency disciplines to take responsibility for the body and engage in body representation. Though it is argued that the paramedic

and traffic officers would prefer to distance themselves from these activities more than the nursing discipline, which perceives body preparation as central to their role.

Howarth draws on Goffman's (1959) 'personal front' explaining how the public do not get to see or learn of the back room activities of embalming. Goffman (1959) claimed that any social organisation should be studied from the perspective of impression management. "Within the walls of a social establishment we find a team of performers who co-operate to present to an audience a given definition of the situation. This will include the conception of own team and of audience and assumptions concerning the ethos that is to be maintained by rules of politeness and decorum. We often find a division into back region, where the performance of a routine is prepared, and front region, where the performance is presented" (p.231). All three emergency disciplines are involved in dramaturgical representation of sudden death. The back room activities of body handling and preparation involves covert participation prior to overt theatrical presentation of the body for the supposed benefit of the relatives. Building on the work of Aries (1994), Bradbury (1993; 1996) discussed contemporary representations of good and bad death. In an investigation into how people behaved at the time of death, access was gained in natural death settings specifically, the hospital, the funeral parlour, the registry office, the crematorium and the cemetery. Additionally, interviews of grieving women identified categorisations of good or bad death (Bradbury, 1993). Bradbury concluded that there is no single, all-embracing, definition of a good or bad death. Rather, an ever-shifting 'kaleidoscope' of categorisations emerge which suggested that three types of good or bad death were experienced according to three interwoven elements such as how sacred, medical, or natural the death event. Significantly, neutral death does not appear to exist.

The social processes visible in the death processing industry help individuals to understand the world through discourse and patterns of behaviours. Bradbury (1996) forwarded that individuals represent the world to each other through their talk and also through their actions. "When someone dies orderly life is dramatically disrupted

and there is an urgent need to re-present reality” (p.84). Representation of death is discussed at length in literature regarding the idealisation of death and the nature of the deathbed scene in Dicken’s description of the death of young Nell in his classic text, ‘The Old Curiosity Shop’ (Bronfen, 1992). Efforts are made to represent the death as the survivors discuss the quality of the deceased’s death and mortuary practices not only reflect or emphasise the label applied to that death but also serve to produce further representations. So, to create representations of death can be perceived as a means of gaining control over a “potentially chaotic situation” (Bradbury, 1996). To this end, good death was associated with positive statements among professional death workers, about the appearance of the body, the painlessness of the death itself, and the analogy of death to ‘falling asleep’. Viewing the body is more likely in those circumstances. Reference was made to the timeliness of the death event, and relatives were guided to temper excessive expressions of grief as it was considered to be inappropriate. In contrast, the death worker adopted a self-imposed role of ‘protector of the bereaved’ to shield the bereaved from upsetting information which would make the situation more difficult to manage. This was manifested in selective avoidance of information giving or even downplaying the extreme nature of information regarding for example, mode of death, pain experience, and physical mutilation. Viewing of the body was less likely, indeed discouraged by the death worker. Back room possession of the body empowers the death worker because the bereaved can not contradict the medical representation of the death, the bereaved are disempowered and have no choice but to believe the information given to them. This situation is transferable to the emergency personnel, suddenly bereaved interaction.

The spatial organisation and communication format and their influence on choices of goods and services are important features of the organisation. The ‘closed network’ explains the undertaker’s relationship with other death workers. Scientific transformation or humanisation of the cadaver is explored using the embalming and theatrical presentation techniques, which have significant impact on ritual viewing of the corpse. The perception of the dead body as polluting is common to many societies (Hallam et al, 1999) and the public health drive since the nineteenth century is

concerned with the separation of the dead from the living because the corpse is considered capable of contaminating the living. Morticians are charged with the responsibility of rendering the corpse harmless and this 'expertise' represents a professionalisation of death management. Pseudo-scientific techniques are used e.g. arterial embalming enables the mortician to re-establish the body's social and conceptual boundaries using invasive procedures which drain body fluids and rehydrates with formalin, a preservative chemical. "A metal rod with a length of tubing attached to it is inserted into the lower abdomen. The rod is then twisted and turned until the body fluids begin to flow out via the tube. The next step is to replenish the emptying vessels with formalin. A small incision is made in the carotid artery at the base of the neck. From here the chemical is pumped into the body. Gentle slapping or massaging of fingers and lower extremities of the limbs assists the movement of chemical around the body. The chemical revitalizes some of the fundamentally human characteristics of the body, transforming the colour of the skin and artificially restoring its elasticity" (p.130). Bradbury (1999) provides a photograph portrait of hands taken in an embalming room, which clearly demonstrates the in-elasticity of the skin prior to the embalming procedure compared to the embalmed hand. The distinction between good and bad death is about control over the death and dying. It is about separation and privatisation of death and sorrow.

Smale (1985) explored the funeral directing occupation as retailers of commodities necessary to move a dead body through specific stages to final disposal. Those who hire them will normally only see the outward consequences of their service since their work-practices and actual work areas are concealed from all except those claiming a legitimate work involvement with the dead. The occupational skills and techniques, which are part of their regular daily work are not open to public view, and the customers who employ them come to judge their competence on the basis of a small but highly visible part of their total work. What goes on in the concealed areas of a funeral 'home' must be guessed; what degree of dignity, care, expertise or efficiency are commonly exercised remains unknown. It is the performance of the particular firm when a body is viewed in the funeral home or when the funeral is staged, that

makes or mars the credibility of the funeral director and most people judge the occupation from their particular experience of it.

Smale tracked the emergence of the funeral industry since medieval times considering issues of secular power, religious piety and social control which influenced the conduct of such a service. The obvious source of error in historical accounting is the fact that much of the evidence concerns only the behaviour and attitudes of the nobility and upper classes in that "The poor are silent and faceless" (p.62). Today funerals are 'functional', fulfilling a specific social need whereby relatives and the total community need to be liberated from the cadaver, by sanitary disposal. By examining the actual funeral procedures widely practised in Britain since the medieval period, Smale claimed that it is possible to trace the emergence of the modern funeral director. Social control, specialisation, commercialisation and secular rationality have been integral to their rise from obscurity to dominance in funeral affairs.

Funeral workers are actors with first draft script, make-up rooms and rehearsal halls, supportive casts and demanding directors, stages to strut and positive roles to sustain. They have entrances and exits to negotiate, 'props' to handle, and interpretations to project. They are crucially concerned with 'impression management' and the presentation of occupational selves that will be authenticated by knowledgeable audiences (Goffman, 1959:183). The stage represents a world of events experienced by human performers. Dramaturgy should not be regarded as a metaphor of real life it is a descriptive account of everyday life. Life is a drama and it is the stage, which reflects its incongruities and passions. It is possible to judge the consequences of playing out particular roles by observing the staged performances, which encourage greater sensitivity to the 'real world' of social drama. The central question addressed by Smale's research is 'what is going on?' but this must be focused on a time, place, a circumstance, a social occasion, or on specific individuals.

Dirty work

Dirty work is significant to the study of sudden deathwork in terms of the emotional impact of body handling by emergency personnel (Taylor and Frazer, 1982; Jones, 1985; Alexander and Wells, 1991; McCarroll et al, 1993). Dirty work is considered so because it may be physically disgusting and a symbol of degradation which is wounding to an individual's dignity and works counter to moral conceptions. In 1958 Hughes (1981) explained how in describing the nature of their work individuals select the most favourable of possible titles to their audience. The salesman may use the term 'I'm in sales work' or 'I'm in promotional work' rather than 'I sell skillets'. Even the social scientist may emphasise the 'scientific' dimension of the role in a self-awarding of prestige and status. It is established then that an individual places much importance on the contribution of work in relation to social identity. Hughes believed that characteristics of high-prestige occupations are identified when applying the concepts learned about low-prestige occupations. An example is the apartment-house janitor (Gold, 1952). This employee makes a living out of doing other peoples dirty work. Some elements of the role of janitor do not necessarily fit the criteria of dirty work including security or cleaning functions, and the overall role is likely to comprise a range of activities.

When asked what the toughest part of their job as janitor was Hughes reported how they were bitterly frank about their physically dirty work. "Garbage. Often the stuff is sloppy and smelly. You know some fellows can't look at garbage if its sloppy. I'm getting used to it now, but it almost killed me when I started" (Hughes, 1981:50). Another janitor commented, "...It's the messing up in front of the garbage incinerator. That's the most miserable thing there is on this job. The tenants don't co-operate – them bastards. You tell them to-day, and tomorrow there is the same mess over again by the incinerator". According to Hughes the second quotation introduces animosity towards the tenant for impinging on the ordered daily activity of the janitor. On the other hand the janitor regains a feeling of power over the tenant by filtering through the garbage revealing a range of information which no doubt the tenant would prefer

not to have revealed to the janitor, from torn-up love letters, to financial ruin, to menstrual sanitary wear.

Of special significance is the study by Alexander and Wells (1991) which explored the impact of body handling following the Piper Alpha oilrig disaster on 6 July 1988. One hundred and sixty-seven men died in the disaster and several months after the explosion one hundred and five bodies were still missing. It was established that many were entombed in the accommodation module of the platform but it was not until several months later that the module was recovered from the seabed to be searched for human remains by Grampian Police Force. "The accommodation module, about the size of a three-storey hotel, was a dangerous and unpleasant environment to search. Seventy-three bodies were successfully recovered; not surprisingly, many were in a very poor condition. They were taken to a temporary mortuary on the outskirts of Aberdeen. There, another group of police officers stripped, washed and photographed the bodies, and aided the team of local pathologists in the post mortems. Nineteen bodies were dissected per day, and each body was allocated to a particular officer who took responsibility for the inquiry into its identity" (p.547).

Usually dirty work will be delegated to someone else to perform and often that tabooed work is given from someone of high status to someone of low status. In hospitals the cleaning role which was once carried out by nurses and hospital porters was strongly resisted during the militant 'work to rule' era of the early nineteen eighties. The mopping up of spills was considered by these groups of employees as the domain of cleaners, and only of cleaners. However, where emergency care is the issue at stake, the dirty work of body handling becomes an intimate part of the very activity, which gives the occupation its charisma. Hughes suggested that within medicine dirty work somehow became integrated into the whole and into the prestige-bearing role of the individual performing the occupation. The janitor does not tend to integrate the dirty work but simply abhor it and the people who generate that aspect of work for him. For emergency personnel there is a very real distinction between those

individual cases of dirty work, which would be considered appropriate for integration and those, which would not. Consider the cleaning of vomit from a patient. If the patient was drunk, abusive or violent perhaps the emergency personnel may be more likely to abhor the individual who required the dirty work. Where the same dirty work is performed on a frail elderly and co-operative woman suffering a brain haemorrhage the dirty work would be integrated into the prestige-bearing role. Associated comments related to the privileged position of the carer in performing the cleaning may be given.

Overall it is possible to classify occupation, in relation to the performance of dirty work, into those in which it is integrated into a satisfying and prestige-giving definition of role and those in which it is not. Within emergency care allowances are made for it to not integrate when the patient's demeanour deviates from the prestige-giving definition 'carer of the sick'. To emphasise this point, those who's injuries or situation are self-inflicted are considered not to deserve the care and attention of emergency personnel. So emergency personnel may abhor the nature of the task such as wiping away the vomit, whilst not abhorring the person. Alternatively, emergency personnel may abhor the task as well as the person. One scenario described by a traffic officer involved the death of a young man who was constantly in trouble with the police. When he died the officer predicted with a tongue in cheek manner how the local crime rate would reduce by about fifty per cent. The death of this 'wrong un' was met with a sense of legitimacy by traffic officers but created a dilemma for them when dealing with the emotional needs of his parents.

Involvement in sudden death work brings emergency personnel in contact with a range of situations which are potentially abhorrent for example, cleaning the dead body, giving news of the death to relatives, talking with distressed relatives en route to the mortuary, checking and giving property to relatives. However, Hughes (1971) maintained that a task that is 'dirty work' can be more easily endured when it is part of a good role, a role that is full of rewards to one's self. Hughes suggested that a nurse might perform some roles with more grace than someone who is not allowed to

call herself a nurse and when dubbed as a sub or non-professional. Emergency personnel, but in particular nurses, are heard to express a privileged position to be able to be involved in the care and support of the deceased and distressed relatives. For some the role is so perceived that the nurse becomes quite protectionist in terms of retaining this aspect of care within the remit of the qualified nurse rather than the health care worker.

Emotional labour

Adding to the field of dramaturgy is Hochschild's (1983) 'The Managed Heart', which analysed the act of displaying behaviour compatible with the occasion defining such an act as 'emotional labour' and examples of the cheerful flight attendant and the compassionate nurse are provided. A number of studies have explored emotional labour in commercial organisations, particularly, Disney employees (Van Maanen and Kunda, 1989), Mary Kay cosmetic agents (Ash, 1984), and on secretaries and their bosses (Pringle, 1988). When conforming to role expectation, and in considering its importance in western society, individuals may pay a psychological price for involvement in certain aspects of their occupational role. Emergency personnel are designated aspects of their role by senior colleagues however, an element of preference exists in relation to certain duties an individual would choose to participate in and those they would feel resigned to perform. Ashforth and Humphrey (1993) define emotional labour as the "display of emotions by service agents during service encounters". Discriminating between Hochschild's 'feeling rules' of flight attendants, Ashforth and Humphrey prefer to use the term 'display rules' in that the former is a statement of what ought to be publicly expressed and the latter refers to that which is actually demonstrated. The act of displaying behaviour compatible with the occasion (display rule) relies on facial and physical gesture and is termed 'emotional labour'. Emotional labour is "the management of feelings to create a publicly observable facial and bodily display" to be "sold for a wage". The focus is on an emotional performance that is bought and sold as a commodity, which can be readily applied to service based professions such as emergency personnel. Zeithaml, Parasuraman and

Berry (1990) referred to customer evaluations highlighting dimensions, which they considered were important in service provision involving courtesy, credibility, access, communication, responsiveness and understanding. So the service encounter is a social encounter in which it is assumed that customers know what constitutes good service, whilst service agents are literally 'on stage'.

Hochschild's surface acting provides some protection from some of the effects of emotional labour. In surface acting the body, not the soul, is considered to be the main tool of the trade and is manifested in perhaps, the raised eyebrow or the tightened upper lip. Surface acting refers to the expression of feelings in institutionally approved ways inducing an emotional attachment in the audience, yet the actor is simply acting as if there was feeling whilst the audience is the mirror of the surface enactment. Deep acting focuses on inner feelings and demands greater psychological effort and there are two ways of deep acting: by directly exhorting feeling; and by making use of trained imagery. Individuals use phrases like, "I psyched myself up" for such situations or "I squashed my anger down", or "I try not to feel disappointed" adjusting to a situation. Deep acting is considered to be an indicator of a strong concern for one's customers in a service-based role and has a strong link to method acting in that the player becomes absorbed into the fantasy of emotional feeling. There seems to be a fine line between deep acting and loss of emotional control and this provides a third route for emotional labour. The display of raw emotion is considered genuine and occurs when a point of exhaustion is reached. In emergency care, showing concern towards relatives and managing the situation can unexpectedly change however, whether this metamorphosis is related to extremes of behaviour from relatives that trigger subsequent responses from the nurse is difficult to determine.

In one's private life the individual is the locus of the acting process however, institutions create more complex mechanisms for such acting. Emotion management becomes the business of the institutions through a wider range of actors, rules and customs and acting is directed to control the desired feelings of worker's emotions

and subsequently the worker's use of the term 'as if'. Some institutions have developed very sophisticated techniques of deep acting, which suggest to the worker how they might imagine and how they might feel. Hochschild (1983) refers to Lief and Fox (1963) who explain how the scientific rather than emotional climate is created. "The immaculate, brightly lit appearance of the operating room, and the serious professional behaviour required, justify and facilitate a clinical and impersonal attitude toward death. Certain parts of the body are kept covered, particularly the face and genitalia, and the hands, which are so strongly connected with human, personal qualities, are never dissected. Once the vital organs have been taken out, the body is removed from the room, bringing the autopsy down to tissues, which are more easily depersonalized. The deft touch, skill, and professional attitude of the prosector makes the procedure neater and more bloodless than might otherwise be the case, and this increases intellectual interest and makes it possible to approach the whole thing scientifically rather than emotionally. Students appear to avoid talking about the autopsy, and when they do talk about it, the discussion is impersonal and stylized. Finally, whereas in laboratory dissection humor appears to be a wide-spread and effective emotional control device, it is absent in the autopsy room, perhaps because the death has been too recent and [humor] would appear too insensitive" (p.12).

Attention is drawn to the distancing of emotion in academic work through student instruction to avoid the use of the word 'I' and other distancing techniques e.g. use of Latin script. However, this is questionable in the field of social sciences where it is legitimate to demonstrate involvement and close proximity to the area to be studied. Collective emotional labour is demonstrated at its best in team working. Hochschild (1983) uses the example of US flight attendants and explains the commercialisation of feeling rules. Team intimacy is high among the crew and is outwardly acknowledged as a valued dimension of team harmony and productivity in that the job could not be performed well in the absence of collective emotional labour. The job is described as an "emotional tone road show" in which friendly conversation, banter, and joking generates cohesion. "Indeed, starting with the bus ride to the plane, by bantering back and forth the flight attendant does important relationship work: she checks on people's

mood, relaxes tension, and warms up ties so that each pair of individuals becomes a team. She also banter to keep herself in the right frame of mind. As one worker put it, "Oh we banter a lot. It keeps you going. You last longer" (p.115). There is a mutual avoidance of negative dialogue and a sense of community spirit, fostered in reciprocal positive interaction.

Wouters (1989) vigorously challenged a number of Hochschild's assertions, claiming that both Hochschild's point and also Wouter's critique had been mutually misunderstood. Wouter claimed to have had no objections against the concept of "emotional labour" and "feeling rules", indeed the emphasis on the expanding service industry and demands on emotion management of employees on the 'human assembly line' was considered excellent and stimulating. However, the reporting mechanism and the way data was incorporated into the framework were the chief objections. Certain contradictions were considered by Wouter to exist in the book, 'The Managed Heart'. Many examples of feeling rules that are deep inside the individual were neglected within the theory and Wouter went on to expose a defensive Hochschild, "...she accuses me of projecting secret, even sneaky intentions into her text" (p.447). Further, Hochschild is exposed as having performed some 'display work' herself in order to become readable and to get her book printed, as many businessmen would 'turn on the charm' to sell something.

The issue of power, privilege and class in relation to emotional labour had not been raised at all. Wouter claimed that today (1989), emotional labour had crossed the old dividing line between social classes and is performed by people who do not belong to groups, which formed the previous establishment such particularly, doctors, writers, priests, administrators, businessmen and politicians. These people were on the subordinate side of power relationships and like the working classes were considered to be outsiders more likely to be ranked in the middle classes, perhaps because they shared some of the features of the middle classes regarding experience and expression of emotional labour. When emotional labour was deemed to have descended the social ladder via an expanding service industry the middle classes paradoxically

expanded. The extreme differences in class (i.e. status and power) reduced and did so in particular, through diminishing contrasts in showing superior and inferior feelings.

Wouters agreed however, with Hochschild's assertion that the expansion of the service industry increased demands on emotion management. As increased numbers of individuals made a living through the performance of emotional labour, pressure was put on each individual to take more of each other more into account whereby stronger levels of integration and tighter knit networks of mutual inter-dependence create a mutually expected level of self-restraint. Hochschild contributed to the acceptance of the dramaturgical perspective by explaining service industry attitudes and behaviours permitting service industry employees to profit from the emancipation of emotions by allowing more "jazz in human exchanges" (p.449).

Tracy and Tracy (1998) investigated the use of emotional labour in the emotionally charged atmosphere of an emergency 911 centre using tape-recorded calls to the police and 911. The analysis unfolded blatant and subtle conversational moves that enact rudeness and considered what features of the work environment that challenged the call-takers' management of emotions in institutionally approved ways. Two earlier studies (Mumby and Putnam, 1992; Putnam and Mumby, 1993) challenged Simon's (1976) assertion of a 'bounded rationality', which emphasised a dichotomy between rationality and emotion whereby efficiency and effective functioning was disrupted by the influence of emotion. Putnam and Mumby preferred the ideal of 'bounded emotionality' arguing for the importance of emotion to be recognised in the workplace.

Tracy and Tracy pose two arguments to Hochschild's work. First, Rafaeli and Sutton (1987) questioned whether it is categorically harmful to fake emotion if it is done in good faith or bad faith. Hochschild declared that it is more harmful to "feel happy when you're not" than to follow expression rule, which require that employees "smile at all customers". Such organisation rules, regulating the internal feelings of the employee are also considered harmful when the employee does not believe in them.

The second argument centres on emotion suppression rather than display, which is prevalent in service based disciplines employing emergency personnel who employ techniques involving rationalisation, distancing, or denial, to make an encounter emotionally safe. Emotion suppression is a necessary part of professional work, but it is far-fetched to consider it a commodity, as Hochschild clearly did.

The theoretical frame relating to sudden deathwork builds on the work of Wright (1991) who captured the inner life of individuals traumatised by sudden death. Influenced by his passion for the subject and his charismatic rescuing aura, a reflection of his role as nurse and crisis intervention counsellor, Wright's text becomes quite absorbing. Whilst in therapist and researcher role he was at pains to describe in some detail particular events from both the experiences of the distressed relatives and also those of the emergency nurses. Wright discussed reactions among relatives, which incapacitate the carer. It is interesting to note that the emotional responses to news of a death, which carers identified as inducing personal discomfort in handling, similarly relatives identified the same aspects at a later date. So the relative is aware of the carer's difficulty in handling the event. One nurse recalled a relative who expressed how sorry she was that a young nurse had to bear the burden of her pain whilst the relative was going through such a traumatic event. Nine emotional responses from relatives that emergency personnel find difficulty in coping with are: withdrawal, denial, anger, isolation, bargaining, inappropriate responses, guilt, crying, sobbing and weeping, and acceptance.

In withdrawal the relative becomes inaccessible or mute and there are long periods of silence spent waiting for a response during this period the carer is often at a loss as to what to say and finds lengthy silence most difficult to handle and sometimes wanting to leave the scene. Yet this period of withdrawal is functional in that the relative is taking time out to assimilate the meaning of what has been said and later reflection would suggest that those relatives valued the carer 'being there' even though nothing was said.

Denial is accompanied by a declaration, which defies the reality of the news of the death. "This can't be true" or "You must have the wrong person". Sometimes the statements are vigorously defended and can be reinforced physically by the relative perhaps turning their back on the news giver or covering their ears to eliminate the sound. Such denial requires that the carer repeat the information, which makes the carer feel as if they are "kicking someone when they're down" (p.93).

Anger is often perceived in a negative way yet it is an extremely effective cathartic expression of emotional pain in the crisis of sudden death. It is manifested among relatives in a range of behaviours from mild irritation to outbursts of physical rage, which can become a real problem for emergency personnel in terms of personal safety. Of much discomfort for emergency personnel is the anger directed towards the deceased such as the driver who in the eyes of the relative "always was an idiot at the wheel".

Isolation can sometimes be expressed by relatives, which remind emergency personnel of the vulnerability of being suddenly alone, of being helpless and having nothing more to live for. These powerful expressions can generate feelings of ineffectiveness among carers who find they have little to offer in terms of comforting words and inability to put things right.

Bargaining can be an amazingly strong mechanism to observe in a relative, which involves an attempt to postpone death by arranging a pact. Often there is remorse for poor behaviour or a promise of reconciliation of conflict with another person, or to God. I remember a mother whose teenage son was brain injured who persistently pleaded with me to save her son. An offer of any specified amount of money to buy the skills of the best neurosurgeon was repeated over and over again. The proposal was expanded upon whereby the neurosurgeon would transplant a portion of the mother's brain to replace her son's perished brain tissue. Repeated explanations of the futility of her plea were met with more vigorous attempts to bargain.

Inappropriate responses are bizarre to observe and can leave the carer feeling awkward. Usually the result of intense pressure the bereaved individual blurts out the first thing that comes into their mind in a clumsy, stupid or even nasty way. Carers may find difficulty in responding to this type of outburst however, because of the need to maintain sentimental order, carers often accept the response with supportive comments such as "It's all right to feel the way you do" or "It's OK to say the things that you feel you need to say". Such ambivalence is more usual than unusual but in sudden death it is commonly understood among emergency personnel that 'anything goes'.

Acceptance is a tricky response to handle when there has clearly been insufficient time lapse for the relative to have reasonably worked through their grief. The sudden loss becomes manageable, ordered and it appears incongruous to the carer that the person could feel such calmness and containment. This is not to be confused with denial however, as the individual's perception of the event is not impaired, they have simply and immediately accepted the loss.

Guilt is an extremely harrowing response to witness and unfortunately a fairly frequent one. To feel blameworthy by perhaps failing to act and prevent the death is frequently expressed in 'if only' statements such as, "If only I'd called the doctor quicker" or, "If only I'd got there earlier?" One young mother was guilt ridden because she had instructed her child not to return home via the underpass because the lights were not working and she was concerned for her child's safety. Instead her child ran over the road only to be hit by a vehicle at speed. When dealing with situations like this it is difficult for someone to accept that an accident had happened. Self-blame is such a strong emotion it is difficult to convince the guilt ridden individual that they could have done anything more to protect their relative.

Crying, sobbing and weeping seem to incapacitate carers least and is perceived as a therapeutic cathartic expression of emotional pain. Despite the appropriateness of such behaviour some difficulty is encountered concerning male relatives who cry, sob

or weep and the difficulty is more exaggerated when the carer is a female. However, most carers would recognise crying, sobbing and weeping as an accessible cues for comforting dialogue they are responses, which enable the concept of caring to really kick-in. Interestingly, Brewis (1989) concluded that police officers found the converse was true in that police officers feel more comfortable with withdrawal than crying. A possible explanation lies in their need for emotional distancing and suppression of any inclination to nurture and contact with officers attending the Mobile Police Officers Training Course bears this response out.

The use of thick description was of significance to this thesis in aspects of the sudden deathwork encounters of emergency personnel, and this is utilised as a theme throughout. On capturing these scenes in some depth the emotional highs, lows and frustrations of working with human tragedy, brokenness and emotional pain of sudden death in emergency care were revealed for subsequent interpretation. Wright used reflection in an honest declaration of his own struggle, his own fumbling for the right words and subsequent dissatisfaction at his own performance and effectiveness, he concluded that, "...armed with this theory, we can enter reality".

On discussing dramaturgical aspects of deathwork attention was given to the use of theatrical representation to render the cadaver safe and manageable, and it was established that such a process involved what Hughes described as dirty work. It is clear that dirty work not only involves abhorrent practical tasks but dirty work also features as a characteristic of the emotional labour of deathwork whereby emergency personnel may consider meeting the emotional needs of grieving relatives as abhorrent. The issue of dirty sudden deathwork as linked to relatives' emotionality will be further developed within Chapter Eight when discussing the reluctance of emergency personnel to perform certain sudden deathwork.

Conclusion

A range of major texts underpinning the sudden death thesis has been discussed. Beginning with Sudnow's thick description of his hospital encounters with some 200–250 deaths, which illuminated specific procedures and processes in which death was locatable and visible. All texts have in one way or another captured the essence of the sudden death event, offering trajectories to understand better the route to the eventual death of the patient and the manner in which emergency personnel react to and manage the event. Glaser and Strauss's (1965; 1968 and 1971) and Strauss and Glaser's (1970) valuable death trajectories offered a temporal route to the study of the subject. Timmermans (1999) forwarded four death trajectories within the accident and emergency sudden death specific context and drew attention to unequal social value in determining resuscitative effort and hence, outcome. In relation to sudden deathwork Hochschild's (1983) concept of emotional labour explained how display rules govern service encounters between emergency personnel; patients and relatives and explained how emergency personnel are literally 'on stage'. Wright's (1991) narratives from relatives traumatised by the sudden death event exposed emotional pain and rawness brought about by their experiences and explained aspects of caring that incapacitate the carer. Goffman (1957) and Burke (1969) discussed back-room activities of service personnel, which would rather be concealed whilst Prior (1987) explained the physicality of the mortuary and associated methods of retaining governmental control over death. Turner (1991), Hallam et al (1999), and Frank (1990) contributed to an understanding of an embodiment of death in relation to a dominant discourse surrounding death processing. Howarth (1996), Bradbury (1999), Smale (1985), and Naylor (1989) discussed the representation of death by the death processing industries, whilst Hughes (1971) reported on abhorrent tasks associated with such dirty work. Clearly these texts have been invaluable in providing a strategy to examine sudden death processing within an accident and emergency milieu. This thesis provides an ethnographic account of sudden death within accident and emergency using a temporal frame whereby the procedural basis to sudden death events is revealed, with

consideration given to the impact of the event as expressed within the narratives of the emergency personnel involved.

CHAPTER TWO

Introduction

The following chapter focuses on the sequential presentation and discussion of the method used to execute the research identifying the main sources of influence and rationale for the choice of method. Commencing with a discussion the epistemological foundation that justifies the application of the Chicago tradition an inductive frame is presented. Selection of the grounded theory method enables the emergency care sudden death milieu, usually hidden within dualistic public/private, inside/outside binaries to be exposed. Consideration is given to the use of the constant comparative approach until reaching a position of theoretical saturation.

METHOD

Chicago tradition

The Chicago tradition is associated with qualitative research. Post war sociology attempted to close the embarrassing gap between theory and empirical research with dubious success. The dominant positivist approach of the time valued vigorous quantitative verification on issues such as sampling, coding, reliability, validity, frequency distributions, conceptual formulization, construction of hypotheses, and parsimonious presentation of evidence. Advances in quantitative methods meant that qualitative research was relegated to the ranks of preliminary, exploratory, groundbreaking work for getting surveys started so that the categories and hypotheses could be tested

The Chicago movement brought a new dimension by challenging previous conceptions of arriving at reality which involved a rejection of modernist assumptions in which one super-ordinate truth was sovereign. Reflecting a decline in the value of absolutes, no longer could the adherence to 'the correct method' guarantee results. An openness to new and different ways of 'knowing' was acknowledged about how to do research (Punch, 1998) manifested in the displacement of scientific orthodoxy to embrace a fresh approach to making sense of phenomena. Weber's notion of 'verstehen' provided one of the intellectual precursors to qualitative research with the term 'understanding' (translated from German) at the forefront of Weberian sociology and two forms of understanding were acknowledged. First, Weber supported direct observational understanding of the subjective meaning of a given act. Second, explanatory or motivational understanding within a sequence of actions helped to explain social phenomena (Bryman, 1996). Verstehen supports the viewpoint that a study of society requires more than the understanding derived from the natural sciences.

The Chicago tradition supported first a tradition of pragmatism acknowledging that social life is not fixed but is dynamic and changing. To generate understanding it is necessary to undertake detailed and meticulous inquiries, becoming part of that world. Second, while social relationships may differ from each other, they take forms, which display similarities. A comparative element is introduced in the way in which data are judged to be typical of other settings or groups and subsequently this may help to validate the data (May, 1997). Where changes occur individuals must construct new forms of action and subsequent meaning.

Grounded theory

Glaser and Strauss (1967) discussed the emphasis on verification which dominated logico-deductive theorising, explaining how the quantitative research approach inhibited the generation of theory. The emphasis on verification was considered by Glaser and Strauss to inhibit the generation of theories and an attempt was made to reverse this effect without actually divorcing the two research paradigms. The role of grounded theory was to acknowledge the conflict between verification versus generation of theory, to de-emphasise verification and utilise more readily the generation of theory.

Glaser and Strauss attempted to strengthen the mandate for generating theory and in so doing provided a defence against doctrinaire approaches to verification. Generation of theory became a legitimate enterprise, which protested against the stifling of creative energy required by sociologists for generating theory. Indeed, it is exactly this creative energy that provides the mechanism to explore concepts more freely and also with respect for temporality in that a phenomenon may change its properties over a period of time. In advocating a systematic approach to qualitative theory generation creativity is to be encouraged and an emphasis is instead placed on work in process rather than the published product. It is the explicit intention of the grounded theory approach to “strengthen the mandate for generating theory, to help

provide a defense against doctrinaire approaches to verification, and to reawaken and broaden the picture of what sociologists can do with their time and efforts” (p.7).

The narratives of the lived experience of emergency care personnel provide clear understanding of the sudden death milieu and, in particular, insight into their concerns, anxieties, problems, dilemmas and solutions, that could only be generated through an inductive qualitative approach. Positivist approaches focusing on death statistics could provide inferential data for health economists regarding mortality and morbidity trends useful in formulating revised strategies to target health divides and more efficient distribution of funds. However, within this sudden death processing study the notion of positivist inquiry is considered to inhibit the process of accumulating detail. In line with Garfinkel’s (1967) approach, it is important that the design of the research helps ‘make common sense’ of the observations made using an item-by-item approach so that any temptation to formulate generalisations too early is avoided. In this way the concepts may be thoroughly explored to establish the characteristics of each and consideration can then be given as to how the characteristics and concepts are similar or apply in alternative ways in different circumstances. Grounded theory defends against the influence of verifiers who would instil the denial of the validity of their own scientific rhetoric. Instead a creative energy is fostered to facilitate the discovery of theory which is grounded in the data. Generating a theory from data involves a process of research whereby concepts and hypotheses emerge from within the data and are systematically analysed in relation to the data throughout the research process. In this way the grounded theory position is not logical, but is considered to be phenomenological in that the theory has been inductively developed from within social life.

The preferred data collection methods of this approach are those of participant observation. However, the Chicago School was criticised for an over reliance on native informants, and failure to provide data which allowed the reader to reproduce the analysis and it is interesting to note Sacks’s (1963) preferred method, which advocated the use of transcripts of tape recordings of naturally occurring activities

focusing on visible and therefore, observable phenomena. Whilst this technique could have been applied to this sudden death study by making recordings of naturally occurring sudden death talk during periods of sudden death work ethical and practical constraints made this impossible.

Ethnographic data serves to shed new light on the darker corners of our society to expose taboo subjects, which generally suffer underexposure due to dominant or censoring discourses. Indeed, ethnography in general is sympathetic to the notion of underclass in which opportunities for the exposure of previously suppressed realities are possible. Fielding (1999) refers to the existence of an official and unofficial model for discovery of the formal and informal aspects of the organisation under research in that there is a law in the books and a law as it is practised 'on the street'. So sudden death may be visible through documented procedures related to hospital death policy, but it is also visible in the way individuals go about their daily dealings with hospital death. The selected ethnographic research design adequately captured informal happenings, those moments when the activities and responses of the emergency personnel did not necessarily meet the requirements of the profession or the public permitting a pathological discourse to emerge on occasions.

Verification rhetoric may be expressed in such studies in the following phrases: "the hypothesis is tentative", "we had only a few cases", "we need more definitive proofs in future research", and "we checked this out many times". Taken to the extreme this approach requires that data collection procedures be highly standardised and stringent coding procedures adopted. There was temptation for this sudden death study to replicate these data collection conditions and focus groups interviews were conducted with standardisation in mind, though in hindsight it was probably not crucial to the overall quality of the study and was considered not to be true to the Chicago research tradition. Within the alternative paradigm of qualitative approaches emphasis is placed on elaborate description within an explanatory discourse. This primacy of emphasis should only depend on the nature of the subject, the researcher's experience and training, and the kind of materials required for the study.

It is only fair to report that the grounded theory approach has been challenged on a number of bases. First, concerning whether the researcher is genuinely capable of suspending his or her awareness of relevant theories and concepts until the later stage of the research process (Bryman, 1996). The notion that research can be conducted in a theory-neutral way should be challenged however, the strength of the grounded theory approach allows the researcher to start afresh and not be influenced by established knowledge. This approach opens up the possibility of looking at old problems in new ways though, insider knowledge of the accident and emergency sudden death environment meant that suspension of judgement was quite difficult to achieve and this is acknowledged as a limitation of the study. Despite this the grounded theory approach was useful for exploring a phenomenon for which little theory had been previously developed. Second, it is questionable whether the grounded theory approach actually provides theory but rather concentrates on the generation of categories rather than theory. In keeping with the grounded theory approach data collection, analysis, and theory stand in reciprocal relationship with each other therefore one does not begin with a theory which is to be tested but an area of study is identified and the relevant concepts and categories emerge from within the data. Third, where an understanding of events and activities is grounded in the specific milieu under examination, this tendency could discourage theoretical development by inhibiting comparison with other contexts. Researchers may also experience difficulties when conducting a range of fieldwork activities such as interviewing, taped recording of conversations, time for transcribing, making it practically impossible to achieve the desired constant interweaving of categories and data true to the grounded theory approach. It is argued that the comparative element actually enhanced the sudden death theory by providing opportunities to challenge established practices across a range of contexts.

Finally, the integrity of the data is also at risk with the effect of losing touch with the 'real world' should researchers move away from their subjects constructs and interpretive devices. The elaboration and application of theory prior to, or even at a relatively early stage of a qualitative study may prejudice the researcher's ability to

see through the eyes of his or her subjects. It is possible that theory may constrain the researcher by excessively blinding them not only to the views of participants but also to the unusual and unanticipated facets of a strand of social reality of importance to the participants. Much effort has been made to report with accuracy and detail the values and experiences of those individuals immersed in sudden deathwork any attempt to do otherwise would invalidate the findings and the overall purpose of the study.

Constant comparative method

Comparative analysis as a general research method can be used for social units of variable size and provides a sound means of validating characteristics and properties through comparison of data collected from comparative groups. It is useful at this point to explore the concept of the 'fact' as determined by the grounded theory method. The subject matter of the social sciences concerns people and their social reality that create fundamentally different implications to that of the natural sciences rendering the application of scientific methods problematic. Understanding social reality must be grounded in an individual's experience of social reality and this can only be accessed through his or her own interpretive devices and motivational context and such a position makes the result of any exploration of social reality meaningful. Contextual variation permits the analysis of comparative groupings and facilitates exploration of meanings ascribed to personal behaviours and also to the behaviours of others. Meaning is set in the context of the values, underlying structures and the various perceptions individuals hold of their setting. The values and constructs related to categories and properties identified within daily events and happenings are of relevance to the grounded theory approach and the constant comparative method is concerned with generating and plausibly suggesting but not testing the categories and properties. Further, since there is no requirement to ascertain universality or proof of causality only saturation of data is necessary rendering the term 'fact' of little use.

Comparative analysis enabled conceptual categories or properties to emerge from the data and the specific conditions under which the categories existed. The evidence from which the categories emerged was then used to illustrate the concept. A relevant theoretical abstraction regarding what was going on in the area studied was established, and this in itself provided accuracy of the evidence. Structural boundaries central to selected events were identified and comparative analysis enabled the identification of conditions in which the selected properties occurred or did not occur to arrive at an accurate description of the area. In this sudden death study comparative groups comprised the three emergency disciplines, the procedures the emergency personnel engaged in, and the three accident and emergency departments and mortuary settings.

Constant comparative method combines an explicit coding procedure with a theory development approach (Glaser and Strauss, 1967) in that joint coding and analysis generates theory systematically whilst identifying new properties using analytic procedures. The outcome is the generation of a theory, which is integrated, consistent, plausible and close to the data. The constant comparative approach is dependent on the skills and sensitivities of the analyst and does not guarantee the same outcome in the event of two independent analysts working with the same data so what is declared is a flexibility enabling the creative generation of theory. It is acknowledged that 'theory as process' is constantly developing and due to its momentary quality a social theory can never be perfected. In the following thesis sudden death forms the substantive area to be studied and the comparative groups involve accident and emergency nurses, police traffic officers and paramedics in relation to their dealings with sudden death.

In verifying theory Glaser and Strauss (1968) discuss the issue of intentionality of verification and the assumption that the greater the volume of data, the greater the assurance of verification of evidence. Drawing on Becker et al's (1961) assertion that "mountains of time and evidence" cannot doubt notions of findings supposedly reduced the possibility of academic challenges to the theory. Additionally, in

generating theory as a prime goal Glaser and Strauss caution against the inappropriate fixation with gathering accurate evidence and verified hypotheses. Evidence and testing will not destroy a theory, only modify it, and as such are not crucial process elements in grounded theory. The nature of the theory generated is one of an integrated set of propositions presented in a style, which explains or predicts something and is most commonly expressed as a running theoretical discussion using the conceptual categories and their properties. It is a dynamic, ever developing process rather than a momentary product and Glaser and Strauss (1968) caution against a risk of “freezing” the theory rather than permitting its continual development so that it becomes richer, more complex, and dense, with a “fit” and relevance which is easy to understand.

Two kinds of theory can be developed through comparative analysis: substantive and formal. Substantive theory involves the development of an empirical area of sociological inquiry on aspects of patient care, race relations or, sudden death practices. Formal theory involves conceptual areas of sociological inquiry, which are more abstract in nature regarding issues related to spirituality, stigma, and deviance. It is necessary to distinguish which approach is being developed or if both substantive and formal theorising is integrated then to declare that this is the case because each theory requires different approaches. This sudden death thesis integrates both in that comparative analysis exists between groups, within the same substantive area and also comparison of concepts occurs within a range of categorisations.

Glaser and Strauss advised against the inappropriate forcing of “round data” into “square categories”, which arises from inter-researcher/colleague disagreement over categories and concepts. Previously published literature within the area under study was ignored to prevent contamination of emerging categories by concepts better suited to other areas. Similarity and convergence are established following emergence of the categories and a useful way to avoid this problem is to explore virgin theoretical territory in which no previously established theory exists.

The two essential features of concepts are first, that the concept should be analytic and sufficiently generalised to possess the characteristics of concrete entities and second, the concept should be sensitizing in that it yields a meaningful picture. By harnessing these two features a cohesive picture is presented illustrated by incidents and expressions from individual's encounters with the phenomenon. Joint collection, coding and analysis of data are the underlying operations in the generation of theory and the notion of 'theory as process' requires that all three operations be conducted together, intertwining and blurring continually throughout the investigations overall life-span. To separate the operation is to fragment the analysis.

Theoretical sampling is the process of data collection for theory generation, which involves joint collection, coding and analysis as the theory emerges. It was the emerging theory itself, which determined the process of data collection and was shaped by the general subject or problem area and in this case, how emergency disciplines manage sudden death in accident and emergency. The research process was initiated by the identification of local concepts whereby principal features of structure and process were established for study. In studying sudden death in accident and emergency it was useful to select patients, relatives, and emergency personnel in addition to the physical resources and procedures provided by hospital departments and documents. However, these aspects did not form the explanatory categories within the theory, it was the concepts about the problem 'sudden death' that were of interest.

Theoretical sensitivity in the development of a theory required that the researcher conceptualized and formulated the theory as it emerged and through its continual development. The personal and temperamental style of the researcher added to the theory by supporting a questioning approach coupled with insights into the area of study. Theoretical sensitivity was jeopardised when only one preconceived theory was allowed to distort the researcher's thinking and risked doctrinaire, defensive or preoccupied allegiance to a singular model such as the researcher as 'nurse' seeing only what was desired.

Selection of sampling groups and subgroups for the purpose of multiple comparison were chosen according to theoretical criteria. Although selection should be based on as many comparison opportunities as possible within a temporal and cost-effective frame, which considers access, it is imperative that theoretical purpose and relevance override structural circumstance as the key determinant in selection. Data collected through a pre-determined approach force the researcher into irrelevant directions whereby unless the design is modified the study will yield data contaminated by personal researcher violations, which controls the relevancy of the data.

The rationale for the inclusion of comparable groups and exclusion of non-comparable groups was succinct, there were sufficient shared features with other groups to be included. Traffic officers, accident and emergency nurses, and paramedics all operated in and around the accident and emergency department, managed sudden death, had contact with relatives, processed dead bodies, and engaged in inter-professional interaction. For a group to be excluded required that the group showed fundamental difference. Fire-fighters had been considered as a potential comparative group within the study however, certain features were not shared with the other disciplines in that fire-fighters were considered to have no contact with accident and emergency departments, have restricted contact with relatives and body processing, and inter-professional contact which is limited to police officers and paramedics. The purifying approach to comparison group selection was useful because accuracy of conceptual and factual variables was desired, but it is not always necessary for these two factors to be held constant. Rigidity over group constancy could have inhibited theory generation by excluding non-comparative groups, which could provide rich data. The three comparable emergency disciplines were centralised in the study with inclusion of data from many other non-comparable groups, which nevertheless contributed significantly to the study by illustrating scenarios in which features varied, so consideration was given to inclusion of material about the activities of mortuary technicians, receptionists, porters and hospital chaplains. Glaser and Strauss (1968) suitably illustrated this issue with the example of death awareness contexts of patients whereby conditions in the hospital setting

were compared against a range of other settings from nursing homes, to inside the ambulance, in the home, and in the street following an accident. The similarities and differences from each scenario can explain similar and diverse properties central to nurse/patient interaction. To explain, in the sudden death study the pace at which a nurse disengaged from body processing work is much slower than that of a paramedic following a sudden death in the patient's home.

Glaser and Strauss claimed that the constant comparative method is characterised by four stages: comparing incidents applicable to each category; integrating categories and their properties; delimiting the theory; and, writing the theory. This method of theory generation was used to continuously develop the stages simultaneously throughout the analysis. Comparing incidents applicable to each category involved the coding of each incident into categories and there was a possibility of few or many categories emerging. The defining rule is that while coding an incident for a category the researcher should, "...compare it with the previous incidents in the same and different groups coded in the same category" (Glaser and Strauss, 1967:106). Constant comparison of the incident generated theoretical properties central to the particular category, the dimensions of the category, then emerged. Glaser and Strauss used the highly relevant category example of 'social loss' of dying patients to highlight how categorising through the constant comparative method identified categories of high and low social value of patients as perceived by nurses. The categories then changed following the identification of social attributes related to occupation, age, marital status, ethnic groups, and education and it was possible then to identify clusters of patients with a specific degree of social loss.

Recording memos of ideas is the second rule of the constant comparative method. Coding temporarily ceased to facilitate the recording of details of awarding a category so it was captured whilst still fresh in the mind. The dynamic nature of the coding and recording of ideas meant that the analysis was developed without a strict schedule. Emphasis on one section of data may have taken longer than others, depending on the relevance of the material, saturation of the categories, new material emerging, stage of

theory development, and the attitude of the researcher. It was helpful to expose the categorisation to the scrutiny of other analysts with the aim of enriching the constant comparative process through the generation of additional theoretical ideas. Field notes were coded to a memo for immediate feedback of an idea however, some incidents were to be coded to a number of memos because they were complex accounts of incidents, which during deconstruction could fit well in a number of places. It was more helpful to use the incident as an illustration of a concept only once to avoid increasing the volume and complexity of the data to be analysed. Overall what was required was the generation of theory, which dismantled the story within the data and the story needed to be sufficiently disentangled and each idea illustrated for a more complete integration of the theory and examples shine through in later chapters.

As the coding progressed the constant comparative process changed from an incident with incident approach to a comparison of incident with properties of the category. In the sudden death research the category 'emotionality' was initially coded and properties of emotionality identified as black humour, coping, annoyance, exhaustion. Constant comparison led to a recalculation of the property 'black humour' to find that 'incongruity' was a predisposing characteristic in relation to black humour among emergency personnel. The knowledge accumulated regarding a property of a category became integrated and presented as a unified whole. As the emotionality related properties integrated further redefinition of 'emotionality' by emergency personnel was related to their development of an emotionality story, the ingredients of which involved a continual balancing of factors associated with the experience of emotion when dealing with sudden death. Each category became integrated with other categories so that emotionality was integrated with role resignation in that there are aspects of sudden deathwork like body handling and dealing with relatives that emergency personnel would much rather someone else perform.

Occasionally sudden death related data did not readily fit into a classification category having not been recognised previously and despite an attempt to deconstruct an event

or incident. In this situation the properties were addressed using the process of theoretical comparison and an opportunity was created whereby the researcher may ask what the dialogue, symbols and metaphors central to the event suggested. This approach clarified certain meanings to increase understanding of the event and helped classify the properties of the event, the purpose was to become sensitive to the number and types of properties that might pertain to phenomena that otherwise might not have been noticed. To do so it is necessary to move beyond the analytic blinders that inhibited the identification of properties within the data.

It is argued that the three emergency professions constitute fairly similar comparative units in that they are all uniformed disciplines with an orientation to public service. However it could also be argued that the organisational culture of policing as compared to nursing provides a very different organisational culture and as such constitutes a far-out comparison (Hughes, 1971). The theory developed when different categories and their properties became integrated through constant comparison and made theoretical sense of each comparison. Qualitative data tends to be voluminous and it is necessary to use delimiting strategies to render the data manageable. The delimiting features of the constant comparative method occurred at the theoretical level and also at the level of the categories with significant changes in the incident to category comparison becoming less frequent. Reduction in categories formulated the theory with a smaller set of higher level concepts. By further reducing the terminology it was possible to discover areas where generalisation of a property occurred such as all three emergency disciplines reported that they would prefer not to deliver the death message. As such, parsimony of variables and formulation, and scope in the wider application of the theory emerged, which Glaser and Strauss (1967) claimed were important features of theory.

Theoretical saturation

Category reduction provided a mechanism to order the data and to make it more manageable. "In large field studies, with long lists of possible useful categories and

thousands of pages of notes embodying thousands of incidents, each of which could be coded a multitude of ways, theoretical criteria are very necessary for paring down an otherwise monstrous task to fit the available resources of personnel, time, and money” (p.112). When the original categories were reduced a more selective and focused coding and analysis of incidents was created and comparison became easier. The point of theoretical saturation was reached when the systematic coding of incidents revealed no new categories. Further, unnecessary coding merely added volume to the material rather than adding strength to the theory. Glaser and Strauss argued that where coding for new categories are identified well into the coding process analysts should refrain from retrospective coding of previously covered material. It may well be that the newly emerged category will reach a point of saturation anyhow, making it unnecessary to make return journeys through the previously coded data and this stage was readily recognised in the sudden death research. At the writing up stage all the data and memos had been coded, and a theory supported by the discussion was generated from within the memos regarding the major themes of the theory.

The sites and their location

The study took place in three different accident and emergency departments in different hospitals in the North East of England. The area has a nearby airport, docks and extremely busy road and rail systems, though much of the previously thriving industry within the locality is now in decline. The first accident and emergency department is a major trauma centre, which serves a predominantly urban population of a large industrial coastal town. It is a busy sub-regional centre for burns treatment and plastic surgery, neurosurgery and maxillo-facial surgery and treated approximately 75,500 patients in the year 2001-2002. The other two accident and emergency departments are situated in acute general hospitals and also serve the population of towns nearby but neither have the specialities of the major trauma centre. The two Trusts merged within the time span of this research and statistics for

the year 2001-2002 showed that the two departments collectively treated approximately 79,700 patients.

Senior House Officers work in any of the three departments for a period of six months whilst on general practice, medical or surgical rotation. The majority of nurses working at or above 'E Grade' in each of the departments studied had taken an In-house Nurse Practitioner course and/or a Post-Registration Specialist Practice Qualification to equip them with the knowledge and skills to adopt an expanded accident and emergency nursing role. A number of outlying agricultural and coastal villages have a nurse practitioner service within minor injury units though staff were not inclined to rotate between these minor and major units. Internal rotation of qualified nurses to night duty for approximately one month every year was a contractual obligation though some nurses would spend a greater period on night duty if it suited their personal circumstances. Such rotational duties were considered by management to be helpful in the professional development of the team.

Of particular significance for this study is the proximity of the mortuaries in relation to each accident and emergency department. An outdated mortuary, built around the year 1900 and which was located in the centre of a visitor/staff car park serves the major trauma centre. This rather unfortunate mortuary location was a problem combination in relation to the concealment of death from public gaze and this public versus private dualism is explored further in Chapter Five. All cases of unexplained or suspicious death requiring post-mortem were taken to this mortuary which became known as the 'Coroner's Mortuary'. Recently plans were drawn to transfer the trauma facility to nearby hospital site where much more contemporary mortuary facilities are available. The second mortuary was also extremely outdated and not particularly pleasant for those who had need to visit it whether for personal or professional reasons and this point is explained further in Chapter Five. The third mortuary, constructed in the 1960s, was located at the rear of a large acute general hospital and accessed from the accident and emergency department through a long basement corridor. Compared to the other two mortuaries this facility was much more modern.

Accessing the field

On researching the concept of sudden death it was necessary to consider the role of 'researcher within' and anticipate how data collection could be conducted effectively. Coffey (1999) discussed body boundaries in relation to ethnographic fieldwork claiming that the ethnographer as fieldworker needs to 'carve out a space' for the physicality of the body. "At a very simplistic level, the ethnographer has to sit or stand or lie or be *somewhere*. Whether that place is at the back of a class-room, to the side of an operating theatre, in the middle of a gathering or on a street corner, is no matter. A space has to be made, or found, or negotiated for the body – thereness of the ethnographer" (p.73). The embodied field and the embodied fieldworker are concepts, which capture a physicality of ethnography, which previously had not been addressed.

Embryonic ideas about sudden death being a researchable phenomenon emerged during primary degree dissertation study when it was possible to access the clinical field of accident and emergency on a daily basis and carve a route to conduct the research. A reputation as the 'sudden death expert' had been developed over about fifteen years in the field of accident and emergency nursing and teaching and built on previous primary degree work in a much more focused way. Initially, due to contractual employment as a Staff Nurse in one hospital and a Departmental Sister in another, access to the field was constant and exposure to the phenomenon of sudden deathwork was at its height whilst working in the resuscitation room and mortuary, dealing with relatives and emergency services colleagues in sudden death related contexts. Later, as a Nurse Teacher and following this, as a Senior Lecturer in accident and emergency nursing contact was possible on one day a week, though what was lost in terms of time spent working in one department was enhanced by an extended range of contact in the accident and emergency departments in the three hospitals. This widened repertoire solidified relationships between clinicians and researcher, enhancing the scope for comparability of sudden deathwork across the three hospital sites.

Immersion within the phenomenon of sudden death required engagement at three levels. First, as accident and emergency nurse and later as accident and emergency nurse teacher brought with those roles the experience of interacting directly with the phenomenon and led to the accumulation of insight associated with the two roles. Parahoo (1997) referred to the risk of researcher over involvement when immersed in the culture under study to the extent that objectivity is lost. Atkinson (1992) asserted that a principal feature of ethnography is the emphasis placed on entering the culture. However, Kelly and Long (2001) counter-argued, "In the nursing context it may be difficult for nurses to examine their own group and become cultural strangers when they have already become familiar with that culture and when the rules and norms inherent in the culture have been internalised" (p.138). Young (1991) drew attention to the extreme moral or physical problem experienced by ethnographic researchers when placed as 'insiders' in limbo, somewhere betwixt and between two worlds.

Second, to engage further required that the researcher crash through limits deemed central to professional status as a nurse and teacher to expose those elements of practice, which nurses would rather not acknowledge exist such as that nurses laugh at sudden death is considered contrary to the nurses' professional code. Smith (1991) refers to the existence of 'split affinities' which could seriously impair the research analysis so what was required was a shift in thinking to acknowledge not what nurses would like to think happens in clinical practice but to acknowledge the presence of what does happen.

Sound practice in qualitative analysis, which offers a belief in the significance of the subjective, required that the researcher reveal the values, interests and influences associated with their own subjective experiences (Cormack, 1996). Therefore, third, the recent traumatic personal experience of the sudden loss of an immediate family member required that the research be put on hold until such a time as emotional repair and resolution took over, which lasted for a period of one year albeit an arbitrary calculation. It could be argued that the decision to withdraw regarding the latter aspect was due to a felt obligation to disengage from the study rather than to engage.

However, the overall research is most likely to be more enriched by the traumatic experience and the analysis now contains the interspersed subjective biography of the researcher. It is suggested that the lived experience is the closest a researcher will get to the phenomenon.

Recruitment and characteristics of the research participants

Recruitment of research participants was unproblematic within this highly reflexive, ethnographic research design involving fieldwork within the accident and emergency departments only. All accounts related to sudden death encounters outside of the hospital setting as reported by paramedics and police officers were limited as imported constructs, to second order interpretations of what 'sudden death' is. Paramedic happenings were reported and discussed during the focus groups in the eating rooms or lounges of the three ambulance stations, the place where much time was spent awaiting the next emergency call out. A Senior Paramedic Training Officer was present at the beginning of the three occasions and this was most helpful in initiating the data collection in less familiar territory. The police focus group discussions were conducted in various offices and seminar/teaching rooms in one constabulary. Traffic officers were recruited via one Sergeant who was particularly cooperative and agreed to coordinate the three events.

In each accident and emergency department the Sister/Charge Nurse provided a copy of the 24 hour rota or 'Off Duty' and a target population of seventy eight qualified nurses were made aware of the impending data collection and given a written invitation to participate in one of the focus groups (APPENDIX ONE). A reply slip was completed and this was useful in determining numbers of individuals proposing to attend. Thirteen qualified nurses participated in three group discussions, five in the first group and four in the remaining two groups. Groups were comprised of mainly D and E Grade Staff Nurses and one Departmental Sister. One Staff Nurse represented the Night Duty establishment and with the exception of one male Staff Nurse, all participants were female. Despite an initial intention to attend, some nurses declined

on the day and this was always a potential problem in the research design. Further, due to the location of the research in the accident and emergency departments, there was always the potential for disruption during data collection should staff be called away from discussions to respond to emergencies. However, such disruption was not a feature of the nursing and traffic officer groups in that the paramedic groups at their ambulance station locations exclusively experienced emergency 'shouts' during the taped discussions.

Fourteen participated in the traffic officer groups, five in the first two and four in the last. Officers were predominantly male with the exception of one female whilst the rank of Constable predominated one Traffic Sergeant also participated. All officers worked a shift pattern consisting of night shift, late shift and early shift duties. One officer worked within a sub-specialist unit within the traffic division involving follow-up family liaison. There were fifteen paramedic participants, four in the first group, six in the second group and five in the third group. They also worked rotational shift patterns and with the exception of one female all of them were male. Most participants were trained and experienced paramedics but comments provided by paramedic technicians at one venue were of value in clarifying and enlarging on situations described.

Individuals provided supplementary information at locations within and out with the departments both through incidental conversations from informants either over the telephone or during visits to the accident and emergency departments or mortuaries, following attendance at meetings in the department or in the training schools and education centres. Having successfully carved out a space and being accepted within the sub-culture of the department as a legitimate person to be there individuals were most forthcoming and cooperative, occasionally expressing gratitude for the rare opportunity to discuss events of the day. The extent of overlap was high concerning those staff who participated in the focus groups and those individuals who provided narratives or informant information though such a position was not considered to create a problem in the overall aim of the descriptive study. On the contrary, some

data was useful in constructing a picture of 'what goes on' and helped to reveal some of the anomalies of instances when things do not happen according to plan and which otherwise would remain undisclosed.

Data collection

The essentially ethnographic nature of the research advocated a qualitative approach to data collection involving three instruments: participant observation over a period of two years combined with the reflexive biography of the researcher's fifteen years of experience within an accident and emergency culture; use of informants to obtain narratives and information regarding sudden death related happenings; and, nine focus group discussions with the three emergency disciplines to gain perspectives on sudden death practices and perceptions.

Ethnographic and reflexive accounts were possible from the researcher's own account of historical accident and emergency experiences and this approach is supported by Young's (1991) reflexive account of policing whereby the subjective "I" was part of the discourse. Ethnographic boundaries cannot be described as being "geographically north of anywhere" so the insider who studies his own society is really the "anthropologist at home" (p.8) and data collection is all around, all of the time, it is "at home" in a "parallel culture" (Halstrup, 1987). During a period of approximately two-years data collection concerned an internal exploration of fifteen years of personal history within the accident and emergency culture. Data was collected which was based on the personal biographical account from the researcher perspective which included reference to a wide range of incidents and encounters with nurses, police and paramedics and others whilst working in the accident and emergency departments and mortuaries.

It was impossible for the researcher to conduct fieldwork related to police and paramedic happenings outside of the three accident and emergency department settings due to the contractual limitations of full-time employment. It should be

clarified that the researcher did not engage in ethnographic fieldwork at the scene of a road traffic accident or at the scene of a collapse whilst out on emergency 'shouts'. Had this been possible the data would have been so much more enriched but paradoxically voluminous. Participant observation in the three departments was integrated with the reflexive biography of the author's fifteen years of accident and emergency nursing experience and data were made more robust by narratives reporting thick descriptions of sudden death encounters from accident and emergency nurse, traffic officer and paramedic informants following clinical encounters during staff breaks, during teacher/student contact in the clinical area and in the education centre and, during incidental telephone conversations with staff.

Recording of data

Data were recorded from the three emergency disciplines over a period of two years during 1995 to 1997. It was essential to record observed happenings and informant accounts of incidents in field note format and code them to memos either at the end of a shift or as soon as possible following contact. Data were concurrently collected at various venues from nine focus groups across the three emergency disciplines. Three focus groups were conducted with paramedics during their periods of duty at three ambulance stations serving the three accident and emergency departments. Three further focus groups were conducted with accident and emergency nurses whilst working in the aforementioned accident and emergency departments. Finally, three focus groups were conducted with three sets of traffic officers from one Constabulary serving the entire geographical area of all three hospitals. The focus group data were recorded and coded within memos separate from the field note data. Selection and application of NUDIST NVivo computerised qualitative data analysis software is addressed later in the chapter in relation to a combined approach to data analysis that respected the need to incorporate constant comparison.

Ethical issues

According to Parahoo (1997) there are ethical implications at every stage of the research process and in situations where researchers are also nurses their research practices should be guided by the six ethical principles of beneficence, non-maleficence, fidelity, justice, veracity and, confidentiality. In this regard consideration was given to the choice of research subject and the necessity to explore sudden deathwork. It was concluded that the information revealed would add to the substantive theory on the topic from a UK perspective and could help emergency personnel gain insight into their practice. The research was conducted in a way that would cause no harm to individuals and with this in mind serious consideration was given to the issue of confidentiality and anonymity for those participating or present in the accident and emergency departments during periods of observation, informant reporting, and focus groups. To summarise, consideration was given to safeguarding the interests of participants in the planning stages of the research in cognisance of the Royal College of Nursing statement, "the ethics of nursing research must reflect the ethics of nursing practice" (RCN, 1993).

Throughout the following text much effort has been afforded to render anonymous descriptions of sudden death scenes and encounters concerning emergency personnel, patients and relatives. At times much anxiety existed in relation to some sudden death scenes described by emergency personnel and it was very difficult to balance the need for anonymity with the need to make sufficient thick description of an incident in order to understand the nature of the phenomenon such a situation is considered to be typical of taboo or highly sensitive types of studies. It was the intention for this aspect to be professionally executed so the names of individuals whether staff, patient or relative, their rank within the institution and all locations were omitted. In all it was necessary to ensure that responsibility for the welfare of research subjects were safeguarded from risk (RCN, 1993) and this included the institutions under scrutiny whereby it was important to remember that "Entering an institution or community to carry out research is a privilege not a right" (McHaffie, 1996: 37).

It is recognised that it is sometimes necessary to conceal the identity of the researcher from the subject and examples of research generating copious rich data involving researcher disguise are published in relation to criminals, police, homosexuals and nursing auxiliaries (McHaffie, 1996). Indeed situations exist where such data cannot be obtained by any other means but by using covert measures and quite naturally, moral objection exists. Researcher presence in the accident and emergency departments was declared to staff and on occasion involvement in clinical encounters required that the clinician focus within the contractual obligation was the driving behaviour and subsequent reflection on clinical encounters brought the researcher focus into relief.

Ethics Committee approval was successful at three Acute NHS Hospital Trusts. As no such ethical committee existed in the police and ambulance service at the time of data collection, permission to conduct the focus groups was granted from the Chief Superintendent of the traffic division and, within the ambulance service, the Head of Operations. Due to the emotive nature of the study, members of the committees needed assurance that employees would be protected from emotional harm should they find sharing sudden death experiences traumatic and one Acute NHS Trust Ethics Committee requested additional explanatory material.

Smith (1995) referred to the increased popularity of the focus group technique in health research and advocated the consideration of ethical safeguards in relation to participant over disclosure particularly when the topic is related to sensitive aspects such as incest, HIV risk, death, and substance misuse. The synergistic effect of the group activity may lead to over disclosure of personal information, which may be regretted later. Although focus groups in the marketing arena do not entail long-term involvement of members (Mendes de Almeida, 1980) as it is assumed that participants do not know each other, this was not the situation with the emergency care disciplines. Health care research demonstrates the opposite scenario whereby focus group members may not only know each other but may have worked or studied together for a considerable period (Lankshear, 1993; Twinn, 1998; Thomas et al, 1995) and such

was the situation pertaining to all three emergency disciplines in the sudden death research.

Prior to each focus group discussion, participants' attention was drawn to the availability of a well-established occupational health service, chaplain, and bereavement counselling service should an individual wish to talk in confidence following the session. Assurance of anonymity was offered by explaining that the researcher and University thesis supervisor would be the only people accessing the tapes. Also at the point of tape transcription any individuals and locations mentioned would be concealed within the text. Consent to tape record the discussion and permission to share information at the point of publication was also obtained from participants.

Ethnography

Ethnography has been transformed since Agar's (1980) classic text, 'The Professional Stranger'. The second edition (1996) suggested that although the 'new' ethnography is accomplished in much the same way, in that contacts are made, a site is accessed in which the researcher 'hangs around', figures out how to analyse uncontrolled material, and worries about generalisability of the results. Previous ethnographies were incomplete due to over reliance on an ethnographic model, which followed the trails of daily life among some community. The problem with such an approach concerned the impression that ethnographers created stereotypical 'types' that would behave in a certain way captured in time and space, never to change. Rather, new ethnography is responsive to forces acting on the community and considers the ethnographer as part of the story too. Agar distinguished between two types of ethnography: encyclopaedic ethnography, which imports voluminous material about the context in which the phenomenon operates, and narrative ethnography, which depends heavily on stories.

Participant observation is a feature of both ethnographic approaches, though Agar (1996) argued that encyclopaedic ethnography is more about observation than

participation. The ethnographer who utilises personal biographies in the research process is the research instrument and as 'participant' is able to 'stroll' around social life in its 'natural state' undisturbed, to listen, observe and experience and to expose theories and biographies to new and unfamiliar settings (May, 1997). This reflexive, self-contemplative process enables the researcher to relate to the self. Objects get their 'knowability' from what is given to them, so 'when we know objects we are knowing ourselves' (Wiley, 1994). The awareness of experiencing the perceptions and knowledge means that not only do 'we know', but also, 'we know that we know'. A reflexive understanding of a social scene requires engagement of the researcher in a new social milieu reducing the possibility of arriving at hasty theoretical conclusions (Silverman, 1994; May, 1997).

New narrative ethnography centres the ethnographer in the process of community activities. As such participative experience lends itself to the stories that are told and raw material is derived from active participation in everyday moments and the shared knowledge of the community around those moments so data appears in the narrative form that naturally represents them. "One's job as an ethnographer is to account for what goes on, on the ground, in living colour" (Agar, 1996:10).

One of Sudnow's own criticisms was that no detailed accounting of patient care practices were available making much of the work on death in the hospital reliant on field interviews. Field interviews were considered as removed from actual instances of death and dying and retrospective reporting upon their attitudes and happenings was the main source of information and this situation justified his essentially ethnographic position. Sudnow engaged in discussions with Harvey Sacks who was responsive to the painstaking attention to detail of the Chicago School of the 1920s and 1930s assuming that if something mattered, then it should be observable (Silverman, 1994) hence Sudnow's leading section on 'the occurrence and visibility of death'.

Sudnow's approach was influenced by ethnomethodology as described in the early work of Garfinkel (1967) who considered how social reality was formulated by the way in which sense was made of the social world. Ethnomethodology analyses everyday activities by accounting for the method used to make those activities observable and reportable. The distinguishing features of everyday activities as observed and separated are carried out by members who make it happen in the course of their encounters. Those members have knowledge, skill and entitlement to carry out their specific activity, indeed the activity is often dependent on such factors. Members' accounts are features of the socially organised occasions of their use.

When comparable occasions are located, analysed and classified the prescriptions they observe are 'law-like', spatio-temporally restricted, and 'loose'. Occasionally, an exception may occur when all features are not present and such a violation suggests that all preconditions of the law have not been met. Where quasi-law exists it is necessary to adequately explain such a violation by demonstrating the exceptional characteristics of the situation and an attempt has been made to address specific sudden death circumstances, which deviate from the norm.

A number of ethnographic studies were undertaken in a range of milieux and Bryman (1996) cites Sudnow's study as one such piece. However Sudnow himself cautiously categorised his work using the term ethnomethodology in his claim to have provided an ethnography of death and dying in the social world of the hospital. Students of Garfinkel were the major force in the emergence of conversation analysis as a specific style of social analysis, which presents material in an unaltered text directly to the reader (Ten Have, 1999). Earlier Garfinkel concentrated on the procedural study of common-sense activities, which came to be referred to as the 'documentary method of interpretation'. A set of appearances such as objects, events, people, symbols, is taken as evidence of the existence of some underlying pattern (Hughes, 1990). As such the philosophical position is one of neutrality in that the researcher is content to describe the procedures of meaning production rather than address the meanings themselves

(Hughes, 1990; Denzin, 1989). Sudnow was basically saying “This is what death or dying is”.

Triangulation

This emergency care sudden death research achieved triangulation through a single-investigator approach incorporating elements of data, using theoretical and methodological triangulation. Denzin (1989) claimed that multiple strategies of triangulation must become the preferred line of action when theory-work, research, and interpretation are undertaken “...to raise sociologists above the personal biases that stem from single methodologies” (p.247). Four basic types of triangulation were described: data triangulation, investigator triangulation, theory triangulation and, methodological triangulation and these were considered in the execution of this sudden death research. By combining multiple observers, theories, methods, and empirical materials the intrinsic bias and problems associated with a single method, single observer, single-theory study may be overcome and is claimed to remain the soundest strategy for theory construction however, the constraints of time and funding meant that Denzin’s recommendation were compromised.

Data triangulation involved the explicit search for a range of different data sources that have bearing on the phenomenon under investigation. There are three sub-types: time, space, and person. Conveniently Denzin used the subject of death as an example to illuminate his assertion that a focus on time and space as observational units recognises their relationship to the observation of individuals. Researchers can observe activities associated with a time of the day, week, month or year and can also observe the three interrelated dimensions. On researching sudden death it was useful to consider the subject by collecting data using a particular method, then to build on the data by taking the method to a number of different hospital wards. Further, more detailed data were obtained by taking the method to different disciplines involving nurses, paramedics, and police traffic officers. Dissimilar settings provided valuable

comparative information, which when combined created a significant representation of the same generic event 'sudden death'.

Investigator triangulation concerns the use of multiple observers and Denzin considered it to be important that the primary investigator with the most skill should be situated at the 'coalface' to be closest to the data collection. In the following sudden death study the use of multiple observers was not an option. This situation may have been of greater benefit to the quality of the study because in sacrificing impartiality through an increase in principal investigator bias it was possible to achieve simultaneous immersion during data collection, transcription, and analysis stages.

Theoretical triangulation reduces the reliance on polemic criticisms by the use of various perspectives and interpretations so rather than gathering data related to a small set of hypotheses or aims, which reverted back to only those issues, multiple perspectives and interpretations offer a richer analysis. This approach is in line with sociological methods in that the body of data tends not to be repeated and the meaning of that data is always socially constructed and subject to multiple interpretations. In the sudden death research the three disciplines offered a wider range of incidents to draw on and had differing constructs to offer in relation to opinions, experiences and perspectives.

Methodological triangulation required the researcher to use more than one method on the premise that single-method studies are not as defensible. However, within a social research context the use of multiple methods will not guarantee any more than single-methods of enquiry that the findings will form a coherent interpretation. Each method will yield a different range of insights, which contribute to the richness of the total picture. In conclusion, as regards triangulation, the following sudden death study employed data triangulation using a single-investigator approach, with consideration to theoretical and methodological triangulation.

Use of informants

Informants were critical to gaining insight into events and it was additionally useful that contact in a professional capacity with the three accident departments had been close. Contacts were helpful in talking through sudden death situations they had encountered in practice over the course of the research. Some made telephone contact and engaged in accounts of happenings soon after they had occurred whilst others discussed events more spontaneously during a range of opportunistic venues. Dean et al (1967) highlighted an elaborate range of reasons why an informant would come forward and the rationale for such willingness to participate in the process (Hammersley and Atkinson, 1997). Some informants are especially sensitive to the area of concern and there are those who are more willing to reveal information. Outsiders who perceive happenings from the vantage of a contrasting culture are particularly useful in providing objective accounts. Newcomers to the area may greet happenings with some surprise in contrast to insiders who due to their immersion within the organisation may miss the significance of the happening. Those who are undergoing status passage, or the 'nouveau statused' may report issues quite vividly due to the tensions created by their new experiences. Others may put those with a naturally reflective style forward as potentially suitable informants. Informants, who are more willing to reveal, disclose for a number of reasons, sometimes because of their status or background. The naive informant is perhaps unaware of the implications of disclosure whereas a rebellious or discontent person may demonstrate a drive to expose certain disagreeable practices. Those who have lost power but remain 'in the know' may be willing to disclose because their position does not now carry as much risk as those who are perhaps on the way up in the ranks, they 'might as well'. The 'old hand' may be willing because they are so secure that their position will not be put in jeopardy therefore disclosure is not perceived as a problem. The individual who enjoys attention may latch onto the researcher so long as there is an interest shown. Finally, the subordinate generally develops insights to cushion the impact of authority and may be hostile to reveal all. A number of the aforementioned types appeared both as individual informants and also in the focus groups and some

expressed quite sensitive, intimate thoughts during personal reflections of recent happenings.

Narratives

Narratives or story-telling has been described as a natural impulse that is a recollection of what happened, what was done, and what was of interest, in a temporal sequence (Tappan, 1989). Reissman (1990) states that the narrative is a process of reconstruction or re-telling a happening and the narrator convinces the researcher, who was not present when the happenings occurred, that the happenings had credence. The story is its object of investigation, the purpose of which is to see how respondents make sense of events and actions in their lives (Reissman, 1993). The process of narrating an experience is always set within an historical and temporal frame that the teller brings to the story and it is a form of reflection upon an event (Ricoeur, 1986). The central dynamic of the narration is the narrativisation of one's life and identity formation (Mishler, 1992). The discrete unit of text is recognisable in terms of openings and closings that give a stretch of talk unity and coherence (Mishler, 1995) and narrative is defined by Denzin (1989) as a story, which possesses a beginning, a middle and an end is past-orientated, linear and sequential, has a plot and makes sense to the narrator. As people tell their stories they are inclined to fabricate, explain, elaborate, exaggerate, minimise, silence themselves and give themselves away. So narration is essentially a reflection of these deeply embedded notions about the normal course of life (Babre et al, 1989).

The broad underlying premise of narrative research within social science research is the belief that individuals most effectively make sense of their world and communicate these meanings by reconstructing stories or narrating them (Coffey and Atkinson, 1996; Mishler, 1995; Ricoeur, 1981; Reissman, 1993; Wiltshire, 1995). Narratologists assume that all human beings are masters of making sense of experience of the world through narration and Polyani (1985) described three types of narrative. First-person-event-specific stories are accounts, which describe a specific

event. Generic stories are accounts of a course of events occurring over time. Kernal stories are untold stories, and all three are able to act as the primary unit of analysis in narrative inquiry. Bailey (2001) described in detail how the three elements featured in death stories in ten family-nurse units within two hospitals in Ontario. Each of the participants was asked to talk about the circumstances surrounding the patient's acute exacerbation of chronic obstructive pulmonary disease (COPD). They described either a distinct moment in time when the participant thought they or the person they had been caring for had died (and been resuscitated), or a near-death story, or an incident when the storyteller feared dying or witnessing a death event, a shadow-of-death story (Bailey, 2001). They talked of their fear of dying or of witnessing another near-death event.

Punch (1998) claimed that much social research data occurred 'naturally' in story form as in unstructured interviews where people give narrative responses to interviewer questions, which provides uniquely rich and subtle understanding of life situations and is a feasible way of collecting data because it is a device in everyday interaction. Explanations and analysis of narrative data leans towards semiotics and draws on a range of frameworks. Formal approaches to narrative analysis draw on the structural features within the unit of text. Alternatively, narrative analysis could explore the origin of the voices perhaps by differentiating and stratifying voices in the narration and by considering the social and cultural context of the narrative to identify social constructions such as, power structures within a social milieu and this approach leans towards discourse analysis. The use of language to convey meaning can be exposed in narrative analysis and can take a number of perspectives specifically, use of imagery and metaphor can reveal shared meaning and understanding in a social milieu. Metaphors are used in a number of ways to make sense of an experience and to express the meaning as a literary device or trope, which figuratively expresses meaning by comparison of similarities but not difference such as 'pieces of meat' to describe the cadaver. Metaphors may also express a view from the opposite or incongruous position in that 'Deathograms' for example, describes how police officers perceive the process of delivery of bad news to relatives. Synecdoche links

instances to a larger concept such as opening the resuscitation room windows may be linked to the wider concept of the 'freeing the spirit'. Metonymy concerns the representation of the whole in terms one of its parts as manifested in the universal negative comments about all mortuaries when only one of the mortuaries was in a poor, dilapidated condition. Throughout the following chapters the use of narrative assisted in gaining valuable insights into descriptions of what sudden death means to those involved.

Focus Groups

The focus group formed one of the data collection instruments and nine sessions were conducted on the three disciplines involving three groups of accident and emergency nurses; three groups of police traffic officers; and, three groups of paramedics. Prior to switching on the tape recorder participants were provided with a typed schedule of areas for discussion. The duration of each focus group was between thirty and ninety minutes and sessions began with a broad question aimed at settling people in and getting used to the presence of the tape recorder by asking "Tell me what might happen when somebody dies suddenly, what sort of things might you get involved in?" Participants were then asked to discuss a range of practical and emotional aspects of their role in the sudden death situation (APPENDIX TWO).

Originally used as a qualitative research method in the marketing arena (Krueger, 1994; Morgan, 1988), focus group interviews are increasingly used to evaluate service provision in a range of contexts including health care (Gray-Vickrey, 1993). It is typically a group consisting of four to twelve participants who meet once for one to three hours for the purpose of exploring a research question. The unique nature of this approach is that group dynamics theory is integrated with qualitative research methods (Dilorio, 1994), and as such a rich data gathering instrument is produced.

Kitzinger (1994) argued for the overt exploration and exploitation of such interaction in the research process, declaring that the singular distinguishing feature of the focus

group is the interaction between participants. Indeed it is her assertion that even when group work is explicitly included as part of the research it is often simply employed as a convenient way to illustrate a theory generated by other methods or as a cost-effective technique for interviewing several people at once. On reviewing over forty published reports utilising focus groups it was also her opinion that despite the distinguishing feature of interaction in the research data robust conversation between participants of three or more, gave way to turn on turn talk restricted to two members of the group at a time. Sim (1998) highlighted the tendency for the more self-confident and articulate members of the group to be more willing to agree to participate in a focus group. Indeed this situation occurred with one police group in the current study in which an officer with a specialist role within the department initially dominated the conversation, whilst other officers drew on his expertise to clarify issues and make comparisons to their own work. With these limitations on the data gathering process in mind a deliberate effort was made to encourage the inclusion of all participants in the sudden death focus groups by facilitating inclusion for quieter members and seeking challenges to statements made. Despite this safeguard, developing analytical methods and reporting strategies are inevitably flawed from the outset should a study masquerade as interactive data when the data is really individualistic. The competing elements involved in the private versus public discourse was apparent in the manner by which individuals agreed or challenged some statements and provided an insight into their language, concepts and frameworks for understanding their world. A hierarchy of importance can be established in vigorous response to some issues demonstrating a shared perception of a particular image such as the universal defamation of one particular hospital mortuary by certain police officers. However, it is only possible to attain context specific responses from situated accounts that are tied into a particular context of interaction, which is a simulated interaction. The notion of achieving external validity in a context-neutral perspective can not be supported within this epistemological frame.

Caution was advised in using focus group data (Sim, 1998) for the following three reasons. First, it is misguided to attempt to infer attitudinal consensus from focus

group data, when apparent conformity of view is a property of the group interaction and not a reflection of an individual opinion. Second, any attempt to measure strength of feeling about an issue is problematic. The capacity exists to utilise the same indicators for focus group data as would be used for orthodox survey research. However, where comparison of data across groups is desirable it is only possible to draw inferences about the presence or absence of an issue, and not to determine the relative strength of the issue. Third, methodological and epistemological objections could be raised to deter from attempts to generalise from focus group data. Theoretical generalisation is feasible when data gained from a particular study provides theoretical insights, which possess a sufficient degree of generality or universality to allow their projection to other contexts or situations comparable to that of the original study. However any attempt to declare empirical generalisation by assuming that the data is representative of the wider population in a strictly probabilistic sense is flawed.

Reed and Roskell Payton (1997) concluded that the focus group is not a 'quick and easy' method of collecting data, and that issues of validity and the relationship between focus group data and other data require careful consideration. A lack of representativeness has led to doubts about validity in relation to the degree to which a procedure really measures what it is supposed to measure, and there are suggestions that the data from focus groups may be idiosyncratic. Reed and Roskell Payton explained how the debate about validity was linked to terms more usually used in the marketing arena with positivist methodologies as such the focus group approach is located as a qualitative instrument within a discipline, which has strong positivist leaning.

Agar and MacDonald (1995) argued that the focus group was sometimes used as a 'stand alone' instrument the risk being that the 'quality in qualitative goes the way of fast food' (p.78). The use of focus group material in isolation to other data typically establishes high face validity due to the credibility of the participants' comments (Nyamathi and Shuler, 1990). To take this comment one step further, Reed and

Roskell Payton (1997) claimed if face validity is all that the focus group can offer then the instrument is capable only of confirming and supporting assumptions and prejudices. The interpretation of focus group data is severely limited in the absence of prior ethnographic work with which rich meanings can be established in its relationship with other data.

In relation to research on sudden death it is very much dependent on creating a harmonious group, which considers the emotional vulnerability of some participants, but when performed in a permissive non-threatening environment, a multitude of perceptions can be explored (Nyamathi and Shuler, 1990). Krueger (1994) highlighted an important characteristic of focus groups in that it accesses the attitudes and perceptions of humans as it relates to their needs in terms of products, services or programmes and how the hallmark of the focus group is the quality in which spontaneity and candour is achieved.

Literature searching revealed a range of studies citing the use of the focus group as a research instrument yet only one utilised this instrument to study the concept of death (Johnson, 1994). In a study of Diploma in Higher Education (Project 2000) Adult Branch nursing students, the phenomenon of death was investigated in relation to their perceptions and experiences. Two focus groups of four participants each expressed views on the basis of their perceived reality. Relationships with supportive staff were considered desirable at the point of the death experience, however this was compromised on occasion by conflicting philosophies.

During the nine sudden death focus groups initial discussions were somewhat stunted with evidence of clipped sentence construction and censored dialogue probably due to the presence of the tape recorder, mixed seniority and experience among fellow participants. Consideration was also given to the perceived socially taboo nature of the subject 'death' as highlighted by Gorer (1955) whereby despite the participant's willingness to contribute to the discussion, some individuals may not have felt able to openly discuss the subject. Participants were reminded that there was no correct or



incorrect comment, the purpose of the session being to explore their experiences and feelings towards aspects of sudden death. Institutional talk was apparent particularly in the early stages when individuals referred to 'the multidisciplinary team' or 'the procedures to follow', which did not guarantee an expression of their perceived reality or internalised feelings, but was perhaps a reflection of institutional compliance. This situation subsided as sessions progressed and participants lapsed into a more relaxed, spontaneous conversation, which gleaned a large volume of data. The approach to the analysis of the data will be discussed in the following section.

Data Analysis

The following section explains the collective approach to data analysis (i.e. concurrent analysis of information obtained from participant observation field notes, informant accounts and focus groups).

Data transcription and coding

Transcription of tapes was conducted by the researcher alone and constituted an extensive period in the execution of the research compounded by the demands of full-time employment but the benefit of achieving deeper immersion into the data could not be achieved by involving a third person. Data analysis involved the use of computer assisted qualitative data analysis software to enable theory building. The rationale for the selection of the software was based on the epistemological position and ethnographic need of the study, and also the volume of material to be managed. In total the focus group transcripts provided two hundred and twenty five A4 pages of dialogue and one hundred and eight thousand words for analysis. Initial browsing of the transcripts revealed a plethora of possible categories, which required the use of software that would accommodate an unlimited number of categories. The non-numerical unstructured data indexing, searching and theorising (NUDIST NVivo) package was selected, which allowed codes to be attached to data, retrieved and sorted within a tree structured index system (Fraser, 1999) of sufficient complexity to permit

overlap among categories as well as relationships between categories (Silverman, 1994). The nine focus group transcripts were converted to Courier text then individually imported to the NUDIST NVivo programme to create nine text units. Data from field notes and informants was subsequently coded to memos.

Despite creating a more labour intensive analysis the decision was made to recognise the size of databyte to be coded using the single line hard return, rather than paragraph hard return, to arrive at a more accurate level of meaning within the data. A line wrap around facility of variable length was utilised when an understanding of the context of the dialogue was required (Richards, 1999). It was possible to track the sequence of the conversation to identify when individuals were in agreement with others, occasions when individuals challenged the opinions of other members of the group, or situations when an individual re-conceptualised his/her personal frame as a result of the impact of the conversation. The coded data units were supported by what proved to be a very useful category entitled 'thick description', which accumulated an extensive range of lengthy descriptions of sudden death scenarios as explained by Geertz (1975). Some of the previously mentioned sequences were more easily interpreted with a fuller appreciation of the scenario and many individuals had been keen to describe in some detail accident scenes, encounters with colleagues, descriptions of mortuary facilities and other practices.

The hierarchical indexing system then required refinement in order to clarify ideas about links and possible mergers, and also in recognition of omissions. Bazely and Richards (2000) claimed that, "...far too often researchers struggle on, encumbered by a confused or cluttered index system that inhibits rather than enhances their analysis" (p.114). Reviewing the index system led to a series of steps to create a better-organised, well-conceptualised structure, which helped towards the overall conclusion of the analysis. Initially seventy-six nodes were created pertaining to thirteen categories. Subsequent refinement reduced the data to a more manageable sixty-eight nodes pertaining to ten categories. Five nodes were eliminated, as they had no data entry after all. Others were merged, and finally, a few were relocated such as 'black

humour' was relocated to a sub-category of 'emotionality'. 'Role resignation' became one of four child nodes within the parent node 'role', the others being 'role uncertainty', 'role obstruction' and finally, 'role routinisation'. A large portion of data was dedicated to the node entitled 'information'. Within this particular node a section was created entitled 'sudden deathtalk', which documented the reported interactions and dialogue between those individuals involved in the sudden death scenario and provided a location for three sudden death trajectories to be situated. Concept ordering enabled the chronological arrangement of the dimensions within the category. To illuminate, paramedic sudden deathtalk with other paramedics at the 'shout' occurs immediately prior to sudden deathtalk between paramedics and relatives when at the scene.

Thick description

Data analysis and presentation concerns: the use of thick description of material within: three sudden death trajectories and a descriptive account of the delivery of the death message (Part Two); and, the use of Schutzian relevances (Part Three). Thick description (Geertz, 1975; Denzin, 1978) within the analysis values the highly developed, multisensitivities of the author, the richness and subtlety of the observation, awareness of contextuality, and command of expressive language. Geertz (1975) claimed that the whole discipline of anthropology arose around a semiotic concept of culture; the semiotic label being derived from the Weberian notion of man as an animal suspended in a web of significance, which he has spun himself. Culture was the 'web' and the analysis of the culture was for Geertz, an interpretive search for meaning. To study culture required an ethnographic approach, which involved establishing rapport, selecting informants, transcribing texts, keeping diaries. However, even though the emphasis on method was of much significance in the 'how to do' ethnography issue, of most significance was the nature of the intellectual effort supporting the ethnography. Gilbert Ryle's 'Collected Papers 11' (1971) use of thick description explained the complex nature of the 'winking of the eye' as a cultural category, elaborating on the array of possible interpretations to arrive at the conclusion of what constituted a wink or a non-wink, a twitch or a non-twitch.

Such inferences were the constant source of confusion for the ethnographer in categorising what was encountered. The extraordinarily thick descriptions supported by Geertz form the ethnographic data within anthropological writings and we considered this to be the researcher's constructions of what was going on though these constructions were generally insinuated in the background information prior to detailed examination. In essence, ethnography is thick description. It is the unravelling of "...a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and inexplicit, and which he must contrive somehow to grasp and then to render" (Geertz, 1975:10). The relevant question to ask is "what is getting said?" Geertz claimed that culture is public because meaning is, so it is not possible to engage in an activity such as winking, without knowing what constitutes the activity, and because of this Geertz cautioned from the use of thin descriptions in determining actions.

Denzin (1989) claimed that thick description has two basic characteristics. First, thick description captures the meanings, actions, and feelings within an interaction. Second, it is interpretive by unfolding the meanings that individuals bring to the interaction. Thick description creates the conditions for thick interpretation (Denzin, 1989; Denzin and Lincoln, 1998), transporting the reader through essential features or 'conceptual structures' (Geertz, 1973) of what is being described whilst thick interpretations interpret thick descriptions in relation to the local theories that are structuring people's experiences. Humphreys (1975) analysis of gay behaviour in the United States explained how thick description illuminated patterns of intimate male to male attraction and sexual behaviour, which as taboo subject, would not otherwise have been exposed. Young (1991; 1995) used thick description in his accounts of thirty-three years of policing in Newcastle, highlighting how the data "...comes hurtling at the ethnographer so that the classic use of 'anthropological informant' is hardly necessary" (1991:41). Instead the researcher finds a mechanism to record and sort the bombarding mass of detail, which renders the discipline potentially dangerous in the sense that thick description creates a mechanism to expose the undercurrent of activity and cultural values, which the police would prefer not to be declared. Thick

description by the 'insider' with practical mastery of the system creates a more transparent view of the organisation.

Dey (1995) suggests that thick descriptions include information about the context of an act, the intentions and meanings that organise action, and its subsequent evolution. In contrast, the use of 'thin description' reduces the burden of fact by 'explaining much by little' (Sayer, 2000). Such economy of contextual explanation is of minimal value in understanding the complexities of social life. Further, absence of ostentatious, theoretical terms usually associated with objective social research methods, does not equate with an atheoretical analysis, but facilitates just the opposite in that the examination of previous assumptions is more likely. Criticisms of quantitative social research similarly point to three areas: a reductionist approach to studying human behaviour loses sight of the complete picture second; it oversimplifies social reality due to an emphasis on measurement and, it eliminates context from the data (Punch, 1998). It is not possible to give the full picture unless the full picture is available. Within the sudden death analysis thick descriptions of practices and perceptions are revealed in rich detail illuminating the way the dead body is manipulated, the washing of the body, the combing of the hair, the packing of the property and valuables, the expressed thoughts of the practitioners in dealing with the intricate and intimate emotional moments of their working life.

Anthropological writings are based on second order interpretations, as such the writings can only ever be imported constructions, imported from the researcher's interpretative frame. To arrive at first order interpretations the researcher would need to go native within the researcher's relevant culture. An important distinction to acknowledge is that culture exists within the field, whereas anthropology exists in the writings, it is not a social reality but a scholarly artifice (Geertz, 1975). The ethnographer is not central to the cultural events, can not claim to have direct access to the cultural events, but can report only what informants might infer. Through observation of behaviour or social action the 'cultural forms' are articulated, supported by artifacts such as objects and symbols, and the use made of them. To

analyse the manner in which emergency personnel interact during encounters with sudden death is to establish what sudden death is about.

Denzin and Lincoln (1998) describe three qualitative realist writing styles: mainstream realist, interpretive realist, and descriptive realist. Mainstream realist writing style presents both thick and thin accounts of the social world on the assumption that the author provides an objective account of the realities leading to analytic and interpretive texts. Interpretive realism concerns the author's personal interpretations of the life situations of the individuals studied the realities of social life being filtered through the author, in contrast to the subject's voice or eyes. Descriptive realism however, requires the researcher to develop a greater degree of objectivity to permit the social world to speak for itself. It is the latter, descriptive realism, which is expressed in the use of thick description within this sudden death study.

Schutzian 'relevances'

Schutz (Natanson, 1962) claimed that the common-sense and scientific interpretation of the world involved constructs of a set of abstractions, generalisations, formalisations, idealisations, and there were no such things as pure and simple facts. Facts were derived from the activities of the mind. Building on Whitehead's (1929) 'Anatomy of Some Scientific Ideas' and Dewey's (1938) 'Theory of Inquiry', Schutz cautioned against committing the fallacy of misplaced concreteness in that the so-called concrete facts of common-sense perception were not as hard and fast as one would prefer to believe. The difference between the natural sciences and the social sciences became apparent when considering which facts and events are topically and interpretationally relevant to their purpose. The selective and interpretative activity of "man" determined relevance and further, relevance had a particular meaning in terms of the common-sense constructs of the reality of daily life. Typicality of constructs was arrived at when a perceived perception was transferred to another similar object to recognise a 'type' of object. Dissimilarity was recognised when the construct was

set against a previous construct and stood out as different to previous experiences of that construct. Some constructs then, we deemed to be typical of others. Formulating constructions of daily life concerned how certain objects stand out from experiences of other objects and how the characteristics of such objects were determined as 'typical'.

To use the term 'relevant' was to acknowledge the biographical underpinnings of "man". The physical and socio-cultural environment as defined by "man" determined 'the sedimentation of all man's previous experiences, organised in the habitual possessions of his stock of knowledge at hand, and as such his unique possession, given to him and to him alone' (Natanson, 1962:9). Future practical and theoretical activities were termed 'purpose at hand' and it was the purpose at hand which defined those characteristics as compared to others in a given situation that were selected as 'relevant' for that purpose. A system of relevances determined those characteristics, which contribute to the generalised typification of an object.

'Texture of meaning' was established within a universe of significance in that everyday life was interpreted in order to come to terms with it. Cultural objects of daily life became symbols of typification, which formed the tools, symbols, language systems, and work and its history was important in determining purpose. A cultural object was considered to be impossible to understand in the absence of the human activity from which it originated, and further, an object could not be understood without first knowing the purpose for which it was designed. Hence sudden death practises are understood in its historical and cultural context, as a mechanism by which a culture disposes of its dead. Within this understanding there are sub-understandings involving perhaps, the spiritual processing of the dead in which religion and ceremony feature, or the disposal of the corpse whereby environmental infection control is a feature.

Schutz's (Natanson, 1962) analysis of the common-sense interpretation of the social world described how the biographical situation determined the purpose at hand

whereby the system of relevance selected particular objects and typical aspects of such objects as standing out from other taken for granted objects. In rejecting the scientific method as the single truth “man” determined what was and what was not of relevance to be investigated and the constructs required in considering the problem. The scientific problem was the locus for all possible constructs relevant to its solution and once established determined alone the structure of relevance. The social scientist needed to abandon, the scientific attitude in order to engage with the social scene, to facilitate contact with the group under study and to act as a “man” with the group under study, a “man among fellow men”. It was then possible to observe human interaction in that it had become accessible to observation and open to the observer’s interpretation.

Conclusion

In conclusion, grounded theory has been discussed in relation to the 'Chicago' movement, which supports the development of an inductive approach to theory generation supported with an item by item approach to the accumulation of detail and leading towards the 'common-sense' analysis of observations incorporating thick description. On applying the constant comparative method to the three fairly similar comparative units the joint coding and analysis of data was facilitated, the outcome of which was an integrated, consistent and plausible theory that was close to the data. Theoretical saturation has been discussed and was reached when the systematic coding of incidents revealed no new categories and this stage was readily recognised. The ethnographic approach was an important inclusion in that the reflexive personal biography of the author shaped the data by being able to apply insights on occasions that needed greater explanation and perhaps would only be understood and accounted for by those immersed in the emergency care field. Schutzian 'use of relevance' permitted the observer's interpretation of the data through the development of systems of relevance leading to the common sense interpretation of the world of sudden death in accident and emergency.

Access to the research field was made easier due to my being 'known' to specific departmental staff and these personal contacts were most facilitative. However, it was necessary that permission was sought through formal channels via senior staff and ethics committees and this process was not as smooth as it could have been had those making judgements on the quality of the research proposals had greater insights into qualitative paradigms. This is often a problem when qualitative research shares the same academic platform as other types of clinical research, though the need for comparable academic rigour remains the same. Once access was gained the process of accumulating data was lengthy but unproblematic and all sessions and requests for supporting information went according to plan. Informant narratives were most useful in providing 'thick descriptions' of incidents and interpretations of how those involved perceived the situation they found themselves in and various metaphors and

analogies were revealed for interpretation. The nine focus group discussions revealed a wealth of data, sometimes duplicated within the groups, but caution was heeded that it was only possible to draw inferences from the data and not to determine the relative strength of an issue so consensus was not reached. The accumulation of rich detail from informants and also focus groups meant that Young's (1991) "bombarding mass of detail" really did come "hurtling at me" and begged questions regarding how the volume of material was to be analysed. Selection of appropriate computerised data analysis software was made difficult because of underexposure to the range of qualitative packages available. A preparatory one day programme was attended related to NUDIST Version 4 then despite the labour intensive process of steering my way through the 'help me' section of the software, an insight into the application of NUDIST NVivo was eventually arrived at, an isolating and frustrating process. Whilst coding of data was in progress the writing up of Schutzian relevances commenced so as to create a dynamic process of reporting on data whilst simultaneously remaining immersed in the data. The sequential reporting of the three sudden death trajectories (Part Two) and Schutzian relevances (Part Three) is now ready to commence.

PART TWO

PART TWO

SUDDEN DEATH TRAJECTORIES

Part Two concentrates on death as a locatable phenomenon, possessing both visible and audible characteristics to be concealed by emergency personnel if possible. Thick description of three sudden death trajectories follow, which map the collapse to death career of the patient en route to a mortuary as 'cadaver'. The problems associated with sudden deathwork are presented within the reported encounters of emergency personnel highlighting in particular, the way news of the death is delivered and some of the emotional highs and lows of working with and experiencing human tragedy.

Reference to three hospital accident and emergency departments and three mortuaries is made though but it is not intended that one overshadow the other two. Similarly, the procedural base to sudden deathwork is explored from the standpoint of the three emergency disciplines. It is not intended however, that one discipline should overshadow another, merely that issues of relevance are declared in relation to a given aspect of sudden deathwork and on the basis of the reported statement or observation. Italicised and bracketed responses are a presentation feature of the chapters to come and represent sections of the reported data and its appropriate location in the computerised data coding system.

CHAPTER THREE

Introduction

Chapter Three considers sudden death as a locatable, visible and audible phenomenon, which is manifested in the procedural base to sudden deathwork by emergency personnel. Three sudden death trajectories are introduced which identifies the collapse to death career of the patient and sudden death practices central to the event.

Locating sudden death

Sudnow (1967) referred to the visibility of death by explaining how death occurred in various places in the hospital setting and how people were spatially located to be able to see, or to not see death, as it happened. For example, the 'microecology' of the hospital fostered the restriction whereby the administrative part of the hospital is separated from the 'sick part'. Spatial separation from the sick part of the hospital meant that clerical staff did not encounter clinical aspects of hospital life so they rarely came across death. "Such personnel can work out a career at County, only occasionally ever seeing a patient or smelling those odors associated with the sick parts of the building" (p.42). In the accident and emergency departments observed in this present sudden death study the secretarial and administrative personnel were located in the office section of the department separated from the clinical activities by a corridor. In contrast to the hospital setting the sudden death event may occur in any location and is chiefly accessible to non-clinical individuals in the first instance, before emergency personnel arrive at the scene. What this means is those individuals who at the time of the observed collapse were simply passing by or were in the vicinity at the time for example strangers, colleagues, neighbours, or friends who intervene in the sudden death scenario. Intervention may take the form of raising the alarm, attempted cardio-pulmonary resuscitation or placing the person in the recovery position. It is precisely this observation that has led to the development of the 'First-Responder' system of resuscitation throughout the United Kingdom, which aims to

provide immediate bystander intervention. It is envisaged that resuscitation equipment including synchronised defibrillation machines will be accessible at public venues such as sports and leisure centres, community centres, those locations that are used for public gatherings.

Sudden deaths mainly occur in ordinary circumstances (ordinary to emergency personnel) whereby the individual dies at home from medical causes like a heart attack and does so in the immediate vicinity of the family, friend or neighbour. However, some sudden deaths occur in unusual locations creating more unusual circumstances for the emergency personnel. Consider suicidal death by jumping onto a railway line when a train is coming, which can result in the fragmentation of the cadaver. One traffic officer reported what he had encountered following such a death. *“Yeah, when they go under the train basically the front (of the train) gets them and they just go underneath it as the train goes along and they just get shredded so you have to walk miles, I would say probably about two miles picking bits up er, and that’s before the foxes get at them as well. Yeah, foxes run off with bits that they never recover sometimes”* (TPB para 1185). Alternatively, sudden death following an industrial explosion may result in a charred body due to burn injury and a paramedic reported his most disturbing experience with a man who was still alive on their arrival at the scene. *“We was one of the first there and when we went in we tripped over what we thought was a hose pipe and it was a man’s torso and the chap we got out, his arms and legs had been burned off and his face was unrecognisable. He had just a puckered (gesture to the face), but he was alive, and he was asking us to suffocate him. Thats sticks in my mind”* (PB para 476). Sudden death in an isolated location may result in delayed discovery of the body leading to various stages of decomposition. An array of activity unfolds leading up to the death and occurring after the death related to those specific unusual death locations. The location of the activities prior to death are important considerations in providing explanations of the pattern of activity leading up to the death and hence the possible cause of death.

Unusual death locations exist within the home with people frequently dying in the bathroom or behind the toilet door. It is even more difficult to gain access when considering how the toilet is probably the only interior door in the home to be locked. *"They'll be stuck behind the door and you'll be saying, "Is he alright?" and ... you have to grab hold of them by the hair and writhe them out the way you know, to get into them"* (PB para 584). To labour the point further at times like this the all too hilarious, awkward encounters are the material for incongruous laughter, which filters through the very core of the emergency care culture. Young (1995) described how an ability to respond calmly to a sticky 'sudden death' or fatal accident helps to determine whether the new boy is to make it as a 'good copper'. Black humour is one way in which the inexperienced teenage lad who has become the category 'police officer' can handle the problem of being perceived as an expert when he simply wants to vomit. "By crashing through the limits of good taste and decency with barbed and wicked disrespect, these all too human icons can (perhaps) remain one-up during a course of events which often annihilates the possibility of retaining any human dignity, and which constantly flouts the idea of social predictability" (Young, 1995:159).

Sudden death is manifested in various dimensions concerning location, sight, and sound of death. The location of a sudden death is a focus for gawping crowds of onlookers at the scene of an incident but it is not visible to the public gaze when someone dies suddenly and in isolation. Research into the problem of 'dying alone' could provide rich insight into an otherwise unreported subject.

The sight of sudden death creates images in the minds of witnesses that are friends, relatives and onlookers who retain these images for later recall. The resuscitation room in one accident and emergency department was very poorly located which meant that although staff tried to conceal sudden death 'happenings' it was virtually impossible. The corridor immediately outside the resuscitation room was the thoroughfare for the other clinical areas such as the plaster room, sluice, theatres and linen room. Further, many staff and visitors to the department would enter the door

adjacent to the relative's room. This situation was wholly unsatisfactory in concealing the death. *"I mean its not ideal though is it, you've got plaster room and everything at the bottom and people can be down there. You can try and shut the doors but people still wander don't they and they're coming in the ambulance doors and they don't realise"* (NC para 1282). The geographical layout of the department is also problematic when staff tries to conceal death from newly arriving relatives. *"Well they could be going in (to the relative's room) and see things I mean, 'cos the curtains were not always closed properly. There's people running in and out and they're x-raying"* (NC para 1274). Concertina wooden doors separate the resuscitation room from the corridor in one department and although attempts are made to close them when a patient is there, the doors are cumbersome and awkward to manoeuvre. Reliance on the curtains around the trolley is all that conceals death from the gaze of those who stumble across it en route to other parts of the department. *"I mean at least they have the curtain but I've known the curtain not to be shut"* (NC para 1365).

Sudden death is not only visible to those staff who would prefer it to be concealed, but it is also audible to those staff who may prefer not to hear the sounds associated with sudden death. Resuscitation sounds within the resuscitation room are most distressing to hear even to the most experienced of staff that may be desensitised to the noises. When the curtain is the only mechanism to separate death from outside gaze and hearing it is difficult to contain. *"You could hear things that were happening... you could hear everything"* (NC para 1271). Sounds may range from resuscitation orientated commands to patients groaning and crying out in pain and the staff acknowledge the need for space and a more suitable location for death and dying where the public would be oblivious to the sudden death happenings. Another department was able to conceal the sight and sound of sudden death more effectively by channelling patients through a totally separate entrance straight into the resuscitation room, a self-contained section of the department, being totally walled and without windows. Relatives were guided to the reception area and then on to the relative's room but the thoroughfare was rarely used by patients or staff or relatives to

access to other areas of the hospital and hence did not expose the happenings to the public gaze.

Sudden death is audible in the handling of the body. The silence created by the cessation of cardiac beats from the cardiac monitor, the withdrawal of resuscitation related activity of the emergency team, the absence of conversation when preparing the body, and the noise created by placing the body into the metal container for transportation to the mortuary. Komaromy (2000) drew attention to the dichotomous behaviour of staff in nursing homes whereby the visibility of death was concealed from other residents yet the sound of death was not afforded the same regard. Despite theatrical attempts to remove the body without the residents' knowledge by drawing curtains around the body or using alternative exits away from the residents, the audibility of death provided residents with evidence that death had occurred. Such contradiction of concealment pointed to the collusion of silence among nurses and residents who recognised death and the deceased status of the body as taboo.

The sound of sudden death could be associated, in a nihilistic sense, with the sound of silence, but at certain stages in the sudden death process association with silence is very much not the case. Where an array of resuscitative activity occurs it is more likely that the sudden death scene generates a high level of noise. It is only after death has been declared that in stark contrast, an eerie quietude resumes and then only in some cases because the knowledge of the death for some onlookers generates strong emotional reactions and accompanying emotional verbal expression. *"I've had to deal with the parents of a little boy that was knocked over and the dad was in here and he was virtually having a nervous breakdown and he was a known psychiatric patient. Anyway, he started stripping off his wound (child's) you know, he was going absolutely wild..."* (NB para 79). Paradoxically, the boy's mother was really calm.

An intuition that sudden death has occurred is linked to the notion of 'intuitive knowing'. How do nurses know when a patient is unwell, when we are 'losing him' or when the patient presents with a condition that is quite apparent to the nurse that it

is not quite right? How does a police officer know that a person may be dead inside their home and require that the officer break the door in to gain access? It is usually when the pieces of information gathered from neighbours, family and friends are assimilated, which lead to the conclusion that an individual may be dead in their own home particularly if the individual has not been seen for a number of days or weeks.

The frequency with which emergency personnel encounter sudden death varies according to experience and discipline and involvement is strictly influenced by the role an individual has within the particular emergency discipline. Some emergency personnel become desensitised to the event due to years of experience, whereby sudden death becomes an everyday occurrence. Others reported never to have been involved in dealing with a sudden death at all during their short career in the emergency services. One traffic officer commented, "*A police officer could be on the beat all day and they might not come across anything*" (PA para 422). Other emergency personnel are extensively and directly involved. One accident and emergency nurse reported how she regularly managed, "*...one, two maybe every day of the week*" (NC para 236). A paramedic reported how he had, "*...three cot deaths in one night, and that was the only night I've ever thought, 'Is it time for me to Jack this job in?'*" (PA para 273). Another paramedic disclosed how paramedics are involved in fatal incidents of one type or another every day of the week, "*...and we could have a couple of dead uns' a piece*" (PA para 431). One Monday morning shift four 'shouts' (the term used for an emergency call for a paramedic crew) had turned out to be sudden deaths which all came in on the one morning so it is possible to get a run of sudden deaths comprising the, "*...usual sort of 'trash' that you can pick up*" (PA para 456). For an explanation of the use of the term 'usual trash' refer to Jeffery, (1998).

Few paramedics reported to have been involved in suspicious deaths. When they are involved the body is left well alone and the police arrange transportation of the body to the Coroner's mortuary by a forensic team. "*I've never ever took one in to Casualty that was suspicious no! Unless we were working on them, but er, if there'd*

been sort of well I mean one of them had fifty-two stab wounds in him, they never took him. He was left where he laid and that was a job for the Coroner's Officer" (PA para 832). The Coroner's Officer is generally a civilian employed by the Coroner's Office who records the circumstances of the incident and initiates an investigation into the death. This role always use to be performed by uniformed police officers however, these positions are now largely civilianised. During weekends and Bank Holidays or if the Coroner's Officer is busy dealing with a death elsewhere, the uniformed officer may attend the scene to initiate the process instead. Road traffic accidents are handled in a different way whereby officers within a dedicated Road Traffic Accident Unit co-ordinate the investigation into a road traffic incident.

The word 'incident' is used cautiously because of the alleged misleading nature of the word 'accident'. It is acknowledged that many road traffic incidents are not actually accidents but are the result of drink driving, joy riding, speeding and reckless driving rather than accidental. In response to recommendation 6.1 of the Independent Working Party Report for the Families of Road Death Victims (Victim Support, 1994), which aims to hear the voice of the public affected by road deaths the word 'accident' should be replaced. In the context of road deaths, words such as crash, incident, fatality or road death, should be used in official statements and documents. Howarth (1998) argues that as long as traffic fatalities are categorised as accidents, road death will continue to be processed through the Coroner's Court through a separate system from the criminal justice system, which is the domain of responsibility and culpability. Many of the so-called accidents which also have parallels to occupational accidents, may well have been avoided had individuals with responsibility been more careful. The point Howarth is making is that the social management of sudden death cannot be divorced from its surrounding discourse. Where the language of accident and blamelessness is used to explain road fatalities road deaths will be constructed and defined as accidental.

Rarely do traffic officers get involved in sudden deaths but the majority of their time is spent dealing with road traffic incidents but occasionally the traffic officer may

become involved at the scene of a pedestrian collapse if they happen to be the first professional at the scene. One officer estimated that he had been involved in about seventy-five incidents, another about twenty-five, but the exact figure was uncertain. The latter was eager to humorously add that the accumulated number was not used as 'notches on his bed-post', an interesting analogy to express in relation to the need to conquer the awesome nature of the subject. Overall, it seems likely that the first, second and possibly the third are significant incidents to remember some years after, and most remember their first sudden death encounter. However, the more service one has the more likely it is that the sudden death incident is remembered because of unique characteristics central to the event.

Sudden death trajectories

Dying trajectories display two properties, duration and shape (Glaser and Strauss, 1970) and variation in duration may alter the trajectory from instant death to taking months to die whilst the shape of the dying trajectory can be graphed to display the sequence of events through periods of relapse and reprieve to eventual death. Duration and shape are subjective features, they are perceived properties based on the individual's definition of the dying trajectory rather than the actual course of dying itself. Sudden death possesses a temporal dimension in that although death is certified as having occurred at a specific time it could be argued that death occurs over a period of time. Such discussion has long been the problem of philosophers and medics who are at pains to establish a definitive concept of time of death which fits well into a contemporary legal system that highly prizes specificity. It has been established that death occurs following respiratory, cardiac and brain stem cessation though it is also known that some tissues continue to function for some time following respiratory, cardiac and brain stem cessation (Pallis and Harley, 1996) making death a process rather than an occurrence. Declaration of death at a specific time generates ritualistic measures among emergency personnel related to care and management of relatives within a practical, spiritual and religious dimension, and measures to deal with

making safe and disposing of the 'polluting' body through theatrical representation of the body (Howarth, 1996).

In the following chapters I will argue from an emergency personnel perspective that three sudden death trajectories exist: the 'Direct Trajectory', the 'One-stop Trajectory' and the 'Elaborate Trajectory'. The three trajectories take an individual from a state of collapse to subsequent death and deposition in a mortuary and with the exception of undiscovered deaths, all deaths will lead to a mortuary. Selection of the appropriate mortuary is dependent on location of the death, categorising as a suspicious death and subsequent emergency personnel involvement.

Death in the home will normally result in a funeral director visit and transportation of the body to the funeral home mortuary, however, there is an exception. Occasionally a police officer may attend the house where there is suspicion that the death was unnatural or violent. Certain criteria need to be established to inform a decision that the death qualifies as a 'Coroner's Case' to be subsequently investigated. It is not unusual for a cot death (i.e. Sudden Infant Death Syndrome (SIDS)) to be investigated and for the police to remove items of clothing and bedding, even the child's cot from the house for forensic analysis. Extreme emotion from relatives is generated on the removal of such items and the expression of such extreme emotion is considered by emergency personnel to be quite difficult to deal with.

In contrast, there is a need for vigilance on the part of emergency personnel as there are occasions when a violent death may be concealed. Such incidents can be quite alarming for emergency personnel as in the following fatal stabbing. *"I mean, "The patient's dead!" you know. "She looks as if she's fallen off the steps and you know..." We're waiting for the doctor and we we're waiting, waiting, waiting and anyway the doctor turns up and sometimes you always used to think, "God why does he need to bother, stethoscopes and all this going through the whole situation and you could see from a mile back that the patient's dead" you know. And of course he come over and he lifted her jumper up and of course there was this big gulley, a big knife*

stuck in her chest. He's (the assailant) stabbed her and pulled her jumper over her you know? An old lady with lots of jumpers and cardigans and what have you that they have on" (TC para 261).

The 'Direct Trajectory' does not involve the hospital in any way. The paramedic attends the patient at the request of a relative or general practitioner and arrives at the patient's home or in the immediate vicinity of the home ideally within the nationally determined 'paramedic to scene' time. Occasionally the paramedic may request the attendance of the general practitioner if not already at the home. The patient is certified dead at the home by the general practitioner and a funeral director is appointed by the family to transport the body to a funeral home. Paramedic involvement is restricted to a domiciliary encounter with rapid disengagement from contact with the family and particularly, the body.

The more complex 'One-stop Trajectory' takes the dying patient to the hospital and involves a brief encounter with hospital staff immediately outside of the accident and emergency department for the purpose of death verification. The patient collapses either at home or elsewhere and resuscitative effort commences with a view to intensive resuscitation on arrival at accident and emergency. These patients subsequently die in the vehicle en route to the hospital accident and emergency department. The patient does not survive beyond the intervention of the paramedics in the ambulance and the body never enters the accident and emergency resuscitation room. The single stop involves a team of emergency personnel entering the vehicle, which is parked immediately outside the resuscitation room, and recording brief details about the body to determine identity following which the body is transported in the ambulance to the hospital mortuary. A phase of post-death activity occurs in the mortuary and the relatives' room and the paramedics are inclined to rapidly disengage from contact with the body, mortuary staff and relatives. Minimal interaction occurs between paramedics, other emergency personnel and relatives and within the accident and emergency departments it is the latter two disciplines which are likely to be involved in the aftermath of the sudden death.

Third, the 'Elaborate Trajectory' is much more complex involving the decision usually by a doctor, to bring the patient into the accident and emergency department to continue resuscitative effort. The patient may have collapsed at home or any location. Transportation to the accident and emergency resuscitation room involves an intensive period of resuscitative effort with the intention to continue such effort in the resuscitation room. Resuscitation is continued and eventually death is declared in the accident and emergency department and the subsequent death of the patient leads to a host of interactions with other emergency personnel and hospital staff related to the management of the sudden death encounter. Disengagement from the body, relatives and other emergency personnel is still fairly swift for paramedics, but certain hand-over talk delays their departure. For other emergency personnel there is an intensive period of activity ahead.

Within a sudden death context variation in duration may alter the sudden death trajectory from a 'Direct Trajectory' to one in which life extending behaviours exist, specifically, a 'One-stop Trajectory' or even an 'Elaborate Trajectory'. The location of the collapse is important in determining the nature and duration of contact with emergency personnel and subsequent dialogue surrounding the event. An emphasis on dialogue signifies that there is a distinct emergency personnel language central to the sudden death event previously reported by Palmer (1983) and Noe (1996).

Sudden death interaction

During interaction in the course of their work emergency personnel engage in dialogue at various points in the patient's sudden death trajectories. Behind the scenes it was possible to develop an interaction matrix or interaction field for each of the three emergency disciplines which evidenced who interacted with who, and which also identified the content of the deathtalk and linguistic style of the emergency personnel. Spatial and linguistic boundaries were tracked within individual roles through an emerging collection of interaction pathways. Sudden deathtalk was plotted against the patient's sudden death trajectory to identify a chronology of events from the scene of the incident to the deposition of the body in the mortuary. Such

utterances gave shape and identified the loci of sudden death in relation to a range of occurrences from the 999 shout; the initial incident and resuscitative effort; transportation of the body to the accident and emergency department; declaration of death in the ambulance; declaration of death within the resuscitation room; retention of the body in the department; transportation of the body to the mortuary; police notification of relatives; transportation of relatives to the department; discussing the death with relatives; and walking with relatives to and from the reception and the mortuary. The matrix of utterances occurred in a range of locations and extended to other deathworkers, relatives, neighbours and the public.

Interaction and subsequent dialogue is by definition “two-way” whereby individuals have an opportunity to respond to one another, however, sudden deathtalk between the nurse and the deceased could only be “one-way”, when the nurse talks to the dead body explaining the laying out procedure as it is performed. Nurses are known to talk to the body in the knowledge that the patient hasn’t been dead for hours and it was perhaps only a few moments before that death took place, so the nurse continued to talk to the cadaver as if the person was still alive. One nurse informant remembered her distant training which discouraged nurse to nurse talking in the presence of a dead body during the laying out procedure, however, the requirement for silence contrasts markedly with approaches at the turn of the century when it is increasingly acceptable to speak in the presence of the deceased.

It is possible to identify transitions in conversation from forewarning relatives of the news of the death; giving definitive pronouncements about death; giving information about the circumstances of the death; talking more generally about the character or the actions of the deceased immediately prior to the death; and, closure talk. Such conversational junctures were highlighted in Sudnow’s (1967) research in the hospital setting.

Chapter Three established sudden death as a locatable entity, which is visible and audible within the procedural base to sudden deathwork by emergency personnel.

The procedural base to sudden death requires that deathworkers engage in mutual deathwork, deathtalk and hence sudden death interaction and it has been possible to identify who talks to whom and the content and manner in which utterances are communicated. The following descriptions of three collapse to mortuary sudden death trajectories incorporate extensive informant accounts of sudden death encounters and the personal biography of the author.

CHAPTER FOUR

The following chapter describes the direct trajectory, which focuses on the emergency call out and paramedic intervention usually in the patient's own home or in the immediate vicinity. The main features of the scene concern failed resuscitation, death declaration and early paramedic disengagement from the body.

The Direct Trajectory

When a sudden death occurs the direct trajectory processes a dead body from the scene of the initial collapse, usually the patient's home, to a funeral director's mortuary. Few individuals are involved at the scene, usually only the paramedic, general practitioner or locum, religious minister, and relatives or friends. Occasionally suspicious deaths in the direct trajectory involve a police officer who attends the scene to record details and initiate an investigation into the death on behalf of the Coroner. When the death is suspicious it is declared as a 'Coroner's Case' and the body is then transported to the designated Coroner's mortuary within the hospital serving that geographical area. Unless the general practitioner is called to the home first, paramedics often have initial contact with the collapsed patient.

The 'shout' comes in on the radio in the ambulance station interrupting a good game of billiards and someone eating their evening meal whilst listening to the football match. The paramedics anticipate that the radio message is not necessarily a true reflection of the scene because information is limited to stating the location, and a brief medical account of the incident. It is a matter of 'all down tools' for the two allocated to the next job to make their way to their vehicle. Frequently, on arrival at the scene, the scenario turns out to be a little bit distorted. The brief explanation of the scene and medical condition is no more explicit whether the control room is describing a 'straight run' type of condition or a more complex situation. Certain paramedics would rather be involved in the resuscitation side of cardiac patients than in the resuscitation of trauma victims, "*Give me a cardiac. Give me a patient to*

resuscitate any day of the week than messing about with broken bones and bleeding all over the place by somebody who's been whapped by a car. You can keep it" (PA para 477). Other individuals express ambivalence in that they wouldn't feel bothered if they had to be involved with any type of sudden death event. They certainly don't feel the need to ask somebody else to deal with it, even though they do not like doing it, it is simply expected as part of the job and they carry on and do it and some do not even give it a second thought. It is not until afterwards when the details of what they had been dealing with sometimes might hit them.

Often partnered up for the period of duty, the paramedic could be required to deal with almost anything and there are wide differences in the type of case that they encounter. *"I mean, me and him can deal with some horrendous jobs can't we? Absolutely horrendous, and yet as soon as we've finished that job they'll give us a routine immediately. We'll go on the radio and we'll just say, "We're now clear of it all" and ... Yeah, the next call's something quite ordinary like an asthma attack"* (PB para 1659). Despite the horrendous descriptions of some shouts, death, mutilation and anguish do not appear to affect their appetite and it is not unusual for a pair to return to the ambulance depot to devour a huge 'Full English' breakfast. On one occasion an offer of counselling by a staff manager was met with an immediate refusal accompanied by a sharp retort, *"No, I want my breakfast!"* (PA para 324).

The proximity of the partnering arrangement is quite close, enough to establish a rapport and trust between the two individuals which involves looking out for each other, 'covering each other's backs'. One informant described in detail an incident in which a woman had died in bed and the husband was becoming increasingly agitated. Whilst one paramedic was dealing with the body his partner went outside to the vehicle. On returning to the house the paramedic got a frightful shock.

Paramedic *"And the next thing, he's (husband) in the kitchen, comes out of the kitchen with a gun. I couldn't believe it. I'm thinking, "Bloody hell!" like.*

Partner He thought he was gonna blow my head off or something.

Paramedic 'Cos he was, he was being quite nasty to him you see, a couple of times. I thought, "I didn't know what to do". I thought, "I'll have to follow him up". So I basically got up close to him and I followed him up and said, "Hey, you're not going to be doing anything silly are you?" He said, "Oh no, I'm just going to lock my gun away in case er, for when the police come". Well, it's the first thing that goes through your mind isn't it? He's going up to shoot my mate, you know, and it was a big twelve bore shot gun he had..." (PB para 966).

Because of the risks of injury some male paramedics reported their preference to work with men. The male paramedics' rationale was that women generally have a smaller physique and although in some situations they can talk agitated people down, when they go into pubs, workingmen's clubs and nightclubs at two o'clock in the morning, physical strength is sometimes needed. All types of people from all walks of life are the lot of the paramedic and they think the situation is getting worse, especially when "...they (public) pile on the 'E' (ecstasy) and God knows what!" (PB para 1031). It is pure aggression, which is escalating to ridiculous levels and it's when the paramedic is least expecting an eruption that all of a sudden the individual they are dealing with will go berserk.

On arrival at the scene there are usually relatives or friends who will direct the paramedic to the patient, gesturing eagerly and leading the way. It can help if all the family is present because they can support each other when they become very emotional. One starts crying and then the next starts and it just escalates. "I've seen it time and time again and they've been stood there thinking, "Oh, God what am I going to do?" and they haven't got any relatives nearby and you know, you try and get a neighbour in. But it's really difficult at some times in the morning" (PB para 1303). However, if there is a house full of relatives the main need for the paramedic is to clear them out as quickly as possible, to 'get them away from the job'. There is apparently nothing worse than "...a house full of people crying and crawling all over

the body” (PC para 36) at a time when the paramedic needs access and to focus wholly on the resuscitation. Some will leave the room when they are asked to do so but others will literally stand and tell you, ‘point blank’ that they are not going anywhere. The relative remains standing whilst resuscitation is initiated within approximately two metres. What paramedics find most intriguing is the contrast in behaviour when the relative can be so upset and aggressive in the house, yet entirely pacified in the accident and emergency department. One paramedic described the opposite response where the relative became hysterical, ran out of the room, and ‘took off’ down the street leaving the paramedics in the empty house. There is no time to console the relatives at that point and it is the perception of one paramedic that the relative is usually not listening anyway, it being impossible to speak sense with them because they simply do not want to know. Children are a particular problem when their mother or father has died and the paramedics consider that it is better if the children are ‘shipped out’ to a neighbour’s house to receive adult assistance and comfort.

Sometimes a relative will pre-empt the paramedic by telling the paramedic that the patient is dead so it is likely that relatives formulate their own diagnostic conclusion in the absence of a professional. On other occasions it has been requested that the paramedic do nothing, ‘just leave him (patient) as he is, let him go to sleep’. It has happened where the relative has attempted to drag the paramedic free of the patient when performing resuscitation. Should the paramedic learn from the relative part way through the resuscitation procedure that the patient has a terminal illness such as an infiltrating carcinoma, and then this knowledge legitimises the cessation of any further resuscitation. The relative might say, “Oh, please don’t bother”, and they will perhaps pull the paramedic’s hand away. Then the paramedic may respond by inviting the relative to come and sit with the dying patient recreating Glaser and Stauss’s (1968) ‘quick dying trajectory’ with few last ditch heroics, having earned their right to die. The relative does not appear to want anything other than to participate in the deathwatch, providing comfort care only and will decline any suggestion of taking the patient to hospital despite the previous emergency call-out.

Conversely, it was stated by one paramedic “...we had relatives who wanted us to resuscitate no matter what” (PC para 77) which proved difficult when the relatives were urging the paramedics to perform CPR on what the paramedics considered to be a non-viable patient. One paramedic reported “You’ve got to switch off especially when they’re getting on your back about something when you know that there is nothing more that can be done” (PC para 255). On one such occasion the partnering arrangement really did ‘kick in to play’ in a situation where one crew described their unspoken means of communication. Dissonance is expressed by paramedics when involved in what Glaser and Strauss (1968) described as the ‘will probably die trajectory’. Relatives observing the scene pressurised the paramedic to continue to resuscitate despite clinical signs indicative of death. “You’ve got to switch off especially when they’re getting on your back about something when you know that there’s nothing more that can be done” (PA para 256). The paramedic considered that it defiled the patient and remembered feeling pressurised to continue ‘last ditch heroics’ when it was appropriate to give ‘nothing more to do care’.

A national training programme for paramedics was adopted in 1984 on government recommendation (Department of Health, 1984; Simpson and Smith, 1996) initiating a radical expansion in paramedic boundaries of practice to include endotracheal intubation, intravenous cannulation, cardiac monitoring and defibrillation and use of selected drugs. A somewhat over vigorous response was noted by some paramedics, “Some lads, not so much now, but when it all first started, this paramedic business, and it was horrific to watch it and the buggers wouldn’t give up you know” (PA para 109). It was said that it was pumped into them when they were training to the point of being brainwashed that you had to vigorously resuscitate yet in recognition that it was a waste of time because you would know for a fact that you would not bring them back but they were expected to go through their resuscitation protocols no matter what. A collapse would need to be witnessed to have a chance of successful resuscitation and current life support protocols have tempered these activities resulting in paramedics being more in tune with the criteria for a resuscitation attempt. If resuscitation has not commenced for ten minutes prior to the paramedics arrival and

there are no vital signs then as long as the paramedic does not administer any resuscitative drugs they are not committed to commence the sequences. It is the considered opinion of the paramedics that some patients do not require resuscitation. *"...with that old lady and fortunately the paramedic I was with, he came in and I looked at him and he looked at me and he knew that we were thinking the same thing. There was no way that we would have you know (resuscitated), it would have been cruel to have started to do that"* (PA para 93). The general practitioner would then come along after what was sometimes considered to be a very lengthy wait and commence the examination to verify death using a stethoscope and checking pulse points, shining a light in the eyes to affirm non-reacting pupils, and the paramedics considered it a waste of time because they 'could see from a mile back that the patient was dead'.

The crew had looked at each other and spontaneously known what the other was thinking, that the patient was not a sound candidate for resuscitation. The decision to withhold CPR places the crew in a difficult situation when the relative's wishes are in conflict with the professional judgement of the paramedic. *"...I had an incident at (location) just a fortnight ago and we went in and it was such a frail lady that obviously it was terminal. And we went in and the relatives said, "Oh, you must please do what you can" but I looked and I thought... You see people don't realise how aggressive resuscitation is"* (PC para 79). It is desirable to look as though the paramedic has tried to do something, because they do not wish to appear as though they have simply walked in, checked the patient over, turned to the relative and said, "I'm ever so sorry but I'm afraid he's passed away". It is a show and the show consists of an attempt to convince the relative that the paramedic has done as much as possible to help the patient. The image that the paramedic would like to leave the relatives with is one of having at least tried to revive the patient. Paramedics empathise with the relatives' distress in that it would be somewhat cold and callous to declare the death to them in this way but sometimes even the paramedic crew disagree over whether the death message should be given, *"...and he (paramedic) said, "Oh, I'm sorry, she's dead". And that was it you know? There was hell on. Everyone*

started screaming you know? I'd (emergency technician) said, "Don't tell em" (PC para 285). Another scenario described the consequences of giving the death message even more vividly when the relative proceeded to 'fling' herself on top of the body and ended up covered in the spray of body fluids from her dead husband as she unwittingly compressed his chest.

Some relatives maintain their poise and cope better than others do, and it is usual practice to ask if there is a relative or friend nearby to give the bereaved relative some support. The wisdom of age and experience is considered most helpful so the presence of a grandmother who has perhaps come in contact with death before is welcomed as the best person to have around. The paramedic will initiate support and attempt to console the immediate family with the relative or neighbour and there usually is someone else that will help in the vicinity. The sequence of events leading up to the death verification is explained to the relatives present and some paramedics may give the relative the Department of Health and Social Security (1988) leaflet 'What to do after a death'. One paramedic had been singled out as especially helpful when dealing with this scenario. He would make the family a cup of tea and sit and have a chat with them for sometimes quite lengthy periods of time before he thought the crew could legitimately take their leave.

Contact with body after the death is to be avoided if possible. During the focus groups the paramedics reported that when the patient dies at home the paramedics could happily leave the tidying of the body to the undertaker and walk away. One paramedic commented, "*One of the things that I don't like about that is that it extends the contact with the body for us*" (PC para 873) in a similar way to the mortuary encounter. However, what stops them from doing so is the effect that this would have on the people going to see the body and the thought that this person might have a high social value to others. Those reporting did not have a problem with guiding either the relative into another room or if another room was not available, moving the body to a bedroom and engaging in limited theatrical presentation by making the body 'generally tidy'. Indeed the paramedic would be inclined to ask specifically,

Paramedic *“Would you like him back in the bed and for us to make him look respectable?”*

Widow *“Yes, and would you mind putting his teeth back in?”* (PA para 527).

This conversation can only take place when the relative is aware that the patient is dead and the relative learns of the death by the messages given out at the scene and most of them do recognise that death has occurred. They are often present during the failed resuscitation and arrive at their own conclusion and the paramedic then initiates a death message. Pre-empting the general practitioner’s verification and declaration of death was previously the only option available to the paramedic and this placed the paramedic in a tricky position. *“All they wanted you to come and do was actually to say, “Well the patient’s dead”, although we couldn’t say that until the doctor come but you would know in a round about way actually when you spoke to the relative... “Oh well you obviously realise ‘he’s dead”* (PA para 127). Recent changes permit the paramedic to notify the relatives that the death has occurred and then to give a completed form to the relative and to telephone the general practitioner. This is carried out when there have been no signs of life specifically, pupil reactions, and no response. It is interesting to consider how news of the death is communicated to the relative. Various phrases are offered which demonstrate the exact words that are selected when affirming death such as *‘Life extinct’* or *‘It looks like he’s stopped breathing’*, *‘It doesn’t look good’* is considered always a good one! Then there is, *“We’re doing our best but it doesn’t look good’* and, *‘He’s not responding to treatment’* is another (PC para 355). When the relative is present, often pacing up and down, they can see the negative outcome for themselves. Despite the forewarning of impending death the relative does not necessarily believe the paramedic’s conclusion and it is the perception of some paramedics that the relative is more likely to accept the death verification when the doctor has arrived, assessed the patient and declared the death, and only then. The paramedics are reluctant to give the lone relative the completed form, not if it means that he/she will be alone in the house with the dead body on the floor and a piece of paper in her hand. They would be inclined to await

the arrival of relatives, neighbour, general practitioner or religious minister before leaving.

When the religious minister attends the family it is usually at the request of the paramedic and the family have consented to his/her arrival. Those paramedics that have called a religious minister have found them to be very helpful in calming the situation. They console the family, easing the path for the paramedic to do the things that they need to do, which primarily concerns packing up and leaving the scene in the shortest time possible.

During the phase when the paramedic is awaiting the arrival of either the general practitioner, the funeral director, religious minister or additional relatives and friends the immediate relative may engage in a range of behaviours. Some are really calm, resigned to the reality that the death has occurred. But death does not only occur during daylight hours it also happens at night when people have returned from the pub in the "*wee small hours, stinking from drink*" (PB para 781). One particular scenario highlights how the husband came into the house in an intoxicated state and he literally lay down on the floor next to his wife who had overdosed, and cuddled her. The paramedics expressed difficulty in handling this man due to his escalating aggression when they disturbed him. They were aware of his need, drunk or not, to be with his wife at this time but paradoxically, were wanting him away so that they could fulfil the task of death certification and disposing of the body. An arbitrary period of time was spent with his dead partner prior to disturbance, "*He's had a few minutes so can we get him out?*" (PB para 863). The son arrived and despite her moribund state thought that her life might be saved. Attention was drawn to the influence of television programmes like 'Casualty', 'A&E' and 'E.R'. in relation to the public's perception of what paramedics can and can not successfully resuscitate. But the paramedic knows that it simply does not work like that because the variables are so wide.

Sudden infant death is a theatrical process. Each individual case is different and it all depends on the scenario whereby sometimes a paramedic may enter the house and know immediately whether intervention is required by interpreting the family's reaction. The relative will say, "I think you're too late, the baby's just gone". The reality is that the infant is dead and probably had been for some time. On other occasions the paramedic can enter the house and think that they are too late, and yet the family will anxiously urge the crew to, "Do something, do something, quick, quick, quick". The paramedic becomes an actor in a drama in which the parents are to think that the infant has a chance and has had every stop pulled out to sustain their foreshortened life. Drugs and invasive procedures are likely to be withheld but basic CPR will be acted out until the general practitioner arrives and confirms lifelessness. Frequently infants are taken to the accident and emergency department accompanied by their parents and the paramedics encourage the parents to unknowingly participate in the scene in the belief that the parents benefit emotionally from their participation. *"I mean you're putting on a show for them for their benefit really"* (PA para 165). *"I mean rather than just run in, grab the baby and run out and then disappear. What you do is you say to them, "Well you come with us, it's your baby, you hold the baby". And apparently they've said that it's supposed to ease the burden of getting over the death you know, that's how we used to do it"* (PA para 135). The most practical position for the resuscitation in this event was considered to be with the parent sitting down holding the infant lying face up across their knees. In any eventuality the paramedic knows that the outcome will be the same. The infant was already dead.

When a sudden death occurs in the home, whether adult or child, the relatives sometimes ask the paramedic what they should do with the body to which they are advised to contact a funeral director. The relative is guided to use the telephone directory and this can help to occupy the relative's mind. The perceived helplessness that some relatives display is viewed as acceptable in the eyes of the paramedic in cognisance that people infrequently encounter the sudden death of a family member in the course of a lifetime. The paramedic sometimes specifically states the name of a

local funeral directing company, *“Well so and so is as good as anybody...it’s a name that is well known isn’t it? You just say that they’ll take care of everything for you basically, and they’re grateful”* (PB para 79). It is a misconception among some relatives who think that it is the paramedic’s responsibility to remove the body from the place of death to a funeral director’s mortuary and the paramedic has to inform them that it is not within the boundaries of the paramedic role.

Not all relatives come across as emotionally fraught and distressed with the sudden death of their ‘loved one’ so sometimes paramedics feel a need to “safeguard their own backs” for fear of reprisal by documenting property and valuables that were on the body. One paramedic described how relatives make the strangest of utterances, claiming perhaps that their dead husband had a hundred pounds in his back pocket. The impression is that sometimes the relative is more concerned about the hundred pounds in the back pocket than about the death of the husband and it also places the paramedic in a vulnerable predicament which requires the back up of their partner.

The paramedic will ask if there is a neighbour or a friend whom the immediate relative would like to have with them. The emergency technician will knock on the neighbour’s door, but usually the presence of the ambulance attracts people from the street anyway, so it only takes a couple of minutes for somebody to arrive and there is usually somebody that they can rely on to take the relative through the experience. When neighbours are approached they are required to take on a number of roles which may involve comforting the relative, organising tea or coffee or as is often the case an alcoholic drink, and organising the notification of other relatives. Often the paramedic will rely on this individual to do all these things so that their own departure is made swift. It takes the pressure off the paramedic when there is a ‘good’ neighbour that can take some of the supportive role from them. An explanation of the collapse and the next steps to take is discussed with the neighbour with such closure talk ending in the paramedic leaving the house to return to the ambulance station.

Awaiting the arrival of the general practitioner can be quite lengthy because some travel a considerable distance from their own home or practice premises. Sometimes the general practitioner may have been telephoned to come to the house by the relative and following an assessment as to the viability of the patient to sustain life will request the paramedic service at the scene. Contact between the paramedic and the general practitioner is brief, consisting of a short description from the paramedic of the patient's collapse and response to paramedic intervention, if any. The general practitioner then carries out an examination of the patient, checking for radial and carotid pulses, listening for chest sounds through the stethoscope, and shining a light in each eye to test for absence of pupil reactions that could indicate that life has ceased. Sometimes the general practitioner will arrive and simply say, "*Oh, yeah, dead!*" and leave. One paramedic described the brevity of an encounter, "*...they've gone before I've actually got back down the ambulance and down the path*" (PB para 1293). A decision is made by the general practitioner to determine the cause of death as it will be written on the death certificate and the form is then completed and given to the relative. Occasionally the general practitioner will telephone the Coroner's Officer if the case fits the criteria for reporting. When death has taken place the paramedics will let the doctor know that they will cover the body with a blanket. Not all general practitioners perform with confidence. One paramedic remembered a situation in which the general practitioner arrived during CPR on a child, thinking that he would take command of the situation and make the decision to certify the child dead. The general practitioner's response of, "What do we do?" was met with some surprise and the paramedics lost faith in the individual's competence. "*That's just written off that doctor straight away*" (PB para 1791).

The direct trajectory offered a detailed description of the collapse to mortuary interval in the pre-hospital setting, which centred on resuscitative effort, death verification and handling of the body and relatives in the patient's own home. Formal death verification as declared by the general practitioner is resisted by ambulance personnel despite their obvious capacity to determine life extinct as well as the relative's need for confirmation of death. Early disengagement from the deceased body is a feature of

paramedic deathwork and withdrawal is reinforced by their discrete departure either through a side or back door so as not to disturb proceedings.

CHAPTER FIVE

The following chapter describes the one-stop trajectory, which focuses on the ‘dead on arrival’ scenario outside the accident and emergency department en route to a hospital mortuary. Minimal interaction takes place between emergency personnel whilst an accident and emergency doctor verifies the sudden death, followed by early disengagement of emergency personnel immediately following the incident. The paramedics transport the body in the ambulance to the hospital mortuary.

The One-stop Trajectory

The one-stop trajectory involves a collapse to mortuary care for the collapsed individual which is fragmented by a brief critical juncture immediately outside the accident and emergency department. At the critical juncture a decision is made whether the patient is dead or whether alternatively the patient could survive.

When a patient has been resuscitated en route to the hospital but is dead on arrival (DOA) at the accident and emergency department a doctor, nurse, and in some departments a receptionist enter the ambulance together. Initial medical assessment of the patient by listening to the chest and looking into the eyes for a few seconds will result in a decision to either cease resuscitation or to continue resuscitation. The first outcome involves confirmation of death in the vehicle and transportation of the body to the hospital mortuary. The second outcome involves an array of resuscitative activity within the resuscitation room prior to transportation to the hospital mortuary following death declaration.

The outcome of the first decision is to declare the person dead and transfer the body to the hospital mortuary, which involves limited dialogue, “*Yeah er, OK take em round to the mortuary*” (PB para 188) or more specifically, “*Righto! Certified dead at such and such a time*” (PB para 812).

When the receptionist is notified of the arrival of a sudden death case in an ambulance the notification is relayed over an intercom system with a coded message of “D1 to check in please” or “DOA in vehicle”. The DOA is entered into the attendance book using the next available hospital number and spaces are left blank for completion when further information is obtained. Most documentation is now computerised in a tick box fashion with categories for DOA or Died in Department (DID). Rarely does a receptionist enter the death processing section of the department. They may regularly leave reception to organise patient documents outside a consulting room or request information from patients and relatives in the trolley section, but rarely do they see dead bodies and those instances only occur in one of the three hospitals. In the ambulance service the code for an uncertified death is ‘D1’ whereas the code ‘D2’ is used for a certified death, which would have received certification by a general practitioner at the home. However, during the one-stop trajectory the receptionist leaves the reception area, walks the length of the corridor to the ambulance outside where information recording is duly completed by resting on a clipboard. On those occasions when the identity is not available, such as when a patient collapses in the street, a clear plastic or white plastic wristband similar to those provided to live patients on routine admissions, is handed to the nurse with the limited information completed, and the nurses fastens the strap around the deceased’s wrist. Minimal dialogue occurs between the receptionist and the nurse or doctor, that which is spoken focuses on the ill fate of the victim and relatives. The interaction lasts approximately three to four minutes closing with the receptionist returning to reception to resume the usual role of documenting the next casualty.

Death verification occurs behind the closed doors of the ambulance again concealing death from the public gaze. The nurse may ask the paramedic if the identity of the patient is known and identity is frequently confirmed by the crew who may have received the information from either ambulance control room staff or on a scrap of paper from a witness at the scene. When there is no relative accompanying the body in the vehicle the nurse will also enquire from the paramedic as to whether there are any relatives en route or at least that are aware of the situation. The mortuary staff are

sometimes notified by telephone that a DOA is due to arrive in an ambulance in the next few minutes, but the nurse does not always do this and the ambulance simply turns up at the mortuary entrance.

Dialogue and interactions between paramedics and hospital porters is restricted to within the mortuary. When a mortician is not available, which is usually during night duties and bank holidays in certain hospitals, a porter will be allocated the task of opening the mortuary for the purpose of unloading the body. The request to open the mortuary is communicated by telephone from the accident and emergency nurse to the porter and an estimated time for access of about ten to fifteen minutes is usual. Such a time lapse is necessary for the porter to complete other tasks involving perhaps the collection of the empty dinner trolleys from wards, collection of mortuary keys, then to walk over to the mortuary. When the hospital is 'on call' to receive emergency cases the timing may also be extended. Once the mortuary door is unlocked the procedure is swift involving the transfer of the body from the ambulance stretcher to the mortuary trolley. The paramedic can then take leave.

The body is totally concealed within a red hospital blanket, positioned on the stretcher and wheeled out through the open rear doors of the ambulance. However, there are occasions when it is necessary to use a body bag. Cadaver bags are not generally used in UK hospitals however, when cadaver bags are used they are used selectively with an external label attached to identify high-risk categories. Of 600,000 deaths in the UK each year, only one per cent is associated with infection (Cutter, 1999). Advisory groups are united in recommending disposal in a cadaver bag for all bodies known or suspected to be infected with blood-borne viruses such as pulmonary tuberculosis, anthrax, diphtheria, typhoid fever, and also HIV (Advisory Committee on Dangerous Pathogens, 1995; Department of Health, 1998). Most hospitals restrict the use of cadaver bags to those with specific infectious diseases, or for cadavers likely to leak large amounts of body fluids. Cutter (1999) argues that it is difficult to justify the use of cadaver bags for HIV-infected bodies where universal precautions are followed

involving wearing gloves and protective clothing, and covering leaking wounds with a waterproof occlusive dressing.

Originally designed in a heavy duty black plastic with handles and a zip from one end to the other nowadays they are made of a lighter weight plastic fabric and it is not possible to see the contents of the bag through the material. There are now no handles for the paramedics to hold the weight of the cadaver and for this reason some difficulty is encountered when the cadaver is manoeuvred. If the body is 'a mess' or contaminated a body bag will be used though the paramedics reported few occasions of actual use during an individual's career, most being limited to one or two occasions. One paramedic even reported the improvised use of the fire brigade's tarpaulins as a body bag, "*They're handy, they're like big things and we use them as body bags provided they're clean*" (PC para 760). Traumatic injuries to the body sustained during pedestrian road traffic accidents, gunshot wounds, multiple stabbing incidents would most likely warrant the use of a body bag. "*Generally though if the patient's in a body bag it's not very nice*" (PA para 1177). However the bag would also be used in cases of either known or suspected HIV, AIDS or Hepatitis infection as well as other less obvious infections. The bag was designed for single use though there are reports of the return of a number of bags from various sources. On those occasions the paramedics simply, "*...threw them in the back*" (PA para 1189).

The vehicle is driven up to the mortuary located in the centre of a busy car park adjacent to the entrance of accident and emergency. Concern is expressed in relation to the difficulty paramedics have in concealing the dead body from visitors to the hospital including children, who may be in the immediate vicinity of the mortuary. "*Now effectively you've still got to get that stretcher off, whilst everyone else can see what's going on*" (PA para 990). What members of the public are able to see is a body, totally wrapped in a red hospital blanket strapped to an ambulance stretcher being wheeled into a mortuary. Paramedics expressed concern that the sight of a dead body and deathwork could have a traumatising effect on the public and especially children. The significance of a nearby school was emphasised in that ambulances

attract children. "*Kids can walk past, kids that are this high (gesture)*" (PB para 1815). Similarly undertakers face the same dilemma when they collect a body to take it to a funeral home. One paramedic suggested that a canopy should be built immediately outside the unloading bay whereby the ambulance could reverse towards the open mortuary door, then close the doors to fully garage the vehicle for the purpose of loading and unloading the body. The suggestion of a canopy reveals the discontent felt by paramedics whereby in the absence of full concealment, the body and therefore death, is undesirably visible.

The mortuary procedure is an unwelcome one, which is compounded by the dilapidated state of some old hospital mortuary buildings. With the exception of the newer hospitals, many mortuaries were constructed around the turn of the nineteenth to twentieth century and are equipped with only basic resources. In contrast to Huyler's (2000) morgue which "had windows and sunlight which filled the quiet room" (p.22), one hospital mortuary in this study is universally criticised. Externally it is of dark red brick construction with the original small painted metal window frames containing frosted glass to conceal the internal activities. "*It just looks so unwelcoming and forbidding*" (PB para 567). A police traffic officer commented on how the building should be condemned and rebuilt, he thought it was appalling that the building was still in use, "*It really is outdated, filthy, dirty!*" (PB para 959). Another paramedic communicated that even inside the quality of the paint and furnishings is dreadful and the smell is inclined to 'knock you' because 'the place stinks'.

On entering the mortuary an array of refrigerators line one wall, there are six huge doors made of cream coloured enamel coated steel with enormous clumsy hinges and handles. When the body is ready to enter the refrigerator one door is opened to reveal a whole section of shelves containing any number of bodies on steel trays. It is possible to peer all the way along the rows of bodies laid on steel trays from one end of the refrigerator to the other, a potential for approximately eighteen bodies when the mortuary is full. It is preferred that separate compartments be used for each cadaver.

Another feature attracting criticism related to the reduced level of dignity directed to the body of the deceased, *"It's when they take the body and they put it on a tray and they don't even have a sheet to cover them with in there. You just put the body out on a steel tray and that's it"* (PA para 1004). Following post-mortem the body is simply wrapped up in a sheet and bloodstains from surgical procedures may seep through the sheet. It was considered unnecessary and unwelcome for paramedics to have to see this particular aspect of sudden death work. An interesting paradox exists whereby paramedics deal with some particularly traumatic incidents in the course of their work yet despite this they do not wish to witness the effects of trauma on cadavers in a hospital mortuary. This may be related to a feeling of control over an emotionally traumatising situation.

Varying practices exist in relation to police involvement in body handling in the mortuary. Primarily, traffic officers attend the mortuary for identification purposes by immediate relatives. *"One of the big things we get involved in is seeking identity and then informing relatives"* (TPA para 21). Seeking identity means that the body is to be stripped and searched for information to confirm that the body is that of a particular named individual. Many searches result in a name and address of the dead person whether in a pocket or in a handbag, though there are occasions when identification is less obvious. One officer described how he had confirmed identity using the dead woman's jewellery, not such an unusual occurrence. Another had recorded details of a banker's card pin number which the deceased had written on his hand prior to death whereby subsequent enquiries with the relevant bank revealed his identity. Tattoos have also been used for identity confirmation and it is particularly useful when the dead person has a criminal record because the tattoo will readily reveal the identity from police documentation.

An immediate relative usually confirms the identity of the body, however, occasionally confirmation is obtained from a friend who knew the deceased. If there are no people at the scene of an accident who can enlighten the officer as to who the injured party is then enquiries begin by searching through personal belongings

including personal belongings found in the vehicle. The registration number of the vehicle will lead the officer to make enquiries at a known address. However, if this is not fruitful then identification at the mortuary becomes necessary. Preparation to view a body prior to identification requires that the body be stripped, cleaned and covered with a hospital sheet. These are the bodies that are certified dead outside the accident and emergency department. One officer recalled years gone by when “...*you basically had to strip the body of nearly every single one didn't you?*” (TPB para 503). Nowadays that seems to be getting less and less due to ‘on-call’ mortuary technician availability, but for most of the deaths there is some sort of preparatory work performed.

Officers on ‘District’ duties (i.e. working across a defined geographical area as opposed to a specialist department) do not tend to get involved in body cleaning because the death is usually straightforward and there is usually no injury whereas traumatic death creates a far more complex mortuary encounter. “*But on traffic you go to an accident and people are disfigured or whatever. Obviously you have to clean the body up for the relatives to come and do an ID*” (TPA para 61). The following incident explains further, “...*just a couple of days ago there was an incident where the fella had a stake through him from an accident and that was still in when they were trying to prepare the body for viewing which was a ridiculous scenario I think*” (TPB para 364).

According to one police officer ‘Sod’s Law’ ironically states that a sudden death shout will occur “...*when the mortuary attendant is not on duty and the police traffic officers are about to go off duty*” (TPB para 358). Resignation to perform the role is clearly expressed in reluctant but cooperative participation whereby the officers are duty bound to perform the function but would prefer to go off duty. This resignation to perform the role means that the officer has no choice but to handle the body unless, and this is only in certain hospitals, an ‘on call’ mortuary attendant is available. Police traffic officers would rather limit the amount of time they spend with the body “*I don't like touching them (the body) but you know, you've got to unfortunately*”

(TPB para 327). When they do spend time with the body it is for two reasons, first, to clean the body in preparation for the arrival of relatives who can confirm identity and second, to document the dead person's property. Police officers who may have been involved in cleaning the body consider the activity unpleasant but perceive the procedure as easier than dealing with the relatives. A special payment is given to the police officer when a body is cleaned but certain criteria need to be established affirming the seriousness of the incident prior to payment approval. Nobody actually verifies whether a body fits the criteria of being bad enough to warrant payment, it is the responsibility of the individual officer to determine. Humour is attached to the notion of receiving payment for performing such a procedure and one commented,

Officer one *"...the bobby that goes down assesses how bad it is and all the ones I deal with are bloody terrible!"*

Officer two *"It's about seventeen pounds now. Now if you have three bodies to deal with and you deal with them all in one go you only get seventeen pounds."*

Officer three *"Well you could make a fortune!"*

Officer two *"But if you have a break in between each one, which you should theoretically..."*

Officer three *"Exactly, for your own emotional welfare!"*

Officer two *"Yeah, and you've got the property to log and the clothing to log and not to mention all the dimensions so you've got a good record of that person."*

Officer four *"Have you become an undertaker on your days off?" (TPC para 473).*

The height of the body and any distinguishing marks are recorded for identification purposes. This information is required when press appeals to the public are sometimes released with a description of the body when an individual is found dead but no one has reported them missing. One officer described how he had to pick the gold chain from around a dead person's neck and pick the pound coins out of his flesh in order to document and package up the property.

The feeling of being 'a little in the dark' is compounded when the police officer enters different hospitals within the same District where each accident and emergency department and mortuary department has unique practices. Participants attending the Mobile Police Officers (MPO) course suggested that officers should be taken to each hospital in the District to be shown the mortuary, the viewing room, and basically what is, and is not, expected of them. In some departments a qualified nurse will accompany the police officer to the mortuary to prepare the body for a visit by the relatives. In other departments the nurse takes relatives to the mortuary only when the mortuary attendant has prepared the deceased. Not all hospitals have a mortuary attendant available during the evening and night so on occasion the police officer may request an on-call mortuary attendant to deal with the preparation of the body. When novice traffic officers go to a 'fatal' with a tutor constable to mentor them it is considered unlikely that the learner would learn much because the tutor constable would not necessarily want anything to do with the sudden death either. Such a culture of avoidance of critical aspects of the sudden death role is likely to disable police officers rather than empower them to deal with the situation.

Divisional officers are perceived as being rather helpless and eternally grateful when a more experienced traffic officer arrives at the scene of an accident, even a 'minor bump' because a lot of them do not know what to do. Traffic officers reported that when traffic officers arrive the divisional officers think, "*Oh thank God for that, the cavalry's arrived!*" (TPA para 1133). In the constabulary studied officers have access to defibrillation machines but the paramedics did not think that the police would use them to shock a patient at the scene of the collapse. Indeed the paramedic

perception was that the police did not wish to defibrillate anyone at all and thought it would be interesting to evaluate how much the police actually do make use of such equipment, as they did not think the police would get themselves too involved in resuscitation. Defibrillation involves the application of chest leads and administration of a synchronised electric shock to the patient's chest, there is no requirement to interpret the cardiac rhythm as the machine has this function then displays the command to defibrillate or not to defibrillate. Police officers expressed apprehension at the thought of using defibrillation equipment and hoped that there would be no cause to use it. One traffic officer commented, "*I refuse to do it*" (TPB para 723), another, "*I am, I'm afraid (to defibrillate)*". When consulted on whether the officers would use the defibrillation machine a third officer commented that he would use it should the situation arise but that had doubts prior to attending the preparatory course. Their saving grace was that, with the exception of rural locations, nine times out of ten the traffic officer arrives at the scene at the same time or just before the paramedics reducing the likelihood of having to defibrillate someone.

When the individual is dead at the scene of an accident no urgency is expressed by paramedics with regard to the person in the vehicle as they would give priority to police officers to collate information regarding the dimensions of the incident. Recently, West Yorkshire Metropolitan Ambulance Service formally complained to newspapers following reports that one of its crews abandoned a teenager's corpse after he was killed in a car accident (Health Service Journal, 2002). It was alleged that the man's body was left at the roadside for between 90 minutes and two hours when paramedics left the scene, however, it was later established that the attending crew were requested by traffic officers to leave the body undisturbed. This request was upheld in the knowledge that a supervising officer was attending the body. Survivors in the vehicle may need to be extricated quickly, not only for immediate treatment of their injuries but because it is assumed that they would not wish to be trapped beside a dead body, no matter how well they knew the deceased.

Relatives entering the mortuary would not be permitted to see the 'behind the scenes' perspective and access to the body is only permitted following preparation and theatrical representation of the body. The relatives are shown to a dimly lit anteroom, which has little natural light. The outer room has muted pastel wallpaper and upright wooden chairs line the wall. Immediately next-door is a mortuary chapel, a small room converted for the viewing of bodies, which has a large wooden cross in front of a window on the outside wall. Another room lies parallel to the chapel room and this used to house the body on a stretcher, segregated from the relatives who viewed it through the window in the chapel room. Traffic officer considered this procedure distasteful because the poor lighting created shadows which made the facial features look more angular, worse than if the relatives had seen the body in the same room. Following proposals from the 'Care of the Dying Special Interest Group' within the hospital and the general investment in caring for the needs of the relatives it was recognised that the relatives needed not only to see the body, but also to sometimes touch and hold it. In one hospital practices were modified to enable this to happen though the message did not necessarily filter through to other emergency personnel and in particular to police officers so some continued to position the body in the viewing room rather than in the chapel.

In conclusion, the one-stop trajectory involves a decision made immediately outside of the resuscitation room entrance, which centres on the resuscitative effort to be made on the individual patient. Once declared dead the body is taken to the mortuary and becomes the concern of the pathology department. However, disengagement of emergency personnel from the body is not possible until body preparation has been completed within the mortuary and this aspect of deathwork induces heightened feelings of disdain particularly among traffic officers. Disengagement from the body of the deceased is only possible when its identity has been established and much effort is put into this aspect of deathwork.

CHAPTER SIX

The following chapter explores using thick description an extensive range of activity and interaction between emergency personnel during the sudden death career of an individual within the accident and emergency department. The elaborate trajectory is complex creating a high level of interaction due to an intricate procedural base, which centres on the representation of the dead body to the relatives.

The Elaborate trajectory

In the previous chapter the decision to verify death was made in the ambulance and the body transported to the hospital mortuary. The second decision, to bring the patient into the resuscitation room, is based on the conclusion that the life can be saved, despite the paramedic anticipating that the doctor will say, "*Well there's no point (in resuscitating), he's dead!*" (PB para 2000). Drawing on one particular senior doctor in accident and emergency a paramedic commented "*Nine times out of ten the doctor wants the resuscitation to continue. He seems to like to have a lot of people brought into resus especially if they're young people or youngish people*" (PA para 871). Delegated nurses are in attendance and aware of the category of code that has been given to the patient. There is usually time to put protective clothing on, such as clear or white plastic apron, protective latex gloves, radiographic protective apron, and tabard. Individual roles within the emergency team are written in large letters on the back of the tabards for others to clearly identify such as 'circulating nurse' or 'doctor'. The nurses are 'psyched up' to deal with the emergency and anticipatory apprehension as to what is about to happen is high. Hochschild (1983) provides a useful explanation of how service personnel in a range of service industries use 'surface' and 'deep acting' to 'psyche themselves up' or dampen their inner feelings down when dealing with difficult encounters with the public.

To ease patient access into the department the ambulance is parked so that the rear doors open to face the automatic doors of the department or adjacent to the doors of

the department. Doors in the immediate vicinity of the entrance and resuscitation room within the department are closed in anticipation that the patient may come into the department and this action provides a degree of privacy from onlookers. The body is unloaded from the vehicle on the ambulance stretcher whilst continuing resuscitation and is then wheeled into position in a resuscitation bay. Following a synchronised count to three the patient is transferred to the resuscitation room trolley and a smooth transfer of activity ensures continuity of resuscitation whilst paramedics report concise information regarding history, condition and vital observations in a clear voice to emergency personnel.

Reporting the incident and history of the patient's condition is a frustrating experience for paramedics. *"We found one of the problems when you go in, you wheel it into resus and a doctor comes up and says, "What's happened? And you explain for about three to four minutes giving him a full run down on the history, what you've done, what's happened, gone through the patients changes that have happened. And then you're no sooner finished there or you got half way through and two more doctors arrive and they ask, "What's happened? So you have to start all over again"* (PB para 1988). When the Consultant enters the room invariably the whole scenario is repeated for fear of a look of disapproval from the Consultant and this risk of disapproval is compounded when the anaesthetist arrives. Orthopaedic doctors are to be particularly wary of when the paramedic communicates a suspected diagnosis, *"... we don't really want to 'cos they all think that you're a clever bugger if you do"* (PB para 2059). Care is taken to give details only pertaining to the suspicion of a fracture or other enclosed injury for fear of a retort from the doctor. One incident described a situation where the doctor asked the paramedic if he had 'X-ray vision' because the paramedic had stated the diagnosis yet it was pretty obvious because the patient's brains were bursting through the side of his head.

According to paramedics, nurses fail to fully appreciate the continuity of care between the pre-hospital setting and activities in the resuscitation room, which is manifested in minimal attention being given to patient documentation provided to nurses by

paramedics. One of the main complaints is that the nurses do not read the documentation. It is frustrating to the paramedic because despite their requirement to document all observations and interventions then communicate them to the accident and emergency resuscitation team, nurses are known to disregard the information by placing it on a trolley or at the back of the patient's documents. *"One of our main complaints is that nursing staff don't read it. We hand them over and they just say, "Oh, right thank you" and they put it down to one side and all the initial obs. are on there"* (PB para 1615). Such an omission on the part of the nurse is a cause for concern to the paramedic who concludes that it is a pointless exercise first, because continuity of care or treatment is jeopardised and second, because comparison of observations to establish changes in the patient's condition is impossible.

Paramedic one *"We hand them over and they (nurses) just say, "Oh right, thank you" and they put it down to one side. And all the initial obs. are on there"*.

Research *Right, as if the care only started in Cas?*

Paramedic two *Yeah, they never read it do they?*

Paramedic one *Yeah, if you don't read it it's pretty pointless.*

Researcher *How does that make you feel?*

Paramedic one *It's pointless isn't it? I mean first of all it's pretty pointless and there is also no continuity.*

Paramedic two *Yeah, they're not able to make comparisons.*

Paramedic one *Comparisons for obs. yeah, blood pressure and things like that.*

Paramedic two *Yeah, and GCS (Glasgow Coma Score)"* (PC para 1615).

The documentation is not necessarily completed at the scene, but if the patient is stable the paramedic is inclined to complete the forms in the back of the ambulance en route to the hospital because it is quicker and easier to do so. Paramedic training officers had led paramedic trainees to believe that a patient documentation form could be completed in about three to four minutes, but the amount of information required

on the trauma forms is considered by paramedics 'on the street' to require about ten minutes to complete.

When the family is present the paramedic will hand them over to the care of the nurse and the relatives are led into the family room for the nurses to care and support them. An option to be present during the resuscitation of their relative is sometimes explained to the family, but often an option is not given. At this point the ethical principle of beneficence becomes an issue in that nurses will be duty bound to care for relatives and empower the relative to make conscious decisions regarding their presence during resuscitation. Hughes (1971) argues that social role and the division of labour consists of kinds of work whereby something is done for, or to, people at least the individual as recipient of the service may think that the work is done for their benefit. Arguably the work is carried out for the receiver. "Perhaps it is well to recall that the opposite of service is disservice, and that the line between them is thin, obscure and shifting" (p.305). An example is provided of the teaching of children whereby the discipline required in maintaining a studious classroom milieu is perceived as cruel and perverse.

Emergency personnel find that resuscitation in the presence of relatives is hard to cope with because the practices of the emergency team are subject to close scrutiny within a highly charged atmosphere. Continuing debate as to the beneficial or detrimental effect of relative's presence is inconclusive (Adams et al, 1994), hinging on whether the relative has a right to be present, if it is their wish to do so, and whether the staff have a right to refuse the relative's entry. However the notion that relatives should not be discouraged from being present during the resuscitation is not the same as actively encouraging them to make a decision to be present, indeed it is usual that relatives are not approached about the possibility of entering the resuscitation room at all. Adams et al (1994) advocate that although the doctor's instinctive reaction is to ask the relatives to leave, it should be done in a way that permits choice, "It is probably best that you leave. We will keep you fully informed of what is happening. You may stay if you feel you need to" (p.1688). One nurse explained to a woman

whose husband was being resuscitated that he was "...really, really poorly". However, the woman insisted on being present, "*Look, I don't want to be in too late*" (NB para 874). The nurse entered the resuscitation room and said to the emergency team, "*Look, she really wants to be in*" (NB para 879). The nurse then took the woman into the resuscitation room and guided her over to a chair which she had put in the room before the woman entered two to three metres away from the immediate activity surrounding the patient. Relatives often witness resuscitation at the scene of the collapse anyway, with some individuals actually initiating the resuscitation themselves. It seems an extraordinary anomaly that the relocation of the patient's resuscitation trajectory to the accident and emergency department subsequently requires relatives to disengage from the experience.

It is more usual for parents to be present in the resuscitation room when the patient is a child than an adult relative when the patient is also an adult. None of the three departments studied had a policy encouraging the presence of relatives at the time of the resuscitation. However, unofficial rules were known to operate. "*We were told on here that we had to allow them to go in*" (NB para 866). On one department the relatives were guided into the relative's room "*...people are like trying to pull them away and say, 'Come and have a cup of tea', and they don't want that, they want to be in there and see what's going on*" (NB para 858). When discouraged from being present some relatives may defy the staff's request. "*If they've seen them going into resus and they've been asked to wait and they'll wander up if its been a while*" (NB para 845). Quite frequently relatives would stand outside the resuscitation room and be able to see quite a lot of the activity. One nurse informant expressed how she would encourage relatives to be present so that they could see what was happening. The rationale was that when doctors and nurses use the phrase "we did what we could" the relative is not able to conceptualise what 'everything' was and requires more detail. The phrase is in danger of becoming yet another sudden death cliché, "*...you come down and say, 'Well we've done everything possible'. They have no understanding of what 'everything possible' is they don't see it...*" (NC para 896). Ethical issues of beneficence and non-maleficence are critical to the decision of

relative's presence during resuscitation. Essentially the debate centres on choice. It is the belief of one nurse that an empowered relative is able to make that decision. *"I think its harder for us to work on the patient whilst the relative is there, but if that's what they want I don't think we should have the right to deny it"* (NC para 902).

Emotional exhaustion is sometimes a problem to nurses who witness the presence of relatives in the resuscitation room because the scene can sometimes be so emotionally charged that the nurse feels raw and personal emotionality can not be concealed for long. During the resuscitation of a woman, the daughter became so grief stricken that the nurse found difficulty coping as the tears were streaming down the daughter's face and she was pleading with the nurse to do something, *"Please, please do something, save her, it's my mam, it's my life..."* (NC para 461). The nurse recalled feeling so overwhelmed that she felt that she had failed the daughter and declared to the other nurse that she simply could not stay, and then choking back tears immediately left the resuscitation room saying, *"I've got to go"* (NC para 461).

Doyle et al (1987) studied seventy individuals who witnessed the resuscitation of their relative yet none of them interfered with the resuscitative efforts. Forty seven per cent of the individuals who responded to follow up continued to believe that they could participate again and did not support the continuation of policies that exclude family members from resuscitation. The possible benefit to relatives of their being present at the time of the death is another element to consider. Following cessation of resuscitative effort some patients continue to have an altered cardiac output, which is displayed on the cardiac monitor, and the patient may attempt to breath. Such physical effort is insufficient to sustain full perfusion of oxygen to the tissues so the heartbeat and respiratory effort eventually ceases. This period of 'limbo' is crucial to consider because the patient is declared dead, yet still has signs of life, which needs to be explained to the relatives who may be brought into the resuscitation room to spend time with the patient as physical effort diminishes completely. Recognition that complete death has occurred usually requires confirmation by the attending nurse, using a declaration such as 'Yes, he's finished breathing now and there is no pulse

now'. Then the nurse will guide the relative to the relatives' room and continue with arrangements.

The emergency team is guided by a litigation perspective which is essentially against relatives' inclusion in the resuscitation room on the grounds that practice must comprise one hundred per cent adherence to correct procedures and this level may not always be achieved. The potential for a clinical negligence claim by the relative is a risk. The medical perspective also focuses on the resuscitation of the patient, and successful resuscitation continues a life whereas failure compounds a tragedy. Occasionally the relative may be so distressed that it interferes with smooth resuscitation. To disallow the relative's presence solely because of risk of litigation requires a strong counter argument as the wishes of the relative to be present at the time of death would then be unheard. A paternalistic stance purports to protect the emotional welfare of the relative when aggressive resuscitation, particularly following trauma, requires invasive procedures such as direct cardiac compression and defibrillation through open chest access to the heart. The physical details of the procedures may leave relatives with lasting memories of an undignified and horrifying assault to the body. Timmermans (1998) claimed that engaging in resuscitative efforts on obviously dead patients amounts to structurally sanctioned denial, a paternalistic attitude in which staff members keep relatives and friends in a closed awareness context or a slippery dance of mutual pretense awareness (Glaser and Strauss, 1965). Staff decide that it is better for relatives not to know that their loved one is dying.

Timmermans claims that hospital administrators and emergency department staff defend the separation of the resuscitation to front stage and back stage productions (Goffman, 1959). The process of dying is removed from the audience that ultimately cares the most yet the presence of grieving relatives during back stage productions is a constant reminder for the staff that the dying person is entrenched in a social network and not merely a body (Timmermans, 1997; 1998). Relatives need to be given the option to attend the resuscitative effort and say goodbye during the last moments that their loved one hovers between life and death. Paternalistic decisions to exclude

relatives centre on the physicality of the resuscitation area and protection from the visual and emotional impact of a brutal resuscitation attempt.

Nurses observe role uncertainty in doctors' interactions with relatives following a failed resuscitation. They do not appear to understand that it is their responsibility to talk with the relatives and explain what happened prior to the death of the deceased. Doctors in training change clinical allocation to accident and emergency medicine for a six-month period and in the early months of the allocation often need direction from an experienced nurse. Some accurately anticipate their involvement in the care of distressed relatives but nurses are regularly disappointed by an apparent lack of volition to deal with this sensitive aspect of the accident and emergency role. When a doctor does become involved it is preferred that a period of time is spent observing the manner in which bad news is delivered by one of the nurses rather than have them faced with a situation in which they do not know what to say.

Cognisance is taken of the emotional fragility of the relatives and their paradoxical need for information and privacy during such an intimate moment. This was considered by emergency personnel to be best achieved by maintaining a professional approach and literally 'playing the part' despite the real feelings of the professional. If an individual was equipped to deal with their role perhaps having had previous experience working with palliative care patients in a hospice setting then it made sudden deathwork a little easier because that individual was more used to dealing with the emotional side of deathwork with relatives. Knowledge of such expertise and acquired confidence meant that other staff would be inclined to let that individual deal with the sudden death. Sometimes the 'expert' did not need any prompting but would go in that direction without asking them to do so. The expert felt it wholly appropriate and natural that they should deal with the relatives. Indeed certain nurses felt that they were better equipped than some doctors were in handling relatives. In a study of fifty-two qualified accident and emergency nurses (Tye 1993) identified perceptions of the helpfulness of thirty-five selected nursing interventions using a Likert-type rating scale and two open-ended questions. Several nurse respondents

indicated that 'ensuring a doctor breaks the news of death' was not helpful and the statement was subsequently placed thirty-first in rank. Supporting comments in Tye's study exposed a deep-rooted feeling about their medical colleagues. "My experience of doctors breaking bad news is that they are very bad at it and often do not make it clear that the patient has died" (p.953). The comments provided reinforced the notion that the way the news was broken and the interpersonal skills used in this situation vastly outweighed professional role demarcation. Another of Tye's respondents commented, "I think it is completely unnecessary for doctors to break news – [it] should be the person who has had the most dealings with them". In response to these statements it seems plausible that when the number of nurses is too low to adequately 'staff' the department nurses are resigned to 'get on with it', burdened with a process which is unwelcome. This could be problematic when an individual does not feel able to take on such a role due to emotionality related to personal events. One individual who contributed to the focus groups preferred not to deal with the relatives saying, "...but I'd rather be in the resus room." (NA para 291).

Nurses equip themselves with information about the patient's death trajectory prior to contact with the relatives despite the time it takes to gather the information. When a patient dies in the department its much easier for the nurse because the information is less fragmented compared to when the patient dies elsewhere. When sudden death occurs out with the hospital it is difficult for the nurse to fully convey all the information that the relative requires.

Nurses encounter difficulty on initial contact with relatives arriving at the accident and emergency department. The part that is considered to be most awesome is when the nurse must say, "Would you come with me?" On walking them from reception to the relatives' room, the nurse is often uncertain of the relative's level of awareness in relation to the severity of the patient's condition. Such uncertainty induces a reluctance to engage in conversation for fear of relatives' questions which when answered may lead to an emotional eruption from the relatives out with the sanctuary of the distressed relatives' room. Sudden deathtalk tends to be restricted within the

walls of the distressed relatives' room and the door invariably remains closed when occupied by relatives. Nurses are all too aware that any breach of these structural parameters are likely to risk a shattering of sentimental order (Glaser and Strauss, 1968) within the department. On one hospital the corridor leading from the reception area to the distressed relatives room takes an eternity to walk along and the nurse will try to walk faster to get them to the room quicker. "*You want the room to be so close to you so that you can take them straight in*" (NA para 416). In some departments the resuscitation attempt is separated from the relatives and public by a curtain and it is possible to hear the sound of sudden death and also on occasion, the curtain has not been closed and death became visible.

Nurses consider it a heavy burden when accompanying relatives to see the deceased in the mortuary and it is also considered appalling to have to take a relative over to "*...that place*" (TP para 547). Such negativity is compounded when the nurse has not been involved in the life/death career of the patient in the resuscitation room. It is negatively described with a self-censoring tone, "*You feel awful saying it, but it's definitely horrible going down there...*" (TPA para 293). Walking with the relatives en route to the mortuary is described as the longest walk that you'll ever do and in the absence of other more willing participants it is a procedure in which emergency personnel merely comply. "*Nobody else wanted to, and I went down, and it was awful. It was upsetting, it was awful, and I didn't want to do it again*" (NB para 1138). This is often a delegated role, which terminates when the relatives return with the nurse from the mortuary to the accident and emergency department for 'closure talk'. In some hospitals it is possible to re-route the relatives around the side of the department to reach the same destination and this provides a more favourable route away from the presence of onlookers.

Sudnow referred to 'death packages', which consist of provisional death certificate, actual death certificate, autopsy permit (relevant to the US), release of personal belongings forms, which during 'slack periods' were collated and stapled together by a desk clerk at the nurses station on medical and surgical wards. In the UK accident

and emergency context death packages do not exist. To centralise the process of death documentation in the accident and emergency department stationary is made available in small stacks, through prior preparation, in the relative's room and death certification is completed once the cause of death is established, usually following post-mortem.

Relatives are offered information consisting of the Department of Health and Social Security (1988) booklet 'What to do after a death', and an A4 size letter on behalf of the Hospital Trust offering sincere condolences at the loss of a loved one, accompanied by a contact number for the department. An in-house publication in pale yellow, consists of 8-10 pages and takes the reader through a series of poems and comforting words surrounded by images of flowers, preparing them for their proposed journey through personal grief. Useful information offers advice on the will, financial concerns, bereavement support groups and an additional card is attached, which identifies the deceased, the name of the main carer (qualified nurse) and the contact number should the relatives wish to talk with that particular nurse.

The deceased is retained in the department for a period of time ranging from approximately thirty to sixty minutes, and sometimes even longer, prior to transportation to the mortuary. It is desirable, indeed practical that the body is removed from the resuscitation room as soon as possible so that cleaning and restocking equipment can commence in preparation for the next case, a perfect example of Sudnow's routinisation of death. An exception occurs when a doctor invites another practitioner (junior doctor, paramedic or nurse) to practice intubation (the insertion of a tube into the trachea to permit respiration) on the cadaver. Concern about the use of the deceased for teaching purposes generated a position paper by the Royal College of Nursing (1994) providing guidance to nurses who may witness such an event. While the importance of clinical competence cannot be overemphasised (Iserson, 1993), a dilemma arises in the absence of permission through an advanced directive written prior to death. As this has been coupled with the covert measures surrounding these acts, the practice may be justified from a clinical teaching point of

view; however, the deception is not (Orlowski, 1988). Following ethical debate, guidelines have been developed which suggest that intubation on newly deceased patients can only be justified if the body has severe head, neck or facial injuries which can not be reproduced in a simulation model. Additionally, the teaching of the procedure is restricted to a senior doctor with experience of intubating patients with these injuries and the practising learner must already be skilled in normal intubation techniques. It is advised that the skill must not be conducted secretly, so the relative must understand what is requested and give consent to such a request. The senior doctor will examine the trachea with a laryngoscope and whilst peering through the open epiglottis invite the trainee to participate in intubation. The trainee selects the appropriate size of tube according to the size of the body and continues the double act of peering down the epiglottis. On declaring to the teacher that the epiglottis is in sight, the endotracheal tube is inserted with subsequent checks to ascertain its location in the trachea and not the oesophagus, the tube leading to the stomach.

It is a dilemma as to where to put the body so that the normal functioning of the department can continue and it is a problem in that the available room is not ideal. Selection of a suitable location is made more difficult because of the need to segregate death from other areas within the department and create a scene, which will provide some comfort to relatives that the deceased was 'cared for'. The word private is selected deliberately and explains the need for the death to be invisible and inaudible to others who happen to be in the vicinity but who are not connected with the situation. Dramaturgy aims to minimise the visual effects of the resuscitation and give the illusion of the deceased being merely asleep, and this sleeping state extends to the arrangement of the immediate resources. One nurse informant said, "*I'd make it look like a bedroom, like they're asleep*" (NB para 1304) assuming that the patient would have wanted to have died in their own bed. In representing death, a bedroom like scenario is created using a pink and blue pastel duvet and pillows depicting soft billowing clouds. In another department a table lamp softens the scene in an otherwise brightly lit consulting room that is easily converted for the occasion. A flowery wallpaper border complements tastefully selected curtains which blend with

the rest of the room. Pastel vertical blinds extend across one wall providing a screen for the wall mounted clinical apparatus such as piped oxygen and suction equipment. The deceased is positioned with the head to the wall so that a number of relatives may gather around the bed and nurses may carry out their procedures. Another department uses a clinical room located immediately next to the resuscitation room and it has a connecting door which makes it ideally positioned for containing the death and hence the sentimental order of the department. Though another department found such close proximity a hindrance and felt that relatives should not be in the vicinity of the resuscitation room for fear that they might hear, see and smell death. The clinical presentation of this room limited the desired dramatic effect. A shower and sink is fitted on the floor in one corner which on rare occasions is used for industrial decontamination and up to more recent times the room itself had tended to be used for gastric lavage procedures. Gastric lavage involves the emptying of the contents of the stomach following overdose of tablets is performed less frequently nowadays; subsequently the room was used less and less.

Getting the body to the 'saying goodbye' room is always a problem in terms of concealing death from undesirable visibility and audibility. Nurses attempt to conceal the body by a combination of totally covering the deceased with a hospital sheet, closing doors within range of the manoeuvre, and a 'post-haste' sense of urgency. The number and type of doors prove problematic when relocating a cadaver in that heavy double doors require two nurses at least to execute the task of opening them whilst also steering the trolley into the room. Wide single doors often have a locked smaller door adjacent, which requires to be unlocked to permit the entry of a trolley. Forethought and a slower technique may permit a trolley may be squeezed through. Inspection of the walls in accident and emergency departments, which usually have protective durable plastic or rubber covering attached at a suitable height, bear witness to unsuccessful attempts to manoeuvre trolleys without crashes or scrapes.

Post death preparation of the body involves disconnecting the leads from various mechanical devices used to monitor the patient's physical response. Often the patient

has ECG leads stuck to the chest, which are always removed following disconnection. Similarly the intravenous drip (sometimes there may be more than one) is disconnected from the cannula, as is the central venous pressure line in the neck. The cannula is placed in a 'sharps bin', but used infusion lines and other disposable debris are placed in the relevant container for safe disposal. The body is now ready to undergo 'laying out' or 'last offices' and at this stage the nurse may engage in the one-way dialogue, *"I must admit I still talk to the person. I can't do it silently, I've still got to tell them what I'm doing. It sounds really silly but I've got to, I mean they haven't been dead for hours, they've just gone that minute...I've still got to talk to that patient and treat him like he's still alive"* (NB para 436).

Sudnow referred to mortuary bundles, containing shroud, towels, soap and identification tags, which were specially, prepared death packages routinely, obtained from a hospital store. No such 'bundle' exists in hospitals nowadays and staff will obtain the required materials from the department linen cupboard as needed. Cleaning away body fluids, which have escaped during the resuscitation concerns mostly, blood saliva, urine or faeces. Staff may improvise to get the body cleaned in the most efficient way by using large post-operative pads usually used to dress surgical wounds, they are especially absorbent providing a useful alternative to the blue or white clinical roll when there is copious exudate to wipe away. Protective gloves are always used when the body is cleaned.

The practice of obtaining a 'morgue bundle' (Sudnow, 1967), containing mortuary body wrapping sheet, identification tags, cotton strings for tying the deceased's feet together, and gauze pads for covering the deceased's eyes, from a central supply office is not practised today in the UK. One nurse informant described how a mortuary 'box' used to be available in the operating department setting for the rare occasion when a sudden death occurred in theatre. Another senior nurse with twenty-four years practice remembers how in a hospital, which has long since been demolished, qualified nurses were required to set up a mortuary trolley. The steel and cream enamel 'last offices' trolley was prepared according to a written procedure sheet and

Conforming to the theatrical acting out of a state of 'decency' by donning 'death attire' is a feasible explanation, especially when the shroud is to be removed prior to post-mortem surgical procedures. The shroud serves no other useful purpose. It is made of white plastic and is split the whole length of the back to ease the dressing procedure on a flaccid body. There are ties similar to those, which would be found on a clinical examination gown, which makes it easier to be placed on or removed from the body. Depending on the design some have a neck frill, which has no other function than to act as another prop in the theatrical presentation of the body to the relatives, it is an attempt to make a redundant item of death attire more pretty and tasteful.

After washing the face with soap and water the facial expression is adjusted in an attempt to create a restful repose but is often unsuccessful. At one time the usual practice would be to support the jaw using sandbags leaving them in position until rigor mortis set in, at which point they were removed. The purpose of the sandbag was to keep the mouth shut in the absence of muscle tone because an open mouth on a cadaver is considered unsightly. The sandbag was discretely positioned under clothing and bedding so that the relatives were not aware of its presence. Sandbags do not tend to be used in accident and emergency departments today. Dentures are repositioned in the mouth if they have been removed during resuscitation, which involves cleaning them with a toothbrush and holding them individually with the thumb and forefinger, inserting them one at a time, into the mouth. It is usually easier to insert the bottom set of dentures prior to the upper set and often it is necessary to manipulate the lips to enable access. The luxury of toothpaste is hardly ever known in accident and emergency departments yet the teeth may sometimes be in a dreadfully dirty state from vomit, blood or mucous.

Placing a few fingertips in a sweeping downward movement creates sufficient light pressure to close the eyelids. Often unsuccessful, the action needs to be repeated on a number of occasions to prevent persistent reopening. On many occasions a nurse will perform this task only to find that one eye may have slightly reopened in the time

taken to bring the relatives to the deceased revealing a half-open eye that has lost its usual lustre.

Positioning the body and in particular the arms and hands facilitates body wrapping. The arms are positioned in alignment with the body placing both hands slightly underneath each buttock. The legs are positioned with the ankles together but do not tend to be tied like they were at one time. On those occasions when they are tied nurses may use a wound-dressing bandage to keep the legs in position. Due to the absence of rigor mortis the body is much more pliable and does not always remain in the required position. On log rolling the body the arms sometimes dislodge making wrapping more difficult and the procedure may need to be repeated on more than one occasion.

Wrapping the body is an intricate technique, which if performed incorrectly can lengthen the time spent with the body. A description of the process by one nurse reveals an interesting analogy, "*...and you are just wrapping them up like a piece of meat, 'cos that's what it sometimes seems like. It's a person who maybe not more than two hours ago was actually walking around*" (NC para 323). It is a two-nurse task; one nurse supports the body whilst the other arranges the sheet. An ordinary hospital sheet is used to wrap the body whilst it remains on the stretcher, but rather than placing the sheet in the classic vertical/horizontal manner across the patient, it is laid lengthways, diagonal to and underneath the body. It is necessary to prepare the sheet by rolling it from its extremity to the centre to create a 'barrel' of rolled sheet with an opposite smoothed out section that drapes over the side of the trolley. Extremely large bodies are impossible to wrap with one sheet so an additional sheet is required to patch up the gaps. The body is log rolled toward the nurse to be supported by her own body whilst the other nurse places the length of the rolled sheet on the stretcher in line with the spine. Further, cleansing of the back of the body may need to be carried out if there is leakage of body fluid and it is not unusual for urine and excrement as well as blood to be cleaned away at this time. Often there are broken glass particles on the stretcher from road traffic accident victims and a small vacuum

cleaner similar to those used for cleaning cars is used to remove the glass. The body is then log rolled over to the other side of the stretcher again supported by the other nurse and the sheet is smoothed out. If sufficient allowance of sheet is not made for the head or feet to be covered then the procedure must be repeated to ensure the invisibility and containment of death. An interesting comment exposed how nurses feel about body handling, *"I must admit when I like, prepare the body for the mortuary I think, "Somebody might be doing this to me one day, you know?" I hate it, I hate doing it, I hate it, I really do!"* (NC para 305).

Covering the head is an important element in the procedure. The cover must be secure enough not to expose the head, yet the head must be easily accessed if a relative wishes to see it either whilst the body is in the department or later, in the mortuary. For this reason the head is covered by the triangular section of sheet that has previously been accommodated in the wrapping procedure, by placing it downward over the head and neck. The act of covering the head is a source of difficulty for some nurses *"They're like a Christmas parcel, it's just horrible that bit, I don't like that!"* (NB para 412), and it is at this final part of the procedure that dialogue may take the form of prayer, *"...I talk to them and I say a little prayer before I cover the head"* (NC para 319). White medical adhesive tape is used to secure the sheets and then one further plain white hospital sheet completely covers the wrapped body draping freely over the sides of the stretcher. A process of de-personification is apparent in the way nurses view the act of covering the head. Once the head is covered the person is then reclassified as a cadaver, *"...to me it feels like they're not a person anymore when you cover their heads"* (NC para 312) and the nursing role of 'caring for people a once live person' is no longer viable. During the departure phase a de-personification process enables the nurse to withdraw from the person that was once alive, walking, talking, and expressing their unique personality. Role transition operates in tandem with the life/death transition of the patient and a critical juncture is reached once the head is covered whereby future activities related to the sudden death centre on the needs of the relatives.

Labelling the body involves entering the known details of the patient onto a white piece of paper approximately two inches by two and a half inches. The paper is then attached with medical tape to the centre of the patient's bare chest prior to dressing the body in a shroud. A duplicate form is attached in the same way to the chest area of the body-wrapping sheet but prior to these activities the information was already recorded on the cadaver's wristband and the band is retained. When recording information in triplicate it is assumed that there can be no mistake with the identity of the deceased though repeated use of labels negates the need to strip the body of its wrapping sheet to determine its identity when recording in the mortuary book.

Ascertaining whether the relative wishes to see the body of the deceased is an extremely sensitive issue. Debate suggests a transition from a passive open suggestion from the nurse to see the body (Cathcart, 1988) towards a firmly grounded assertion that it would be beneficial in the future for the relative to see, touch and hold the body (Raphael, 1986; Wright, 1991). Jones and Buttery (1981) concluded that where relatives had viewed the episode as a 'bad dream', the reality from seeing the body although painful, is easier to manage than the fantasy and this had helped them through the painful years to follow. Preparation of relatives to see the body involves a brief description of what the body looks like and the nurse usually asks if the relative has done such a thing before. Reassurance is given that the nurse will stay with the relative throughout if that is what is desired, or if a few minutes of silence, alone with the body is preferable then it will be honoured. The nurse will maintain a 'close distance' immediately outside the room and with the door ajar for the period. Sometimes relatives may not have not been forewarned that there were tubes inserted into the mouth or the actual degree of injury sustained to the body may have been unexpected and images of the scene may be vividly recalled in years to come (Wright, 1991). The nurse spends a few minutes with the relative talking them through what will happen in the following few minutes and the relatives then enter the room where the body is laid accompanied by a qualified nurse. Occasionally a police officer may be present if a formal identification is required and the nurse or police officer will ask the relative clearly "Is this the person that you know as (states the name)?" The

identity of the body is confirmed by the relative usually in the form of dialogue and often accompanied by heightened emotion. The nurse will stay in the room certainly for the first few minutes and will sometimes leave the room if the relative asks for a few minutes to be alone with the body. The nurse/relative proximity is very close during this situation particularly; when the relative seeks physical support by holding on to the nurse's arm or burying their head in comfort seeking fashion on the shoulder of the nurse. This is an emotionally demanding scenario for the nurse who is often fearful of losing emotional control.

The essentially dehumanising effect of stripping the dead body of clothing and personal property is described as a 'really awful' part of the sudden death role. Conversely, an identity may emerge when the nurse discovers items on the body which enable a character to be built up suggesting that prior to death the individual meant something to someone. The following quotation is an example of how a cadaver re-established itself as not only a human, but also as a grandfather. "*But the man who collapsed had all these packages of money identified for his grandchildren for Christmas, it was Christmas week, and he's obviously gone out and he's got his pension...*" (NA para 281). Sorted clothing and other items such as handbag, shoes, watch and jewellery, is folded into manageable shapes and sizes and placed in a container. The container is most commonly a plastic bag but variations on this theme exist throughout hospitals in the United Kingdom. Some hospitals use a thick white plastic carrier bag with handles, customised with the name of the hospital Trust on the side. They are designed for visiting relatives to take soiled clothing to and from hospital following a relative's visit but not necessarily for use in deathwork. Other hospitals use clear plastic bags, brown paper bags and even yellow 'contaminated' hospital bags when they've run out of anything else to use. Criticism is most commonly directed toward the use of the black plastic bag or bin liner which, is considered to symbolise rubbish and a more sensitive appropriate way of returning items is desirable. Items are to be meticulously listed with a respective serial number in a carbon copy book. Caution against fraudulent claims by relative's is needed in the description of an item particularly concerning precious metals where nurses are

taught to describe them as 'silver coloured' or 'gold coloured' as they are advised that a nurse cannot determine how precious a metal or stone may be. A second person usually a nurse or health care assistant witnesses throughout the procedure.

At one time the mortuary box was a grey or white painted metal container on wheels, which required that the body be placed downwards into the container and the lid was then closed over the casket. This proved difficult for porters to physically manoeuvre because they were required to lift literally a 'dead weight' and drop it gently into the box without damaging it. During the focus groups it was the opinion of some nurses that hospital porters really need specific education on sudden death and they went on to describe how they handled the body in what the nurses interpreted as a disrespectful manner. An animated gesture of a swinging action describes how the two porters manoeuvred a body clumsily into the metal mortuary box. "*...one gets hold of the legs, one gets hold of the shoulders, and it's 'Wey, Hey, Hey', do you know what I mean? It's like (clapping action) into the white box.* A second nurse agreed, "*Yeah, they're rough, they are rough*" (NBC para 421).

To explain this point further, some years ago a police officer who's father had died suddenly in the department, quietly asked me to make sure that the porters handled the body of his dead father gently because he 'knew what they could be like'. However, the procedure is a good example of how attention to dignity and respect is replaced by levers and weights. Nowadays in a climate of manual handling techniques, the body is more likely to be slid across from one trolley to another and a casket type lid encases the body. Some porters continue to use a white hospital sheet to cover the trolley.

Any number of obstacles may be encountered en route to the mortuary, which require careful manoeuvres to ensure that the box does not crash into items such as doors, lifts, ramps and banisters, people and vehicles. The chance of concealing the death during manoeuvres is low and death visibility is compounded by an audible rattling of

the wheels and contents within the box making it quite obvious that death is 'passing by'.

Taking the relatives to the mortuary is a difficult part of the sudden death process. The nurse is at pains to search for something to say to the relatives that would help to ease the journey. One nurse had reported how she had been advised to let the relatives speak about it and to try not to make small talk, but felt that despite the good intentions of her advisers she simply was at a loss as to what to say. Having just arrived on duty a nurse may not necessarily have been involved in the care of the patient immediately prior to death, yet quite often nurses may be dealing with the body of a deceased person and the relatives ask questions which the nurse is not able to answer. *"Quite often we are down there and we don't have any details on them"* (NB para 279). Some nurses will try to ascertain at least partial information about the circumstances of the death by reading the relevant documentation before approaching the relatives however there are a hundred questions that relatives wish to have answered. *"But all the way over they were saying, "Did he have his grey slippers on? Did he have?" and I'd be saying, "Well I don't know really 'cos I wasn't on that shift"* (NA para 288).

Asking the relatives to sign the book to confirm receipt of the property is an unwelcome task because the relative's emotion is often heightened by this event and it is preferable that an easier way was devised for the handing over of items. Practices vary from hospital to hospital but it is chiefly the nurse allocated to care for the relatives, or the attending police officer that would be inclined to hand over property. There are occasions of non-adherence to the property procedure described in the following scenario, which was reported by a police informant from some decade ago. The teenage son of a man, who had died from a heart attack, was asked by his mother to search the pocket of his father's trousers for his wedding ring, as it was known that the father normally put the ring in the trouser pocket when he took it off. On searching the black plastic bag the young son began to shake uncontrollably as he

withdrew his hand, which was smeared, with his father's excrement. Distressing occurrences like that described should have been avoided.

On occasion property is retained and this is usually because the items are significantly bloodstained, or have been cut off in an attempt to resuscitate the person. The reason for retaining items is communicated to the relatives by way of a statement rather than a request. An assumption exists that relatives would not wish to have the items in such a condition and they are subsequently disposed of in the appropriately labelled hospital bag. However, items can be cleaned or dry-cleaned by the hospital if it is the expressed wish of the relative, but they are hardly ever asked. Occasionally items are retained at the request of police officers for the purpose of forensic examination. Discrepancy exists as to the most suitable container to use (Mackenzie & Scott, 1998) and forensic officers prefer that items be placed in a brown paper bag rather than a plastic bag to prevent the accumulation of pathogens capable of reducing the accuracy of the investigation.

Chapter six discussed the intricate procedural base to sudden deathwork within the accident and emergency department and prior to transportation of the body in a mortuary box to the hospital mortuary. The problem associated with paramedic hand over of information to the resuscitation team was explored in relation to a lack of continuity of patient history. Presence of relatives during resuscitation was discussed with a view to empowering relatives to make choices to participate and in line with Resuscitation Council (UK) (1996) guidelines and in the hope that the decision to permit witnessed resuscitation actually is the relative's and the patient's wish. A range of practical dilemmas were exposed concerning the making safe of the 'body polluting' by body handling and representation techniques and associated problems were raised in relation to concealing death from public gaze through the use of visual barriers for body wrapping and transportation, and noise reduction. Emotional labour featured as a mechanism by which emergency personnel faced their daily deathwork and particular attention was drawn to de-humanisation of the individual whose once

live status changed to 'dead' cadaver, juxtapositioning the deceased's identity following discovery of personal items.

CHAPTER SEVEN

The following chapter explains how the news of the sudden death is delivered to relatives by emergency personnel, the reaction of the relatives when receiving the news and dilemmas faced by emergency personnel in meeting the emotional and practical needs of the relatives.

Deathograms

Sudnow (1967) referred to the class of 'announceable events' in which a declaration of a changing status to the relatives and patient was considered mandatory, which involved a sudden turn for the worse, the outcome of a surgical procedure, the findings from a laboratory investigation, and the occurrence of death. The patient and relative may assume that announceable events are delivered as the information becomes known, and also that the announceable event is delivered by the proper person. It is also noted that announceable events are limited to those who are considered to have a legitimate knowledge of the issue and this rule of entitlement ensures that the correct information is given to the correct individual. Deviation from such a position is likely to be problematic as relatives arrive and seek information to support the minimal detail that they may have regarding what has happened. When the relative approaches an individual who does not have the information that the relative requires it is usual for that individual to inform the relative that an appropriate person will arrive and deliver the information that they seek. When the appropriate person arrives the information is likely to be announced with the urgency and solemnity commensurate with the occasion. Wright (1991) reported a situation in which a bereaved relative described the doctor as, "Performing like a bus conductor, swaying on both legs with one hand on the doorpost and looking into the distance" (p.47). In Wright's study most negative remarks were about the doctor's communication style such as not sitting down and being on the same level when the news was delivered. Interestingly, many relatives commented on the poor eye contact of the doctor, and the use of euphemisms whilst delivering the message. Wright

advocated that the use of euphemisms such as 'he has passed on', 'he has slipped away', or 'we have lost her' should be avoided because it may lead somebody who is emotionally aroused to misunderstand the information.

In circumstances where individual 'A' knows that individual 'B' has information to relay to individual 'A' there would appear to be an obligation to directly announce the details and this is a feature of all three disciplines. The obligation to report matters directly is based on the assumption that the receiver is anticipating news which is highly important and that the first opportunity for face-to-face contact results in the revealing of the information. There is, however, a temporal aspect of relevance to the immediacy of the information delivery. Sudnow described how the announcer appears and has such a manner as to convey that there is something to report. The recipient assumes that the reporting happens immediately after the occurrence but this is clearly not the case in maternity departments where it is likely that many individuals will have passed by the recipient's room in the knowledge of the information to be given, yet will not stop to disclose. "In the maternity ward, there is considerable traffic in and out of doors leading back to the delivery room suites, and in the course of that hour or more between the point when the newborn's sex and health are ascertained and the time when the obstetrician will complete stitching the episiotomy, dress, and have a coffee break before emerging from these doors with the news, a large number of staff members will pass the "father's room," having the news the father awaits, yet without informing him" (Sudnow, 1967:120). Similar non-disclosures occur in accident and emergency when the relatives experience delay in receiving the right information from the right person.

'Deathograms' as they are known, are considered by some traffic officers as the worst job in the police force. Officers prepare themselves well in advance of speaking with the relatives, gathering as much information as possible to enable the officer to respond to any eventuality. The officer plans how the death message is to be delivered en route to the relative, and ascertains whether a neighbour or friend will be available to sit in with the officer and to comfort the relative. It would be ineffective

for the officer not to have some basic information about the circumstances surrounding the death especially when the relative starts asking direct questions about what happened. The relatives do access more information through long-term contact with an Accident Investigation Unit officer and it is through this medium that sensitive material is subsequently revealed over a period of time.

Guaranteeing the identity of the body is a real problem in the absence of witnesses or documentation to be found in the deceased's bags, pockets or car. Many people do have some form of identification in a handbag or pocket, which often takes the form of a household bill or receipt with the name and address of the person in typescript, indicative of an official document and hence accurate. It is also extremely helpful when the name and address is written on a piece of paper and placed in a purse or wallet in anticipation of accidental loss or theft of the item. Another friend or relative may also have witnessed the collapse and be available to tell the emergency personnel the identity of the person but frequently the identity is unknown. One traffic officer reported how he established the identity of an individual through a bank credit card that was in the deceased's pocket. The officer was able to contact the bank for details and this made his role less complicated. But when the identity is uncertain and there are no distinguishing marks or clothing it is difficult for the officer to communicate certainty to the relatives, "*...well how far do you go? 'cos you can't say, "Well we think its definitely him" it is more often a case of, "How do you feel if deferring the fact that it might be him?"*" (TPA para 643). The officer is reluctant to make the relative feel afraid that it might be, but it might not be the identity of their loved one. Paradoxically, they do not wish to underplay the situation so that the relative then thinks that it definitely is him. It is a case of striking the balance and coping with the tension from relatives created by the continuing uncertainty.

The immediate family can usually be located quickly but it can take a few hours and, occasionally, in more unusual circumstances, can lead to a press release to call for relatives to come forward to 'claim' a body. Once the location is known death notification is possible whereby an officer is despatched, often to the relative's home

or place of employment. In the case of the latter it is useful to have a manager or Occupational Health service personnel to assist in locating the individual in a discrete, diplomatic manner.

Knocking on the door of the immediate family to deliver the death message generates a feeling of dread in the traffic officer, *"I think every time you go and knock on someone's door to inform them that there's been an accident or that someone's died, every one of those are like the first time as far as I'm concerned"* (TPC para 1105). Some officers are more able to empathise with and respond to the emotional needs of the relative. One traffic officer described how he had crouched down beside an elderly woman as she sat on her sofa to gently let her know that her husband had died whilst out on an errand. She had been preparing his evening meal. Another traffic officer was quite committed to the fact that he did not want to get involved with the emotional support of relatives. He had no interest in it, did not consider that dealing with the relatives was part of his job and believed that somebody else should do it, *"It's nothing to do with a bobby is it, that's not what you're about!"* (TPC para 1326). His explanation was that relatives perceived police officers as not the right person for the role and the sooner they were 'rid of them' the better. Another preferred to have a choice, the outcome of which was that he would rather deal with the body, as it was easier than dealing with the relatives. Brevity of contact is considered better and begs the question of who actually benefits when an officer would prefer to limit contact with the relative. *"If you go and knock on someone's door and say, "Your son's dead, he's at (hospital), jump in the car and I'll take you there". If that's the only involvement that you've ever got, that's great"* (TPC para 831). But people do start asking questions and wish to learn more in order to assimilate the circumstances of the event. Often its simply a matter of saying the words that the relatives do not wish to hear and this means that officers may feel the need to be blunt rather than vague. *"Look, there's been a very bad accident and your son or daughter..." or, "We believe your son was driving...or was involved, or was in the vehicle... would you come and identify him to see whether it is or not?"* (TPA para 643).

One traffic officer disclosed how it is possible to strike up a conversation with relatives soon after the initial delivery of the news, "*...once you've actually broken the news to them, when they've settled down a little bit, I suppose then obviously they want to know a little bit more. So you'll maybe tell them a couple of little bits and pieces like you said there about preparing yourself, and you pad it out as much as you can before you go*" (TP para 129).

It is not possible for the same officer to tend to the body in the mortuary and speak with the relatives, another officer would be despatched to the relative's home to inform them of the news of the death and the need to confirm identity of the body. Officers decide what information is delivered to relatives and can spend up to one hour or so with the relatives after breaking the news, in some cases transporting the relatives to the accident and emergency department. During the journey some officers may strike up a conversation with the relatives once the initial news has been delivered, they 'get them talking' and it makes it easier for the officer to bear though some relatives might become hysterical whilst other individuals withdraw, becoming mute and uncommunicative.

If sudden death is a certainty the officer's role is made easier in that there is no doubt about the finality of the event and there is clarity in respect of the stages of contact between traffic officer and relative to follow. When an incident occurs and the patient has not died, could die, or is certainly going to die, the support and advice given to relatives is much less certain and may even change the course of contact and content of the communication (Glaser and Strauss (1968) referred to the use of 'half-truths' in similar circumstances). If the patient has died then there is no real urgency to rush the relative to the hospital to 'be there' during the last moments of life it may be preferred that a close relative, friend or neighbour should drive the immediate relative instead. In the event of an impending death it is considered imperative that the relatives get to the hospital in the shortest period of time and on these occasions officers guide the relatives into the rear seat of the traffic car and drive them swiftly to hospital. Conversation during this period tends to be restricted to essential dialogue with some

attempt to answer questions about the background of the incident. The officer cautiously proceeds with the course of the conversation but does not wish to declare that their relative is probably going to be pronounced dead despite the relative's suspicion that this is indeed the case, affirming that a state of mutual pretence awareness is in operation. For an explanation of the use of half-truths refer to Glaser and Strauss (1968).

As long as the officer has some knowledge of what happened to the person immediately prior to death then it is possible for the officer to answer most of the relative's immediate questions though there are questions which the officer had not anticipated would be asked. Not that the officer would be inclined to tell the relative everything because certain information may be omitted usually because the officer does not think that the relative can cope with the content. Omission to divulge full details chiefly concerns physical injuries sustained in an accident and such information is 'drip-fed' to the relatives in an attempt to reduce the emotional impact. On discussing a hypothetical case of a badly mutilated body an officer anticipated that he would tell a lie, and say something that he thought they would wish to hear perhaps, 'it was very quick', to communicate that the individual did not linger on in a painful state. Such economy of truth borders on expressing clichés, and is considered to protect the emotional interests of the relative. Some difficulty is expressed in ascertaining how much information to give and it would appear that each situation with each set of relatives is unique. Achieving the correct balance of how much and what content of information to give is anticipated, *"That's right so do you just turn round and say, "Ah yes well he was run over three times and had his legs broken" and so on and so forth. They probably don't want to hear that"* (TPC para 286).

On discussing sudden death encounters traffic officers disclose how difficult it is, in the absence of adequate training, to do some of the things that are expected of them. Hetherington et al (1997) explained how preparation to deal with sudden death is usually delivered during the officer's basic training and focuses on the initial investigation and the completion of a report using a task-orientated approach.

Introducing humane characteristics of empathy and sensitivity within the traffic officer's role is dependent on the character of the individual officer with some officers never displaying these characteristics due to their need to maintain a detached stance. One commented, "*You've never had to do it before and you've never been shown it before, it's the same as anything in the police force, you're expected to know how to do everything*" (TPA para 215). In some cases there had been no formal training but "*You all just train yourselves from experience really*" and, "*There's no formal training as such*". It was considered that traffic officers are probably better equipped than the divisional officers in that they deal with death more frequently. One focus group reported that none of the participants had attended a bereavement-counselling course and this was considered to speak volumes about the lack of preparation for role. A sense of irony was expressed, "*Right well you're going to deal with thirty fatalities this year but we won't bother training you*" (TPA para 887). One police officer was attached to the traffic division for three years before he had the hospital business to deal with. There is a sense of abandonment and a feeling of being placed in a situation of learning to cope by default, "*...you just have to get on with it*" (TPC para 1062). Conversely, when Mobile Police Officer Course participants received a talk from three local CRUSE counsellors the session was considered to be ineffective because the officers devalued the content, style of delivery, and lack of 'street' credibility of those delivering the session. Such a position is contrary to the recommendations of Victim Support (1994), which highlighted the need for training in the support of distressed relatives following road death. Essex Police provide a lighthouse for such work in their Service Delivery Standard for road incidents. Guidelines for the appointment of a named liaison officer to communicate with relatives in the post incident to inquest period is suggested, a role currently offered in the Constabulary studied under the auspices of the Accident Unit.

On arrival at the scene the paramedic crew come in contact with relatives and friends of the victim and they too reported on the ineffective preparation for the role of managing the relatives. They expressed concern that they should not be expected to know what to do in the absence of adequate preparation and having not previously

been in that situation before. Some aspects were 'pumped' into them, particularly in relation to the resuscitation role and dealing with the body of the deceased and paramedics seemed to be more confident in dealing with practical aspects. A less welcome aspect of role involved the care and management of distressed relatives and paramedics reported not to have received any formal educational preparation for dealing with these individuals acknowledging the inadequacy of such a position. One paramedic described the awkwardness of using the well-worn cliché 'we did our best', and described how he would then 'scuttle off', away from the scene which is making him feel ill at ease. The perceived lack of educational preparation in dealing with distressed relatives is considered unhelpful, whilst an accumulation of incidents constitutes the main method of learning, "*It's what you pick up as you go along*" (PC para 51) in that, "*...we haven't got a clue how to deal with relatives*" (PC para 63). Despite the apparent void in formal education to address sudden deathwork with relatives, a self-initiated reflection was reported which may provide a sound means of educational development. A paramedic may think about the experience and challenge ideas, questioning whether the same approach would be used on subsequent occasions. Occasionally automated actions have not registered with the paramedic and it is not until after the highly charged atmosphere in which the 'adrenaline is flowing', has subsided that the paramedic realises that a particular course of action had been taken. Reflection then provides an evaluative function helping these individuals to learn and this teaching method should be integrated in the curriculum for both initial training and continuing education.

Smith et al (1999) explored the provision of death education in the curriculum for emergency physicians, paramedics and other emergency personnel. Typically, death education courses overlook instruction in areas germane to emergency medicine and a curriculum was designed to address the educational void that renders many emergency physicians, and paramedics feeling inadequately prepared particularly, in relation to meeting the emotional needs of relatives. This gap included death notification, interacting with survivors during the immediate grief period, and reducing professional stress associated with caring for newly bereaved individuals. Initial and

continuing professional development programmes in death education could offer emergency personnel enhanced communication skills, which may enable them to cope with the complexity of sudden death in isolated conditions.

In acknowledging the individual characteristics of nurturing and compassion that emergency personnel bring to their work, one nurse informant felt that the bereavement course that she had recently attended had made her less natural and more aware of herself. She described how her own 'text book practice', which guided her to lean forward and make eye contact, seemed somewhat mechanistic. Another felt that everybody working in accident and emergency should receive training in counselling and bereavement, including care assistants, even though the same nurse acknowledged that the three years of education to nurse registration was the best route to achieving better care for those traumatised by sudden death.

Registered Nurse *"But we've got three years training and we're developing our skills continuously and fair enough, I respect the care assistant and I'm not saying that they're not needed on an A&E department, but when it comes to such an important thing as caring for a person who's lost somebody in our department, I think it's wrong".*

Second Nurse *"Yes, I can see your point there like you say, we are needed on the department and they're of great benefit but you've, I mean you've done three years training. They all mean well but well we've got the knowledge, they've just been trained to perform a skill... and I think the more you hand over the less you'll be involved in".*

Registered Nurse *"I agree with you completely, it's the nurses' role".*

An obvious protectionism exists in regard to preparation for role and the nursing contribution rather than the contribution of the care assistant as the most appropriate caregiver. A paradox exists that three years of nurse education is considered sufficient

to equip a nurse with the knowledge and skills required for the management of the suddenly bereaved. Yet, the same three-year programme supposedly can not teach everything, only the practicalities of dealing with the sudden death. Much is to do with the characteristics and personality of the individual practitioner and how that person is able to act sensitively in sudden death situations. What is considered to be most precious by nurses is the 'personal touch' that an individual can bring which is complemented by the life experience often of the mature student. Dealing with a sudden death situation is considered to be more of a shock to the young student nurse who may be inexperienced in life skills.

This chapter investigated ways that emergency personnel deliver the news of a sudden death and it has been established that anticipatory fear of relative's reactions was expressed. Once the initial message is given it is likely that more detailed information will be drip-fed in an attempt to lessen the distressing impact of the information, which if delivered in full may traumatise the relative further. This highly charged emotional aspect to sudden deathwork was discussed in relation to preparation for role and it is clear from the reported experiences of those involved that emergency personnel continue to feel inadequately prepared for such an event. Further, when training programmes are devised attention needs to be paid to the content and style of delivery of such programmes.

PART THREE

PART THREE

SCHUTZIAN RELEVANCES

Part Three takes the reader into a series of discussions based on the Schutzian notion of relevance, which provide common-sense interpretations of themes developed during the analysis of the research. The purpose at hand is to discuss key experiences of sudden deathwork emerging from the data to be interpreted in relation to how they stand out from other experiences and to establish their typicality. The construction of an in depth account of the emergency care, sudden death milieu is reached. Frequent reference is made to the collective term 'emergency personnel' to describe or explain collectively typical situations, procedures and responses. Specific incidents typical of one discipline but not of others will be presented such as when a nurse opens the window of a resuscitation room to let the spirit out will be described. It is notable that traffic officers do not engage in such a procedure during mortuary deathwork, nor did paramedics report on such an activity during deathwork in the patient's own home though this does not mean that it does not happen. Use of italicised brackets report statements from informant transcripts and appear with their relevant code.

CHAPTER EIGHT

Chapter Eight presents role relevance within four themes beginning with role resignation and followed by role uncertainty, role obstruction, and role routinisation. Resignation to perform a role is associated with a duty bound obligation to perform dirty work such as body handling and delivering bad news to relatives and would much rather be avoided. The section on role uncertainty concentrates on a lack of awareness among emergency personnel of each other's sudden death related functions. This is followed by a discussion on how role obstruction makes the work of emergency personnel more difficult, creating a negative working environment. Role routinisation draws on Sudnow's (1967) work and explained how normalisation of sudden deathwork occurs when extreme circumstances associated with sudden deathwork become an inherent part of daily life, it becomes part of what emergency personnel 'do'.

Role relevances

Goffman (1961) claimed that 'role' consists of the activity the incumbent would engage in were she/he to act solely in terms of the normative demands upon someone in his position. He distinguished this from 'role performance' or enactment by defining it as, 'the actual conduct of a particular individual while on duty in his position' (p.75). Earlier Linton (1936) formulated a concept of role in that role enactment occurs largely through a cycle of face-to-face social situations with role 'others' who provide a relevant audience and are known as a role-set. The role that is associated with a position falls within a role-sector or sub-role so role analysis concerns an individual enacting an array of obligatory activities. In taking on a role the incumbent is required also to adopt the whole range of activities determined by the role, a social determinism being implied at this point. Regulation of such roles is assured by possession of qualifications, dress codes, and status cues, which assist people in recognising what and with whom they are dealing and a degree of prestige or contamination is awarded depending on the specific role.

In performing a role an individual must ensure compliance with the demands of the role resulting in outwardly displayed behaviour consistent with role expectation. For example, a nurse is compassionate, a police traffic officer is composed, and a paramedic is competent and these qualities provide a basis for a 'self-image' to be adopted and displayed by the incumbent and which other people will recognise. In Goffman's words, "...a self then, virtually awaits the individual entering a position; he need only conform to the pressures on him and he will find a *me* ready made for him" (Goffman, 1961:77) the incumbent then, becomes a regular performer. The term 'irregular performer' is given to the individual who has limited contact with the role-set in that the regular performer could be a nurse in her occupational role whilst the irregular performer is the patient or relative with their singular contact with the accident and emergency department. An individual becomes committed to a role when it is performed regularly and is locked into that position by the coercive measures taken by others for him/her to live up to that position. To become attached or enamoured to the position requires an affective connection within the incumbent, a desire to view oneself in the position and the role. Attachment and commitment often operate in tandem and the individual or social group may possess a selfless component as seen in public service professions. In terms of rights and duties, role conflict arises when role obligation and role expectation is mishandled. Role obligation is defined as "an action that an individual or others can legitimately perform" whereas role expectation is defined as "an action of others that an individual can legitimately insist upon" (p.81).

Role resignation

Role resignation was expressed in the focus groups by the use of negative descriptors central to deathtalk with terms such as, "that's awful", "it's so horrible", or "it was horrendous", which are very forceful negative descriptors of involvement in sudden death activities. In a study on linguistic reference to emotions in naturalistic conversations Shimanoff (1985) explained how reference to unpleasant emotions outnumbered references to pleasant emotions almost two to one and this should be

taken into account when considering the impact of what is uttered by the emergency personnel. Other descriptors highlighted the internal state of emotional arousal expressed by certain emergency personnel by saying how “it’s really annoying”, “you feel so useless”, or “you feel so bare”.

Resignation to perform a role affected all three disciplines and was manifested in selected sudden death practices chiefly concerning contact with emotional relatives, spending time in the mortuary, and physical contact with the dead body. Both Glaser and Strauss (1968) and Sudnow (1967) extensively addressed the use of measures to avoid body preparation in particular, body washing, body wrapping and, interim repairs and patching up. Resignation to participate in these two practices is clearly expressed, *“I would certainly rather somebody else deal with it”* (NA para 139). Staff acknowledged specific colleagues as being more able to deal with specific aspects of sudden deathwork particularly concerning the support of distressed relatives. *“I mean there’s certainly people in the department who you know could deal with it better than you so if they’re on duty they’d be inclined to deal with it”* (NA para 141). Having declared that the aspect of sudden deathwork is difficult to handle the natural response would be to ask someone else to perform the task instead however, no such requests were ever made. One nurse referred to the lack of choice to participate *“I think it depends on how you feel at the time...whether you feel that you want to go in...and sometimes you don’t even get that choice and you are the only one around”* (NC para 273). When asked whether a colleague would be approached with a request for them to deal with the relatives instead it was established that one would not approach another member of staff with such a request because it would suggest ‘offloading’ of work. Instead the member of staff would be inclined to *“...go in that direction, you can see them going in that direction without even saying to them “Will you go and do it?”* (NA para 146). So it is established that colleagues do not ask and do not expect to be asked to participate in the care and support of relatives on behalf of another member of staff. It is more likely that individuals perform the role because they have to and not because they wish to.

Unwillingness to participate was not necessarily considered to be a conscious process whereby individuals actively avoided taking part because it is often difficult to avoid getting involved due to limited availability of personnel, which means that staff simply have to get on with the task in hand. *"Every time I've had to deal with it though I mean, I didn't relish the fact that I was doing it"* (NB para 75). It was more a feeling of abhorrence towards the particular activity accompanied by feeling compelled to perform what Hughes (1971) described as 'dirty work' that was expressed. *"At the time you don't think, "I don't like doing this, I don't want to do it. You just know what you've got to do and you just do it"* (NA para 235). So it appears that role resignation is an unconscious obligation integrated within their role *"You don't think about it much really in that sense, at least I don't. Never mind 'do I mind doing it?' I just do it, I have to do it"* (NB para 230).

Other individuals who were more explicit in the nature of the avoidance, thought it easier to stay in the resuscitation room, clean up the body and restock the equipment rather than communicate on an emotional plane with relatives *"...but I'd rather be in the resus room"* (NB para 291). One traffic officer reported on how he did not like contact with the dead body in the mortuary *"I don't like touching them but you know, you've got to unfortunately"* (TPB para 327). Conversely, another traffic officer voiced a preference to handle the body than have the anticipatory pressure of facing relatives. *"I personally don't find it difficult to deal with the body, more so the pressure of knowing that very shortly relatives are going to be arriving"* (TPB para 445). One rationale for such avoidance lies in the relative's questioning when emergency personnel do not have answers. *"I was asked an awful lot of questions after the death by the family, which I hadn't even considered"* (TPC para 1421). Of significance was the volume of comments, which suggested that anticipatory willingness became rapidly replaced by feelings of obligation at the prospect of supporting the relatives of a dead child.

If the sudden death was recognised as a Coroner's case then the death met certain criteria (Scott, 1995) and emergency personnel would be inclined to have minimum

contact with the body so role resignation is less problematic. A sudden death is designated a 'Coroner's case' when certain criteria surrounding the event are met and requires investigation by a Coroner's Officer (DHSS, 1988). It needs to be established that a doctor has not attended or treated the deceased during the last illness, or been assessed after the death or within the fourteen days before death. The cause of death may be unknown or the death may have been violent or unnatural or occurred under suspicious circumstances. Further, the death may have occurred while the patient was undergoing an operation or did not recover from the anaesthetic. Finally, investigation as a Coroner's case may also proceed if it was suspected that the death was caused by an industrial disease and also if the death occurred in prison or in police custody. All sudden deaths involving the aforementioned criteria may require post-mortem however not all bodies actually have a post-mortem performed.

Returning to Goffman's (1961) assertion that the regular performer ensures compliance with role performance it appears that emergency personnel outwardly display behaviour consistent with the role. The notion that the incumbent becomes locked into the role and develops an affective connection is not necessarily carried through on the basis of the reported information. Few nurses, traffic officers and paramedics commented favourably on their involvement in sudden deathwork and particularly on the three aforementioned specific aspects. Only two accident and emergency nurses expressed that they felt equipped to deal with the work and perceived such deathwork as a 'privilege' to be involved at such an intimate moment. The predominantly negative comments and difficulty in managing practicality and emotionality associated with the event are symptomatic of role obligation and not that staff may be enamoured to the role.

Role uncertainty

Lack of appreciation of contrasting roles of emergency disciplines during sudden death interaction was expressed. Attempts had been made by individual traffic officers to heighten awareness regarding the traffic officer's role particularly with the

fire service and also between the author as sudden death nurse expert and traffic division officers. Of primary concern was the need for fire officers to be aware of the evidence that could be gleaned from the scene of an accident and the risk of contaminating the evidence by their own actions. Traffic officers nickname fire officers 'Dennis and his Rock Apes' because of the perceived 'Gung-Ho' attitude when they arrive at the scene of a road accident and immediately rip the bonnet and roof off a vehicle with metal cutting machinery to ease access to and extrication of an accident victim. Traffic officers were keen to express that forensic evidence such as tyre skid marks, debris, and road surface gouge marks essential for affirming liability, could be contaminated as a result of the fire officers' actions. A seminar given by a traffic officer provided a series of slides and photographs of accident scenes with supporting discussion to enable fire officers to understand better the requirements of traffic officers. Similarly, the traffic department would be invited to talk with student nurses attending pre and post-registration trauma modules to enlighten them in relation to the preservation of forensic evidence and the role of the police officer in informing and supporting relatives.

There is also a lack of understanding by police officers of the new roles that they observe in the resuscitation room. On speaking with traffic police attending the Mobile Police Officer (MPO) course, it would appear that there is a distinct benefit in explaining the Advanced Trauma Life Support Protocol (ATLS). The difficulty was that police officers did not understand why the recording nurse in the trauma team did not go and speak with the relatives until it was explained that her role was limited to the recording of clinical parameters. The nurse was negatively perceived by a police officer to be 'just stood around with a clip board' when the nurse's role was to oversee the collation of information to enable decisions to be made about resuscitation outcome. The nurse will stand with a pen and a trauma chart listening to clinical measures as they are spoken, documenting each entry such as medicines administered, infusion connected, catheter drainage, blood pressure, central venous pressure, pulse oximetry. The nurse does not get involved in the clinical procedures but will operate peripheral to the activities of the other team members, performing a crucial

documenting role. Traffic police do not understand that the resuscitation nurse does not move between waiting relatives and the resuscitation room activity. Specifically, the circulating nurse working within an ATLS protocol attends only to the patient's needs so that nothing detracts from the resuscitation room activity and the patient benefits from focused resuscitative effort. Care for distressed relatives will remain fragmented and relatives' choices will continue to not be heard until relatives are formally recognised in the accident and emergency department by receiving a case number within the documentation system and a designated nurse.

It is established that anticipating relative's wishes is particularly difficult in the absence of dedicated support and much uncertainty exists, in relation to whether the wedding band should remain on the deceased's finger or given to the immediate relative and who specifically constitutes 'the nearest relative'. Recommendations from the Federation of British Crematorium Authorities Code of Conduct suggest that items of jewellery should be removed after death unless it is intended that they should be cremated. Once combustion at between 800-1000 degrees centigrade has occurred precious metals become partially unrecognisable. An applied magnetic field extracts these metals and they may be subsequently disposed of in accordance with the Code, for example, by burial at a depth within the crematorium grounds (Scott, 1995).

Uncertainty regarding whether items of clothing belonging to the deceased should be retained for dry cleaning by the hospital or returned immediately to the relatives in attendance is another dilemma. Despite the need for an empowered choice by relatives, nurses are more likely to pose statements regarding the completion of the task than a request of their intention to dispose of items. Where infant death is an issue it is usual for relatives to want to take items of clothing with them. Items such as a lock of hair, cot labels, name bracelets which are tangible evidence of the child's existence become treasured keepsakes (Tom-Johnson, 1990) which can be placed in a secure, private place such as a linen drawer in the parents' bedroom or in the infant's own bedroom as part of the sacred shrine to the memory of the infant.

When a religious minister is called to attend the dying or dead person to provide religious and spiritual care emergency personnel are often left with the dilemma of not knowing which person to contact. A list of religious ministers representing a range of faiths is available, usually in the Department or Sister's office, but the unconscious or dead patient who has no relative present is always problematic. In this situation it is highly probable that a religious minister is not requested to attend until relatives can establish the dead person's faith.

Sometimes uncertainty exists over whether relatives actually want a nurse to be with them whilst they await resuscitation outcome and immediately after the death. "*I sometimes find that relatives don't want the nurse there*" (NC para 197). It is difficult to determine what is helpful and comforting and what constitutes an intrusion of privacy at a most intimate moment in a person's life. During moments when their behaviour is extremely exaggerated relatives may not wish to be exposed to people they do not know. The nursing and medical staff may consider the option to offer sedation to a relative, however, this is a rare event in that relatives are encouraged to 'feel the pain of the loss' in order to deal with the grief. This is a situation in which the sentimental order of the department is sacrificed for the 'greater good' of an individual who may perpetually 'scream the house down' on hearing the news of the death.

A great dilemma exists for paramedics who are called to a 'blue light incident' with an expectation to resuscitate, and when they get to the scene swiftly realise that the patient is not for resuscitation. Role uncertainty concerns the need to judge each case on its own merit and not to have any pre-conceived notion that all blue light cases should be resuscitated. Paramedics are requested to attend the scene by a general practitioner not actually present at the scene and in this instance the information is often unclear. When faced with such role uncertainty paramedics tend to use their own discretion. They literally 'read the scene'.

Just recently an on-call mortuary technician service was made available in one of the hospitals but it only operates at the request of a police officer. Unfortunately one traffic officer was unaware that the mortuary technician was available to deal with body handling on night duties. *"I was on my own down there attempting to clean a body and it wasn't until I realised that I was making a right hash of it that er, I got in touch with (name) and he said there was a technician that you can call out. You know, you're not expected to (clean up the body) and I said, "Oh right", you know?" I didn't realise you know, nobody had told me"* (TPA para 48).

Momentary uncertainty exists when the officer is establishing the identity of the deceased. *"I think when you get to the relative's stage, you're ninety per cent certain that the person that they see is their relative"* (TPA para 635). However, there is always that small element of doubt whereby the officer tries to get as much information as possible just to close that ten per cent down. *"You see we got this guy sort of simply identified by the fact that he had his leather coat on and when we got to the father who wasn't at the scene he said, "We're not sure but his brother has a similar kind of thing." So we were sort of fairly uncertain that this was this man. How far do you go to identifying for the relatives when you're not sure if its him or not?"* (TPC para 69).

A critical juncture is reached which affects role uncertainty when the traffic officer learns the positive route to a patient's recovery trajectory. *"As soon as you know that the accident becomes totally insignificant and it is not really important any more now, and soon as you know that you can get his name and address er, and you can clear off. Whereas if its going to be a fatal or if its going to go serious and the injuries were bad em, you need to put another ball game into practice"* (TPB para 1983)

Role obstruction

At the scene of an accident the public display selfishness that the police feel is both obstructive and offensive. Explaining dissonant police roles at the scene of an

accident Hetherington et al (1997) described how traffic officers are required to control the incident and prevent its escalation, to collect information whilst also, as authority figures for the witnesses and survivors, provide a sense of structure, support and comfort. Primarily, traffic officers need to control traffic to permit access to the scene by other emergency services. They also need to identify and approach witnesses to collate information regarding the incident and ascertain names and addresses in order to follow up any investigations. Controlling the becoming increasingly frustrated in situations that are more and more difficult to control. The high profile and public nature of road accidents places officers squarely in the public gaze, which compounds their frustration. A 'nightmare' description was provided of a road traffic incident in a rural location where no sooner the incident occurred the public were blocking the road with kids jumping fences to get a better view of their mates. They were 'stood gauping', taking in the details of the blood on the walls, and remained to stare a little longer despite the traffic officer's command for them to leave the scene. The police meet discourtesy from car drivers with some surprise when the driver does not seem to understand the message. *"You ask them to turn back and you explain, and you know they are still wanting to come through, "Well I have to drive 'cos I have to get to my mates up there!" And you'd like to tell them to F. Off"* (TPC para 836). The message is transmitted clearly enough often with explanation as to the fatal nature of the incident so what is it that the public fail to understand about the seriousness of the message that makes them 'go on and on' about their inability to gain road access? Especially when at that early stage of police activity the traffic officer has more important things to be getting on with than standing directing people. *"You should be able to say, "Right!" to the first one "Turn around and clear off!" and everyone should hopefully have the brains to follow that person, but they don't, you get people coming back and people say, "Oh well I'll just wait, I'm not moving, I'm not going to turn round, I'm going to sit and wait"* (TPC para 855).

The accident and emergency receptionist is another source of obstruction though it is acknowledged that most co-operate if the officer selects an appropriate moment and an appropriate approach. *"You wander through the door and this really friendly girl*

behind the desk gives me this piece of paper so you're half way to your task...And you're walking up and you're smiling and you automatically receive smiles and helpful faces back. And then you go to (other hospital) and you get this really stale old woman who's always there. She works twenty-four hours and she won't give you nothing at all and because you know she's going to be there that you walk in with a scowl which automatically causes her to not like you. So she doesn't give you any information so she gets even more of a scowl. Then you walk up the corridor even more annoyed and the nurses look at you and they deliberately go up the other side of the corridor and pass you and they avoid eye contact and they think, "Oh, he doesn't look like he's in a good mood!" (TPB para 2150). Subsequent interaction with other accident and emergency staff is likely to be harmonious as a result of a helpful receptionist. However, the behaviour of some receptionists resembles a game, which leaves a bizarre impression in the minds of officers. The game that is played concerns an initial request for information regarding the identity of the patient. Such is the request that the receptionist as gatekeeper to the information declares that she can not give the details to the officer. The patient's hospital record is then placed on the desk in front of the officer accompanied by a further statement, *"I can't tell you this". I mean what the hell is the point in that, you know? She won't even, if you say to her, "Is this him?" she won't tell you, but she gives you this piece of paper with his name and address on! I call that covering yourself"* (TPC para 2171).

It is hard get information when the officer telephones the hospital so it is usually more productive when the traffic officer attends in person. Attendance is also for the purpose of obtaining immediate specimens in compliance with the drink drive procedure, a thirty-second procedure, otherwise known in the force as 'baggin em'. Obstructive responses will still be encountered despite the traffic officer's personal attendance and declared patient impartiality. *"Sometimes I don't give a toss about the guy in the bed 'cos I've seen what he's done to somebody else. I just want to see him blow in that bag and I can go, he can die for all I care. I just want to make sure that I can secure the best evidence to support the other party"* (TPC para 2012). One officer estimated that about seventy per cent of requests to 'bag em' are met with

obstruction and it is considered 'a breath of fresh air' when a nurse permits him to perform his role and leave the department as quickly as possible.

Another scenario involved a patient with a long-term injury who was transferred to a hospital ward following treatment in accident and emergency. On telephoning to check the patient's progress at the accident and emergency department reception, the police officer was informed that the patient was in another ward. Identification of the correct ward from the patient's records can take a minute or two to access. The officer's call was then transferred to the relevant ward where a nurse answered the call. The dialogue is such,

Officer "*Can you tell us his condition?*"

Nurse "*Oh er, well we can't really give out that information.*"

Officer "*Ah right we'll play the guessing game then shall we? Is it right he's got a broken arm?*"

Nurse "*No, that's not right*".

Officer "*Is it right he's got a fractured rib?*"

Nurse "*Now that is correct, he has got a fractured rib*".

Officer "*Oh right, so there's one! Is it right he's got a severed artery?*"

Nurse "*No, he never had that*".

The officer proceeds to run through as many injuries as he can remember in his entire injury vocabulary in what he impatiently concludes to be a stupid guessing game.

Due to the risk of divulging confidential information to third parties who do not have the right to such disclosure e.g. journalists, occasionally a nurse may express a wish to check out the number by telephoning the police station to speak directly with the officer concerned. Traffic officers do not object to such safeguards which they acknowledge are for the protection of the patient. When asked what the ideal scenario would be in relation to the giving of information, the traffic officer suggested they should be able to walk up to the nurse and request the information. The nurse should appear to be interested in their request by responding with a more helpful comment such as "*What is it that you would like from us and how long do you anticipate being*

here?" (TPC para 2258). The officer would then respond with, "All I really want is to obtain these details for this form and permission to get a blood sample". Indeed the ideal scenario is reported to have occurred on other occasions the following incident describes how anticipatory frustration transformed into a fruitful outcome.

"I had one the other day with a doctor er, they couldn't find. Everyone was cussing responsibility for the patient that was the problem right? Loads of people looked like they were responsible and they were all pretending to be caring but they were all saying, "Oh no, you ought to be speaking with...". Right, it's a bit like passing the buck. So they couldn't find the doctor, nobody would give us his name. "Oh, we don't know who the doctor is". It was like they were deliberately trying just to palm us off. That's what it felt like when we'd been there nearly an hour. And eventually this young lad wanders up who said he was a doctor. He had training shoes on and he looked the most undocorly looking person. He comes running up the aisle and out of sheer frustration I grabbed him. Sheer frustration, I grabbed him and he said, "Oh look I'm the doctor". Right, er dead simple, "He'd been involved in an accident, we suspect he'd had summit to drink and there's obviously been time for it to take effect". And you need to explain to him why 'cos he's likely to say, "Oh, no off you go!" In he went and took the blood and that was it over. And that's you happy. The doctor came out and they were done" (TPC para 2050).

Usually the officer meets with obstruction from those individuals with direct access to the specific information required for completion of documentation and commencement of investigation and this becomes increasingly irritating to them because if these people can not disclose the information, "Well who the hell can tell us?" (TPC para 2297). Bearing in mind that the level of the subsequent investigation is dependent on disclosure of information, it is useful for the officer to learn about whether the injuries are life threatening. To be refused details of the patient's name and address is considered ridiculous by the officers concerned. According to one officer the request for information is communicated in a "veiled threat" (TPC para 2334) as it was his perception that nurses do not realise how much trouble they could

get themselves into by non-disclosure. Anticipating a serious situation in which allegations of obstruction and criticism could be projected towards hospital staff one narrative drew attention to a then ongoing investigation concerning a patient suffering an initial minor injury which escalated resulting in his death. All the police were able to offer in defence is that despite their request for information they were not told of the seriousness of the patient's condition by the hospital. Traffic officers log all calls to the hospital and support these entries with written comments that the officer was 'unable to ascertain the information'. On accumulating six or seven of these negative outcomes it is not difficult to work out why the enquiry was not conducted properly.

The accident and emergency doctor is also criticised by traffic officers for being obstructive. On one occasion the doctor was 'patronising' and 'blaze' and not forthcoming with a requested statement as he could not see the relevance of it. Subsequently he received a summons to attend court to give evidence. Describing a power clash between doctors and nurses in hospitals, some doctors were described as 'Mightier than Thou', a phrase that strikes a chord in the post-Bristol enquiry (Kennedy et al, 2001). Some traffic officers have no option but to wait lengthy periods of time before being dealt with and one narrative described an interaction which the traffic officer felt was personally damaging. The scene involved a traffic officer who attended the department following a road traffic incident in which he required details from a patient. The officer reported having been in the department for some one and a half-hours and having requested on numerous occasions to access the patient for details. After repeated obstruction the officer initiated contact with the patient himself and was met with an impolite and nasty response from the doctor.

Officer *"Excuse me"*.

Doctor *"I'll be with you in a minute"*.

One hour passed.

Officer *"Excuse me"*.

Doctor *"Oh, I'm busy, I'm busy"*.

Officer *"I'm sorry to bother you, all I need to know is the extent of his injuries".*

Doctor *"He's not badly injured".*

Officer *"Well can I just get his details?"*

Doctor *"Just wait a minute!"(commanding/aggressive)*

Officer *"Oh I'm sorry!"*

Another half-hour passed and the officer became increasingly frustrated at which point the doctor was in the vicinity and completely ignored the officer who subsequently went into the cubicle and spoke with the patient.

Officer *"All right mate?"*

Patient *"Oh, I've just got minor injuries".*

Officer *"All I want is your name, date of birth, telephone number so I can contact you and do an accident report".*

Patient *"Yeah, no problem, my name's ..."*

Officer *"Right, thanks very much, I'll contact you at a more convenient time".*

The doctor then returned to the cubicle and 'blew his top' in front of other patients and other members of staff.

Officer *"Ah well, fair enough".*

Doctor *" I want to speak with your supervising officer!"*

The officers did not consider the staff as deliberately obstructive and recognised the busy nature of the role and the effect that police presence can have on some individuals when *"...you get this guy in a bright orange jacket (traffic officer) wanders in (to the accident and emergency department) and a) people have got this natural fear of them (police officers) anyway just cos that's the way they are with policemen and b) the doctor is the boss of him (the nurse) and the policeman is not the boss of the doctors and you get this kind of clash of er... of agency"* (TPB para 2347).

Officers perceive themselves as inducing a natural fear in certain individuals anyway. However, the needless waiting for permission to talk with relevant people and leave the department is making their enquiries more laboured, delaying the processing of the enquiries and unnecessarily wasting public expenditure on police time. It would be preferable if the staff had clearer guidelines on what information can be given and to whom that information may be given. Officers anticipated that until 'something comes off big style' that requires an extensive investigation into the practise of information giving by nurses to police officers then variation in volume and willingness to give information will continue to be a problem to traffic officers.

Role routinisation

Sudnow (1967) described the preparation for the routine daily event 'death' in the procedural orientation of staff. Particular emphasis was placed on advance preparation of documentation into "death packages", the advance collection of items needed for last offices into "morgue bundles", and the way the design of the morgue tray eased transfer of the body into the refrigerator. This assertion can be carried further in the culture of the emergency setting in that the procedural base not only routinely accommodates the certainty that more deaths will occur, but strikes the very core of emergency personnel thinking and knowing that there are more deaths to come. In doing so, albeit subconsciously, emergency personnel may devalue the nature of the event because what is critically important for the relative can very easily be overlooked, even violated, by the very people who purport to be acting on their behalf. First, emergency personnel may organise practicalities central to fulfilling their role function by routinely 'getting on' with sudden death related procedures. Second, the memorable nature of the event for relatives is reduced to 'just another death' as manifested in the following disregard for the relatives' need for dignity. *"Yeah, well we were creased yesterday. Somebody cracked a joke and we ended up pissing ourselves laughing outside the family room"* (TPB para 2276). It is expected that the more sensational the sudden death incident the less routine the procedural base and the same activities of body handling, recording, announcing and identifying

takes place no matter what the incident entails. A more sensational incident however, may simply attract a comment such as "*Christ, have a look at the state of this!*" (TPC para 409). The procedural base then takes its course.

Specific aspects of role are considered routine "*You see it's second nature for us but for that family it's a one off*" (PB para 847). Paramedics will do what is required within their role but ultimately wish to disengage from sudden deathwork. "*We just wanted to be away didn't we?*" (PB para 872) and this was because "*...one of the things that I don't like about it is it extends the contact with the body for us*" (PB para 873).

SIDS are an example of incidents where routinisation is a feature and one traffic officer interpreted a particular death scene as a routine series of actions, which took priority over sensitivity towards the grieving parents. "*It just seems to me that, I mean they've lost their kiddie and the kiddie has been dealt with and sorted out and everything. And those heartless bastards of policemen want to come along and take the kiddie's bed furniture and stuff like that*" (TPC para 953).

In conclusion, Chapter Eight discussed the various issues impacting on role beginning with a theoretical commentary on role function, and moving into four distinct relevances regarding resignation, uncertainty, obstruction and routinisation it has been established that emergency personnel necessarily engage in aspects of sudden deathwork, which they would rather avoid. Uncertainty exists related to specific aspects of role and in particular, on an interdisciplinary level. It is apparent that role obstruction occurs both between emergency personnel and members of the public and additionally, between the three emergency personnel selected within this research. Finally, participation in some of the routine activities which despite providing structure to sudden deathwork may, simultaneously, be emotionally detrimental to those involved.

CHAPTER NINE

Legitimation rhetoric

The following chapter focuses on those aspects of sudden death which are considered socially viable. Of significance to legitimation is age of death, situations when a member of staff knows the victim, moments of emotional connection in which characteristics surrounding the death lead to a personal analogy and the sometimes distasteful aspects associated with the mode of a death.

Youth, fame and personal analogy

It has been established by Timmermans (1999) that the likelihood for resuscitative effort to be initiated is dependent primarily on patient characteristics. Those patients who are relatively young, famous or known in some way to staff, are more likely to receive greater resuscitate effort. A special subtext is created whereby youth legitimises resuscitative effort and is most difficult to handle when death does finally occur. A resident explained, "I had a sixteen-year old girl the other night who came in after a drowning episode, and those for me are personally harder than a seventy-year old man who has a heart attack" (p.60). In this sudden death research one nurse reported on how "*Dealing with children is more stressful than it could ever be with the elderly*" (NA para 86). This statement signifies the social currency whereby children are to be more highly valued as manifested in descriptions such as 'precious' and hold entitlement to longevity. When a child's legitimate right to live can not be guaranteed involvement in sudden deathwork becomes more problematic for emergency personnel.

Sense of urgency rises among staff when the patient is a prominent person in the hospital or community. Although the protocols remain unchanged, the highly charged atmosphere of the resuscitation room is exacerbated when a famous or locally known significant person enters. This is readily observed when a high ranking nurse or doctor is the patient whereby extra effort is made to meet their needs, beyond the

usual and demonstrates that even in death it is not a matter of what you know, but who you know that counts. I recall the sudden death of a prominent insider to the accident and emergency culture whose relative was permitted to be present in the resuscitation room during the resuscitative effort. Had the victim not been a significant person to the staff it is unlikely that entry would have been facilitated.

When personal analogies are recognised in a patient's characteristics individual staff award that patient increased status. To emergency personnel certain striking characteristics may resemble those of a close family member or friend making resuscitation and coping with their death more difficult for staff when such personal connections are recognised. The patient may be of the same age group, may physically resemble a close family member or friend, or may be living through an emotionally connecting life event, perhaps having recently been married or given birth to a child. *"I remember once I related someone to like, my brother's age and I was in the resus room and you suddenly find yourself not concentrating on the job because...I've related that person to somebody who's emotionally like, attached and you tend to like, lose it a bit"* (NC para 77). A paramedic provided a personal analogy in regard to his twelve-year child. *"...I've had a twelve-year old kiddy and just that it kicked in with my bairn you know, but that'll be the same with everybody I suppose"* (PB para 388). The assumption being that other colleagues would be feeling the same way when confronted with situations that characteristically connect. A traffic officer commented *"...accidents involving kids are always worst because with me having a young family myself you know, I always thought in the back of my mind, "Well, bloody hell it could be my two" and, "What would I do if I was in the parents situation it would just do my head in if it happened to one of my two it really would"* (TPA para 316).

Interestingly, another nurse commented using a personal analogy in relation to her own mortality. *"I always think, I must admit when I like prepare the body for the mortuary I think "Somebody might be doing this to me one day, you know?" I hate it. I hate doing it. I hate it. I really do!"* (NC para 305). Further, the thought of having the procedures performed on one's own relative makes personnel more particular

about how the procedure is conducted on the dead person. *"I always think as though if it's maybe, if it's one of my relatives, how would I want them to be treated?"* (NC para 340). A traffic officer concurred with this preparatory thinking by drawing on his own personal professional code *"That's the way I look at it, no matter what I do really in the police force, and that is to treat the person how you would expect to be treated yourself under the same circumstances, and probably more so in situations like this"* (TPA para 672).

Good innings

The untimely nature of sudden death is a feature of many deaths whether through trauma or collapse. In using the term 'good innings' emergency personnel describe how sudden death can be considered legitimate if it occurs in older people. For an explanation of legitimate death refer to Glaser and Strauss (1968). Comparison of legitimacy between sudden death in old and young ages, or adults and children justifies how a reasonably lengthy and fulfilling life is considered a human right and preparation for death is heightened with age, *"I would like to go like that", you know, I'm eighty years old, I've had a good innings and I've just gone out shopping, got this pain and down you go"* (NA para 304). What constitutes old age differs among emergency personnel. *"Its different when its somebody who's say fifty year old, sixty year old though"* (PB para 136). When sudden death occurs in old age accompanied by infirmity, old age being arbitrarily defined as around seventy years, emergency personnel are more likely to perceive death as legitimate because resuscitative effort is no longer a viable option. The elderly are literally 'dying for resuscitative effort' in that the older the person the more likely resuscitative effort is considered a waste of time and the death is classified as legitimate by awarding the status of 'dying of old age', the mode of death which is considered most desired.

Sudden death in old age does not seem to bother emergency personnel as much as a traumatic death in the elderly, which generates further feelings in relation to legitimisation. Mode of death varies considerably, but emergency personnel remember those of an unusual or particularly traumatic nature. *"I mean that's upsetting, if its*

not to sound too callous, somebody who's come in and died of a heart attack or CVA (cerebro-vascular attack) although its traumatic for the family its not so much a traumatic death as such, but you see like the elderly that have been hit by a car and you think, "God that's so tragic to get through life and survive this long" (NC para 130). Reference is made to the dreadful waste of life, which relates to a lost opportunity to experience 'good death' as described by Levine (1988) whereby all personal business is finished, and the person gently 'slips away'. To summarise, it is acceptable to die when you are old, and old is arbitrarily defined as above seventy, however, it is less acceptable to die when you are old and in traumatic circumstances.

In contrast, sudden death in childhood is not legitimate generating the justification of the wasteful loss of a young life, *"It's a waste of life whereas the older ones are better that they've done it but the younger ones aren't even going to get a chance"* (PC para 163). Sudden death in children intensely upsets emergency personnel more than any other emergency role, *"It's the only thing that upsets me is kids"* (PB para 392). I remember the death of a five-year old girl following traumatic injury and sought justification from a colleague, a female doctor. On posing the existential question of whether there was a 'God up there' and if there was, then 'what the hell did he think he was playing at?' It was not legitimate for the girl to die. I was questioned as to why I was even asking the question when I cannot have the answer. A protective feeling is generated in the emergency personnel in their dealings with a child, which diminishes in linear progression with age. There is an appreciation of how vulnerable they are and a surrogate parenting role is acted out by emergency personnel and is visible in the way in which most cases involving children enter the accident and emergency department. The decision to bring the child into the department is twofold. First, emergency personnel seem to be of the opinion that every child has a right to the best chance of life, *"It hasn't had much of a life to begin with so lets see if we can prolong it a little bit"* (PC para 485). An exception occurs in cot death when it is obvious from the clinical signs that death occurred sometime during the night and the body has not been discovered until the morning. Second because the transfer into the department and continued resuscitative effort is a theatrical presentation for the

supposed benefit of the parents. Though parents have never been questioned about the issue of continuing resuscitative effort for their child in such circumstances an assumption is made that the parents would want to think that 'all stops were pulled out' in an effort to give their child a chance of survival. Age remains the most outstanding indicator of the extent to which the staff is willing to resuscitate.

Mode of death

Mode of sudden death determines legitimacy in that it is considered an injustice for an individual to die in certain types of circumstance. The circumstances, which are considered most awful usually, concern some form of mutilation, isolation or awkwardness, which creates problems in communicating the circumstances to the relatives. Emergency personnel are inclined to use terms such as 'he won't have felt anything', or, 'it all happened very quickly', in an effort to console relatives, however it is questionable whether such a declaration is appropriate in the event of a death by major/multiple trauma. When trauma victims are badly mutilated it is inaccurate to declare that the patient was pain free, *"You couldn't recognise the car as being a car...I thought it was two cars when I got to them. The front end of the car with two bodies in and the back end of the car with another two bodies in about thirty or forty yards apart....Just completely squashed and flattened and mangled"* (TPA para 588). Emergency personnel would rather the relative thinks the victim was pain free, or if not pain free, at least that pain was short-lived. Some of the terms selected resemble clichés designed to protect relatives from the reality of the situation i.e. that the victim died in painful and drawn out circumstances e.g. fire or drowning. When the body has not been discovered for a long time i.e. days or weeks, it is also difficult to provide relatives with an assurance of 'good death' conditions. Finally, where the body is found in awkward situations, perhaps slumped in a heap behind the bathroom door following rupture of the oesophageal varices, gives the relatives the impression of a failed struggle to get help. *"Yeah, the chap at (location) one morning, he'd died on the landing. And you could see where he'd walked from his bed obviously he'd woke up and gone and taken his tablets and whatever. He'd walked through the bedroom*

across the hall into the toilet and he stood there and the stuff must have been gushing out of him and he just fell backwards and it was all congealed and it was along the landing, the toilet, everywhere” (PB para 774).

Finally, the need to apportion blame to someone or something is expressed by some individuals. Those involved in road traffic accidents may be more readily considered as blameworthy when victims calculate the conditions of the crash and arrive at personal conclusions as to the ‘guilty party’. In contrast, in the case of S.I.D.S. relatives have no-one to blame. *“With cot death even when there’s no justification why they died that’s so difficult ‘cos you can’t blame anything and the parents are asking you questions all the time” (NA para 299).* It is often the case that parents will apportion self-blame going over and over their actions on the day of their child’s death.

In conclusion the characteristics of age, fame, and personal analogy significantly affect the sudden deathwork and particularly the way that individual emergency personnel cope with the situation. Some individuals internalise the features of the scenario and think about the incident or the connection with relief at a later time when the situation has calmed such as when off duty or during a quieter period of the shift. Some recognise the need to modify their practices due to an in built social conscience to anticipate and plan how they are going to manage the needs of vulnerable people. Mode of death is a significant indicator of legitimation in that some deaths occur in such unfortunate and awkward circumstances that it is almost impossible to believe that it could happen to a human being. These deaths often involve serious mutilation of the body and images are left with emergency personnel long after the event.

CHAPTER TEN

Emotionality

The following chapter is concerned with emotionality rhetoric and considers a range of relevances: coping with sudden deathwork; reaching a point of emotional exhaustion; situations, which generate annoyance; and, situations, which generate humour. It will become clear that despite Glaser and Strauss's (1968:130) "armamentarium of defenses" emergency personnel feel an intense emotional connection with some sudden deaths.

Coping

Sudden death notification and caring for the relatives in the aftermath of the event is one such example of a duty which would much rather be avoided on the grounds of inability to cope with emotionally. The work of the emergency service employee may expose an individual to mutilation, death, bereavement and constant contact with human suffering and pain (Hetherington, 1994). Referring to the emotional impact of witnessing sudden death from the professional position of police officer one respondent said, "I hate what my mind sees, the blood, the pain, the destruction, the anguish. It is so real I can almost smell that awful smell of death that lingers at the scene... I could always tell when someone was going to die. When they were trapped in their vehicle and I was able to get to them, to offer them some human warmth by touching them, by holding their hand...I remember them all. I see their faces, I feel their suffering. I feel the grief of their families... That is what I feel. That is why I fear wearing the police uniform, when I put it on I feel locked in, claustrophobic, frightened, alone." (Newton, 1989:21-2). Individuals react to the horrors of death by integrating it into his institutions, giving it function, and making it meaningful. Mitchell and Bray (1990) suggest that the personality of the emergency service employee render him/her more resistant than average, though not immune to the psychological effects of the experience. Also coping with the psychological sequelae of the job is dependent on the organisation's capacity to provide support.

Review of social science literature reveals a paucity of detailed information in relation to the sudden death role of paramedics in the United Kingdom. Palmer (1983) conducted research on the occupational group of Emergency Medical Technicians (EMTs) and Emergency Medical Technicians – Paramedics (EMT-Ps) in the United States. Due to constant contact with individuals who are injured and/or dying, they represent another specialist occupational group alongside police officers, nurses and morticians, who handle the physicality and emotionality of death and dying. Palmer immersed himself into the work culture of the organisation using participant observation, direct observation, formal interviews, conversations, listening to hours of official radio traffic, and inspection of written documents to inform the data gathering process. This was complemented by some 500 hours of Emergency Medical Service (EMS) contact and also 91 ‘runs’. He concluded that paramedics employ and are affected by the same mechanisms as doctors and nurses in coping with death and dying.

Various strategies were identified as being of particular importance: educational desensitisation; humour; language alteration featuring scientific fragmentation and escape into work; and, rationalisation. Educational desensitisation is explained as a process, which serves to review critical events in the work of the paramedic. Gruesome incidents are reflected upon and are tempered by a process whereby the event is put under the microscope so that the blood and guts and gore are translated into signs to be surveyed, symptoms to be elicited, and medical protocols to be followed. Humour was considered to provide an escape or safety net for individuals operating in degrading, conflicting or oppressive situations (Coser, 1959). Palmer highlights how paramedics laugh at situations that would be considered sacred by others. Paramedics have developed a linguistic style composed of the unique and colourful use of codes and terms. The use of coded categories of patients and medical terminology, which as an example signifies that a ‘Signal 27’ means that the patient is dead, is common to both US and UK paramedic services and serves to disassociate the paramedic from the patient. However the use of terms such as ‘crispy critter’, ‘greenie’, ‘veggie’, or ‘juice’ in describing the characteristic state of the dead body is

different in the UK but only in respect of the descriptor as the linguistic style remains the same. The words 'stiff' or 'gonner' are widely used to describe the deceased. Scientific fragmentation is demonstrated linguistically where the patient is glossed over or ignored and referred to only as 'that miscarriage that we ran on, that was on Third Street' or the little old hip woman is going to ICU'. Further the paramedic might escape into work and not actually realise that he knows the patient that he is 'working' on. Rationalisation involves the use of terms such as 'he's better off that way' and is expressed by all emergency professions.

Noe (1996) explored the emotional labour experienced by Emergency Medical Services (EMS) personnel on the job in a comparative analysis of work and home communication rules in relation to emotional expression among paramedics and emergency medical technicians in the United States. The emotional labour experienced by EMS personnel, especially their sense of detachment, has detrimental consequences on the home environment and personal relationships. The detached and calm persona that is a key to success at work is resented at home, though there are exceptions when the spouse is 'in the job' too. EMS personnel share common ground with police officers in that the work partner is the person who is confided in most.

In unfolding the multiple realities of emergency work, Noe established the range of rules when EMS personnel go to a scene, are at the scene, following a 'run', and during initiation of a new paramedic or EMTS. The spirit of successful teamwork was expressed when a run went, "smooth as silk", and in general the EMS personnel had good runs or poor runs. In complex situations like emergencies it is vital to anticipate what the partner may be thinking and how he or she is likely to behave. Noe highlights the EMS personnel's opinion that nurses cannot handle the pre-hospital setting. A sense of detachment is even harder to maintain if family members of the patient are present. In highly emotionally charged situations in which ambiguity in regulations concerning procedures exist, paramedics use the phrase "do the right thing for the right reason". Police/paramedic relations are reported as 'good' and a sense of 'diplomatic immunity' is expressed.

A religious minister is designated by the Ambulance NHS Trust to care for the needs of the ambulance personnel. To gain insight into the kind of things that paramedics deal with, one minister spent a night shift shadowing a crew. He was described as 'into' counselling and was available to the ambulance personnel should an individual wish to discuss problems or issues confidentially, though this was viewed negatively in the comment, "*I think he'd be pretty redundant to be honest with you!*" (PB para 1653). Every now and then he would visit the station to have a chat with the personnel. The first 'job' was to treat an eighteen-year old man who had collapsed in the town. The resuscitation procedure to treat 'ventricular fibrillation' was implemented en route to the hospital but the paramedic crew did not manage to revive the patient and on arrival at the hospital the patient was subsequently delivered to the accident and emergency team to continue resuscitative effort in the accident and emergency department. On return to the ambulance station the minister was described as pale and a bit distraught and it did not help when the paramedic sat down and tucked into a chicken tikka masala. "*He looked at me as if to say, "You heartless bastard"*" (PA para 300).

Emotional exhaustion

Sudden death descriptors of emotional exhaustion made reference to the gripping impact of some deaths, which penetrated to the 'core' of an individual and questioned an individual's capacity to cope in that "*You feel like, burned out*" (NC para 949) and "*Yes, emotionally drained and can you give any more?*" (NC para 952). Specific incidents which were said to have had greater impact were analogous to being chased and finally caught up in the turmoil and "*...they are the ones that'll get you aren't they?*" (PC para 176) or "*Yeh, that one got to me, it was awful that one*" (NB para 1115). Staff are always aware of the possibility that carrying out deathwork constantly takes emergency personnel to the brink of emotional exhaustion. Permission to take oneself off for 'time out' is a tricky issue in that in order to engage in emotional expression a staff member is required to declare their impending absence from the clinical area though staff anticipate no objection to them doing so. "*I don't*

think anyone would object though if you were really upset and you said you were going for a cup of tea” (NB para 1173).

When emergency personnel do get upset they may find it hard to concentrate on looking after other patients and express a need to go somewhere and sit and think for a while to assimilate what has just occurred. Emotional exhaustion can result in crying “...if that situation’s really upset you at the time then I must admit I have cried at that time...”(NB para 716). It is the conscious decision of some staff to outwardly express emotion as a personal right even in the company of the relatives “*I think if you cry, if you do get upset, you should cry with them (the relatives)...Your only human*” (NC para 713) but there is an appropriate venue for such expression. “*I don’t see why you should have to hold your emotions back, I mean I don’t expect you should blubber in front of everybody whereas if you want to cry, I don’t see why you shouldn’t cry. I don’t mean to sit in the middle of the waiting room and go “Oh Oh...” Just go in the coffee room and cry*” (NB para 723). During incidents of emotional exhaustion expression is concealed by the member of staff either going to a private place such as a coffee room, consulting room, staff changing room or staff toilet. Further, other staff conceal this activity by facilitating the expression of emotion among colleagues by discretely letting significant members of staff know that a particular individual is upset and needs some time out. The public does not get to hear about the undercurrent of concealment of emotional exhaustion by staff. Acceptable levels of expression acknowledged by staff demonstrate humanity and empathy affirming that the nurse operates from an embodied stance. In such situations it is acceptable to “...talk to them but I don’t mean to bawl hysterically when they have to console you” (NC para 722) and “*I mean even if you shed a tear, I mean so what? Well all that shows is that you’re a feeling person and you understand*” (NC para 725). However, an embodied approach should be situated against a conscious awareness of what is best for the relative by acknowledging your own capabilities and to question “*am I the best person to look after this relative?*” (NC para 958).

Dealing with sudden death is always worse for first timers and one nurse recalled her experience of dealing with the death of a child for the first time “*But that was the only*

time I'd dealt with a kiddy like that one and it was the first time that I'd ever seen a child that's died" (NB para 1119). When sudden deaths accumulate and one person handles them all one after the other emergency personnel are at risk of emotional exhaustion. *"There was something like three in a row and it was always me that was going in with the relatives. There should be a different person if you've recently dealt with one"* (NC para 964). Similarly a paramedic voiced his experience of near emotional exhaustion *"I did have three cot deaths in one night and that was the only night I've ever thought "Is it time for me to jack this job in?"* (PA para 176).

Annoyance

Annoyance and frustration is expressed in two ways: selfishness on the part of other patients with minor injuries who are waiting; and a sense of justice for the victim by police officers. Patients who are required to wait in the accident and emergency department when they feel they should be treated immediately are likely to become impatient. Lengthy periods of waiting have a disruptive effect on a waiting patient's tolerance and there are increasing numbers of cases being reported which involve violence and aggression. Often the reason for the wait is due to the presence of a major resuscitation, which requires that nurses and doctors be displaced from the minor injury treatment area to the resuscitation room. Generally the nurse is empathetic to the waiting patient's need to be assessed and treated in a reasonable time scale. However, following completion of work in the highly charged atmosphere of the resuscitation room and effects of dealing with a sudden death, nurses may perceive minor injuries as trivial. Jefferey (1998) reported on the 'normal rubbish' of accident and emergency departments highlighting how 'good or interesting' patients and 'bad or rubbish' patients are categorised by staff. Good patients are generally interesting from a medical perspective and enable the doctor to perform unusual or difficult skills, "The way to get excellent treatment is to turn up at a slack period with an unusual condition" (p.106). Good patients, then, make demands, which fall squarely within the boundaries of what the staff define as appropriate to their job. Rubbish seemed to be a mutually comprehensive term to describe the category of

patient who deviate from 'good' criteria i.e. trivia, drunks, overdoses and tramps, otherwise described as dross, dregs, crumble or grot. Normal trivia bang their heads, their hands or their ankles, carry on working as usual only to arrive at the accident and emergency department some days later to have a doctor to assess the injury.

'Legitimate' patients are required to fit a mis-match of perceptions, which generates annoyance in staff who perceive their role as an expert emergency service. Trivia do not. Trivia 'pop into' the department on the off chance of being seen because they do not wish to bother their general practitioner. *"And they've sat in the waiting room for two hours and you think "Eee you know, what a waste of time"* (NB para 687). From a psychiatric nursing perspective, May and Kelly (1998) argue that a sense of professional identity emerges from nurses in their dealings with patients. In categorising some patients as 'bad' nurses not only pronounce on patient performance, they also reaffirm their own professional and personal values, and reinforce the functional solidarity of nursing as a group.

Annoyance is not so great when the nurse has been dealing with minor injuries at the time, however feelings are heightened immediately following an intensive period of resuscitation which has led to a death. *"And then when you've dealt with something like that you come out and someone with like the tiniest thing that they've had the nerve to ask for"* (NB para 681). On occasions the waiting patients will at least become irritable, curt and verbally aggressive and at worst, shout at the nurse. Such aggression generates frustration in the nurse when trying to contain her own annoyance at a time when emotions are at a peak. The waiting patient is not usually aware of the nurse's previous activity because it is rare that explanations are given to waiting patients other than in the form of a digitally displayed estimate of the waiting time in the reception area. *"Plus you've also got the stress of them going out and dealing with a major trauma and relatives, and you've got someone who's half mad about their ankle. They're dead, and you've got to keep it contained and that makes you feel stressed"* (NC para 1069). It is desired but not possible to let the waiting patient know what they have been dealing with and why they have been waiting but

disclosure is unusual so the nurse remains frustrated and the waiting patient remains unaware. Censoring behaviour prevents disclosure despite the feelings of the nurse, "...and people tutting in the waiting room after you've just dealt with something and you feel like saying to them, "Get down there and just..." but you can't, and that pulls your stress levels up as well" (NC para 1075). Some nurses feel they would like to escort the agitated waiting patient to the resuscitation room so they may comprehend the extent of the devastation in a failed resuscitation, "Come and have a look at this if you think we are not doing anything" (NC para 1081). Looking at the resuscitation material lying around the shelves and floor, empty packaging from the drugs and infusions, blood stained paper towelling and absorbent pads, which immediately prior had been used in an intensive attempt to support life may drive home the true extent of effort. If someone were to explain to patients that they were waiting because the nurses are resuscitating someone they would become aware that the nurses are actually engaged in meaningful activity and are not simply 'doing nothing'. "God if you only knew!" (NC para 1091). However, the nurses' frustration is usually short lived due to being diverted towards continuing patient care for the remainder of the period of duty.

Traffic officers express a sense of justice in the handling of an incident and feel annoyed when injuries occur unnecessarily to innocent victims. One officer described a serious accident involving an elderly woman. "I personally was annoyed that that lady was injured. I was annoyed at the way the accident happened. I was annoyed at the standard of the other guy's driving...Consequently I bent over backwards to a) get herself sorted out with the car etc. and the family and, b) put the best file I possibly could together to secure the conviction of the driver" (TPB para 1517).

Annoyance is generated in some traffic officers when observing an accident and emergency nurse being nice to the 'guilty party'. Although traffic officers spoke favourably of the accident and emergency nurses and gave praise for their ability to set aside their feelings about the situation in order to prioritise their actions, nevertheless the officer's feelings of 'pure contempt' remain. "I could feel myself saying, "Just let

him fuckin' rot". You know, and I could see this nurse thinking, "I wish this copper would back off and give me some space" (TPC para 1888).

Humour

The use of humour as a primary coping strategy among emergency personnel is related to the management of stress and prevention of burnout (Keller, 1990). High levels of job satisfaction and personal accomplishment were reported among emergency nurses who were able to express humour. Paramedics are exposed to high stress levels as they deal with physical catastrophe, emotionally taut and high-risk situations, and the burden of responding quickly and appropriately in life/death situations (Rosenberg, 1991). Berk et al (1989) reported that objective, measurable and significant changes occur following mirthful laughter. The power of humour in uniting and dividing employees was reported by Meyer (1997) to have bearing on communication in the workplace. Humour as a courage mechanism is considered to allow the modification of concepts and beliefs, situations and objects and to reorganise meaning on the spur of the moment (Mishkin, 1997). Humour also serves as a weapon in an individual's daily encounters with conflict. It shifts the point of view and illuminates absurd or paradoxical elements of a given situation. Incongruity is considered a necessary ingredient for funniness (Nerhardt, 1996) and principles of incongruity and conflict have been proposed as explanations for laughter and humour (Rothbart, 1996).

James Beattie (1776) first linked stress to laughter in six key areas: incongruity, intensity, sympathy, fear, socialisation and, world politics (Rothbart, 1996). First, incongruity exists when two or more inconsistent elements assemble. Second, intensity is exacerbated by an increase in the number of incongruities resulting in a more ludicrous assemblage. Third, sympathy reinforces the incongruity by activating moral sentiment regarding the magnitude of the ludicrous plot. Fourth, laughter results in an attempt to conceal fear, though Beattie also explains how laughter is absent in situations, which cause serious fear no matter how incongruous the situation. Fifth, the notion of 'breeding' as a means of controlling behaviour leads to the stifling

of laughter. Sixth, perceptions of cultural difference lead to an interpretation of what constitutes ridiculous in relation to aspects of attire, deportment, and conduct.

Incongruous humour is a feature of all three disciplines in their interactions with sudden death. One accident and emergency nurse reported how she had been trying to contact the next of kin by telephone to inform her of the critical nature of her relative's condition with a request for her to attend the department, only to be met with a bizarre and somewhat hilarious response. Immediately prior to the call the relative had been listening to local radio who were running a competition whereby the person answering the telephone is required to say nothing more than a predetermined statement. Thinking that the radio station was calling her and that she was about to receive a prize, the relative answered, "*TFM's my favourite station*" (NC para 374) this happened repeatedly despite the nurse seeking repeated confirmation of identity. The nurse recalled being in fits of giggles over the incongruous hilarity of the event.

Censoring hilarity is also a feature of everyday handling of funny events in emergency care. On a personal level emergency personnel are likely to sanction their own behaviour with moderating thoughts, "*...(name) that's not really very funny. Try and interpret that, what a sicko!*" (NC para 1200). Further, censoring is enacted in the stifling of facial expressions. One paramedic said, "*And you think, "I've got to keep a straight face going out of here"*" (PB para 567). Despite spontaneous outbreaks of expression of humour there are accepted levels of disclosure in that some jokes are restricted to the immediate team for fear that disclosure might offend someone and this creates a fear of reprisal. Fear of being disciplined for expressing humour, "*...which is sometimes a little racist, a little sexist*" (TPA para 1967) was targeted towards non-emergency personnel who have cleaning or clerical roles. These individuals were deemed not to understand the tension created by the kind of work emergency personnel got involved in and the subsequent need to 'let of steam'.

Quick wit and camaraderie is a feature of emergency personnel and it is not unusual for the team spirit to operate at various levels of intensity. Within the focus groups

there was a high level of quick-witted humour often involving a ‘twist in the tale’ style as follows:

- Traffic officer “We do have the facility to get clothing laundered for people who want to keep it”.
- Second officer “Oh’ I’ve heard that, yeah”.
- Traffic officer “We haven’t been able to get money laundered yet like!”
(laughter)

Quick-witted quips can take the most simplistic form of clipped singular statements and the paramedics first shout at 6.30 one Sunday morning led to a quip about another unfortunate individual that, “*Woke up dead!*” (PC para 394). Other expressions of wit are more complex and may be targeted to either the dead body, colleagues or other emergency disciplines. When the body is involved it is often related to physical changes or when the death occurs in compromised situations. One paramedic reported the case of male decapitation in which his friend had ‘taken a bad turn’ and become hysterical. Consequently the crew had to ‘rugby tackle him’ to get him into the back of the ambulance. And the jokes were, “*Well what did they use as a ball?*” (PA para 379). On another occasion a traffic officer went to the scene of a sudden death where the cadaver lay slumped behind the toilet door. Despite the paramedic’s instruction to be careful and having not anticipated the awkward location of the body, the officer banged the door into the head of the deceased which generated comments about the absence of ‘due care and attention’ on the part of the officer. There is often a search for a moral in the story and in the latter occasion it was, “*If you’re feeling rough, don’t go to the toilet*” (PB para 604).

Other situations generate sustained laughter in which the emergency personnel find difficulty containing their hilarity. One traffic officer described how a man had burned to death in a road traffic incident and how, “*I absolutely laughed buckets after that in the debrief, in the unofficial debrief. What was said about him was about getting knocked off for having no rubber on his tyres and no tax disc. ‘Cos basically,*

you know, that was the coping mechanism, it was terrible" (TPB para 1196). On another occasion the traffic officers were following a case through the accident and emergency department and, *"Yeah, well we were creased yesterday. Somebody cracked a joke and we ended up pissing ourselves laughing outside the family room"* (TPB para 2276).

Death occurs in compromised predicaments, as in the death behind the toilet door, which can cause considerable difficulty in accessing the body. Humour is expressed which is considered to be 'a bit wicked really' because there is nothing funny about the death itself it is the situations that people get themselves into when they die that creates the conditions for incongruous laughter. One reported scenario described death by hanging of a young male. The unfortunate predicament was that his trousers were down, which led to sexual innuendo about the circumstances of the death and reference to the death of an MP who had been found tied up and with an orange in his mouth, as reported in national newspapers.

Colleagues take the brunt of jokes too. In the case of a death in a racing pigeon loft the paramedics returned from the shout covered in feathers and bird droppings and the other officers had a laugh at their expense. The rest of the team had been listening to the shout on the radio and were aware of the circumstances of the death. On entering the ambulance station the crew were met with a pigeon like chorus of *"Hoo Hoo!"* (PC para 627). Another reported occasion describes how traffic officers involved in the death of a footballer positioned the body in the mortuary to the sound of a football chant. Such camaraderie is accepted as a light-hearted way of getting through the more unpleasant aspects of sudden death work *"Well it does break the ice"* (TP para 436).

Occasionally banter is directed at other emergency disciplines. One reported situation describes how a fire officer questioned a traffic officer as to why he was searching through an accident victim's wallet. The officer retorted, *"Oh, I'm just going through his wallet 'cos I've come out without my money and I need to buy some tea"* (TPC

para 426). The fire officer was appalled at this retort. In fact the traffic officer was searching the wallet for the victim's identity on a driving licence. Humour is also expressed in relation to the victim's property in what can only be described as 'vulture mentality' because the body is humorously perceived as useful for rich pickings. *"I mean we've come back in the depot and the lads have said, "Oh, what was that then?" and, "Oh, it was just someone who got hit by a car like you know, he's in the mortuary now". And they'll turn round and say, "Well what size feet was he?" you know, "I could do with a new pair of shoes". "Was his jacket damaged?"* (PA para 389).

Ironic expressions captured the feelings of one paramedic toward the use of the hospital mortuary box, which is usually covered with a white hospital sheet when porters transport a body to the mortuary. His vision was that it could be covered with false chocolate bars to mask the fact that it is a mortuary box. Similar irony was reported in Wright's (1991) study in which one relative had been given the news of the sudden death of a family member. He expressed how he wanted to return to the department and place a notice above the door of the distressed relatives' room stating 'Good news room' (p.38).

The value of humour as a stress reducing mechanism is recognised by emergency personnel and is acknowledged as a characteristic of emergency care culture. Newcomers to the discipline perceive humour as an unacceptable trait, indeed one staff nurse reported how when she was a student nurse on accident and emergency how she thought that the accident and emergency staff were really sick because they would laugh at something bad that had happened. Five years later, and a fully fledged staff nurse she claims that the use of sick humour in accident and emergency is a feature of the discipline and is of value to emergency personnel in that, if you do not laugh you are more likely to cry. Humour lightens the air so that emergency personnel are not just working among doom and gloom, which returns the argument back to the maintenance of Glaser and Strauss's (1968) "sentimental order". Young's (1991:12) thick description and rationale for the use of black humour among police officers

when dealing with the appalling and dirty work of sudden death provides a significant closing message. Officers literally break the codes of what is considered tasteful and decent by society in order to retain emotional control of a particularly awkward situation.

In conclusion, emotionality relevances has been discussed whereby certain statements expressed by emergency personnel highlight the extremes of what emergency personnel deal with in the course of their sudden deathwork. Coping with sudden deathwork is difficult for some and made easier by camaraderie but in addition, there is a strong undercurrent of emotionality concerning annoyance and situations where individual actually become emotionally exhausted and question their capacity to cope any longer.

CHAPTER ELEVEN

Dehumanisation

The following chapter focuses on the discourse of liminality at the point of sudden death drawing on the dominant discourse concerning the transitional status of an individual betwixt alive and dead. Incorporated into the discussion is the notion of binary oppositions and this dominant discourse is questioned in the light of nihilism.

Liminality

Hallam, Hockey and Howarth (1999) explained binary opposition groupings as a merging of incompatible elements, which result in alienation as follows. In a death related context privileged merging exists when an individual is either socially and biologically alive or socially and biologically dead (A discussion of Glaser and Strauss's (1968) concept related to perceived social value of patients within the slow-dying trajectory was previously highlighted in the literature review (Glaser and Strauss 1968). Concepts of life and death are situated in direct opposition to one another and it is privileged or acceptable to move from being socially and biologically alive to socially and biologically dead. Once dead, participation in society is at best no longer socially acceptable and at worst conjures up irrational images related to dominant Western notions of ghosts and spirits, which are considered threatening. Closure of death processes then brings with it a socially acceptable process of disengagement.

Seale (1998) drew attention to the liminality of death related discourse resulting from the juxtaposition of opposites such as life/death and within Western culture such discursive construction transforms the dying script into an "opportunity for growth" (p.6). Further, by "...incorporating a due respect for rites of passage rhetoric and resurrective language ontological security" is maintained" (p.68). In stark contrast Critchley's (1997) nihilistic discourse associates death with the concept of

nothingness, which negates the possibility of liminality leading to renewal because for some, death is considered to be 'the end' and destiny for the once live person is death, decay and nothingness.

Depersonification

Liminality generates a range of responses, which influence sudden deathwork by emergency personnel and a process of depersonification is made possible in the acceptance of such a transitional state. It is interesting to consider the following statement expressed by a nurse who clearly acknowledged the 'between' status of the person/non-person "*...and you are not just wrapping them up like a piece of meat, 'cos that's what it sometimes seems like. It's a person who maybe not more than two hours ago was actually walking around*" (NC para 323). Holding on to her cultural values, which respects the notion of liminality between life and death the nurse expressed her personal construct of what the act of body wrapping signified. Another nurse explained the death of her own father whereby the 'product', a dead body as it was at closure of the betwixt phase underwent changes "*...before he died he was fit and healthy...but when I went to see him he was a dead body and it was a changed pasty colour and I wished I hadn't gone to see him*" (NC para 380). Her statement signified an acknowledgement of the now deceased status as she referred to the body as the objectified 'it' though arguably personified 'father' he remained.

Liminality also operates in reverse when the objectified body requiring intensive resuscitation is subsequently acknowledged as a person once contact is made with relatives in the following statement. "*Especially when you've been in resus, you're going through your head, through stuff, through clinical stuff 'airway' and 'c spine' and all that and when you go into the family er, it's a person*" (NC para 158). It is then possible to form associations, which affirm the patient's position within the family or community. "*Before you actually come in contact with relatives you don't actually think of that person as somebody's husband, father, brother, uncle*" (NC para 239). Such liminal processes legitimise the movement between life and death status and enable emergency personnel to appropriately shape their practices but it is

necessary for the staff to recognise the dead person as 'dead' for movement beyond the liminal phase. *"I mean the dead body is a body isn't it so the body's become irrelevant"* (PC para 12).

When a person dies suddenly there is nothing more that can be done in terms of life saving intervention. The care system must recognise that it has exhausted its ability to deal with resuscitation and disengage from the once live person once it becomes dead 'non-person'. One nurse recognised this transitional status, *"It's as if they're not a person anymore and we're used to having people that respond"* (NC para 331). Certain activities, which centre on body handling, affirm the carer's perception of non-person status. The covering of the head as part of the body wrapping procedure is one such instance when it feels like the patient is not a person anymore but an objectification of death that is henceforth to be referred to as 'cadaver', 'corpse', or 'dead body'. Objectification of the individual as recipient of emergency care occurs much earlier during the resuscitation when emergency personnel have expressed their distancing from the live person. *"Its another body to go through ATLS (Advanced Trauma Life Support) protocol"* (NC para 246). Similarly one paramedic remembered a death in the home in which he did not relate at all with the characteristics of the individual he was resuscitating.

"You wouldn't recognise it. I only sort of look at the mouth or...

Yeah.

I'd know this epiglottis anywhere!" (PC para 574).

They do not see the mouth, the face, the body, even when the death is a child. Emergency personnel seem to be absorbed in the resuscitative effort to the extent that peripheral information such as framed pictures of loved ones on the walls is lost. The focus is purely one of bodily response to paramedic intervention. *"All you do is your work and you've got your protocol in your mind and things are changing all the time and you look at your monitor and something different's on it and you redo a protocol and it just keeps going like that all the time"* (PC para 602). Beyond the resuscitation there are occasions when emergency personnel are reminded of the personified being that once existed. Referring to the death of an elderly man one particular traffic

officer said, *“Yeah, you try to imagine this person as a young person and find myself thinking, “Well I wonder what they were doing when they were thirty”. They were probably in the war for that matter. And they’ve gone through all that and then they’re just snuffed out and like I say, no one actually cares that much really”* (TPC para 219). Another traffic officer tried not to visualise a badly mutilated body as a person for fear that it would drive him mad. *“Sometimes at the point of contact with it you don’t look at it as a person. You know, you don’t think of the person who’s standing or running about and talking its just like something that isn’t a person at all”* (TPC para 243). Given the few items of property back to relatives confirms to the emergency personnel that this is all that is left of the person for those who had no special memories of them.

During the elaborate trajectory section reference was made to how nurses continue to speak to the dead body as if it were still alive and this typical binary opposition exists because biological death lies in juxtaposition with being socially alive. Such behaviour lasts for about twenty minutes or so, the time taken to lay out a dead body. It is not until body handling is complete that the nurse considers the person as ‘dead’ and dialogue ceases. As soon as dialogue ceases it is appropriate for the nurse to disengage both procedurally and spatially in that the body is handed over to the hospital porter and taken to the hospital mortuary.

In this chapter narratives were presented, which exposed scenarios involving the transitional status between life and death. The notion of binary opposition is also presented, which would appear to assist individuals in coping with the sudden death of an individual from a culturally relevant perspective. The process of depersonification, dehumanisation or objectification has been discussed in relation to the narratives of the emergency personnel suggesting that whilst emergency personnel are able to acknowledge the cadaver status of an individual it is likely that they do so from a culturally defined stance. It would have been interesting and there is certainly scope to explore personal constructs of believers compared to non-believers in

relation to how their attitudes regarding transitional status impacts on their constructs about involvement with sudden deathwork.

CHAPTER TWELVE

Spiritual relevances

Spirituality has been explored within a nursing context by a number of authors (Reed, 1992; Ross, 1994; Dyson et al, 1997; Narayanasamy, 1999). More recently Carroll (2001) used a phenomenological heuristic approach, which encouraged hospice nurses to tell their stories and share experiences of their own personal beliefs and of providing care for patients with advanced cancer. The study revealed how the spiritual dimension of care infiltrates all aspects of nursing care and how nurses integrated their spirituality within their nursing role to the effect that they were working in a spiritual context. Holistic care provided a milieu in which the spiritual dimension permeated all other dimensions of care including, religious, physical, social and psychological. Murray and Zenter (1989) offered the following definition of spirituality. "Spirituality is a quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death" (p.259). In contrast, Walter (1994) argued that definitions of spirituality are so broad as to be almost meaningless and expressed difficulty in differentiating between psycho-social care and spiritual care.

McSherry (1998) suggested that nurses tend to relate religion to spirituality however, a religious link provides only for a restricted concept of spirituality in terms of a codified belief, which focuses on meaning of life as expressed through rituals and practices (Taylor, 1995). The search for existential meaning, which impels humans forward into living their lives to the full is not always expressed through religion (Kellehear, 2000). Further, Burnard (1988) advocated that agnostics and atheists have spiritual needs as well as those who have religious leanings. Dyson et al (1997) assumed spirituality to be neither synonymous nor coterminous with religion highlighting how the lack of an agreed definition and the absence of a conceptual or theoretical framework inhibited the delivery of spiritual care.

Highfield (1992) recommended that nurses 'bracket' personal beliefs to be receptive to the spiritual concerns of patients. Whether disengagement from one's personal belief frame is possible or desirable is debatable and to what extent disengagement impacts on the behaviour of all emergency personnel (i.e. paramedics and police officers) would be a useful area to research within a care, and service ethos. In essence, it is questionable whether spiritual care is provided with equal emphasis alongside the provision of bio-psycho-social care in accident and emergency. Yet, as Reed (1992) previously argued, spirituality is an essential characteristic of humanness in its broadest sense and integral to the ontological foundation of nursing. Further, Carson (1989) argued that spirituality as the cornerstone of holistic nursing practice, should become the fourth recognised domain of nursing (i.e. physical, psychological social and spiritual). However, in order to explore this fourth domain nurses need to reject an exclusively scientific paradigm which has neglected spiritual care and utilise an intuitive element of nursing care.

The centrality of an interrelatedness between self, others and 'God' (or higher power) challenges traditional notions of religion which, although providing a platform for the expression of spirituality, is more about organised systems of practices and beliefs within which a social group engage. The three elements focus on an 'innerness' and inner resources, which provide an individual with inner strength during periods of severe stress. Ross (1994) identified spirituality within the giving and receiving of love and forgiveness. Stoll (1979) referred to the trust and mutuality, which provides hope and strength, whilst Mayerhoff (1971) considered honesty and genuineness as critical factors manifested in behaviours such as touch, listening and committed presence.

Much of the literature on spirituality focuses on the palliative care and hospice movement so it is important to question to what extent are these critical factors prevalent during the sudden death encounters in accident and emergency. Further, it is useful to question to what extent emergency personnel utilise spirituality during sudden death encounters and how disciplines compare in terms of legitimate spiritual

engagement within respective roles. Observation of the practices of individual emergency personnel suggests that there are variable levels of spiritual engagement with relatives in terms of what is done, what is spoken, and moments of engagement when nothing is spoken, when emergency personnel are simply 'being there' through periods of silence, distress and rage.

Relationship and embodiment

Maeve (1998) discussed how nurses live with suffering and death by exploring the way in which nurses used the dilemmas of their patients' lives to weave a fabric of moral meaning over suffering and death. The threat of death and the reality of suffering till death generated the question 'how can you do that?' and two assumptions exist. First, nurses live with dying patients in ways which inform their lives both personally and professionally. Second, concepts of relationship and embodiment are central to the nursing identity. However, the notion of relationship is complex and meaningful relationships are aligned to 'an ordeal' (Maeve, 1994). The inter-subjectivity of the nursing experience assumes that nurses practising from an embodied frame recognise and associate wholly, the experience of the other. Nurses who are embodied are fully present to, and aware of, their own bodies directly in relation to the experience of caring for an individual and despite the emotional pain that it generates for them.

Embodiment is not to be confused with empathy, the imaginative projection of a subjective state of another, because the experience is not separate from the relationship as in the following comment from a nurse. *"I wouldn't want to leave go of my baby with having a nursing background and the knowledge of them going in the fridge, it would just tear me in two...I think myself grateful because I don't think I could sleep knowing where my child was"* (NA para 428). Embodiment leads the nurse to feel the feelings appropriate to the relationship, to cry and to laugh with the patient or relative as an embodied experience. The disembodied nurse dissociates consciousness and is not truly aware of, or present to, the suffering of another. Nurses

frequently disembodied to prevent personal suffering and this response is viewed as a defence, which is necessary to tolerate the realities of disease and death. Mitchell (1996) questioned police coping methods in sudden death however despite the recognition of three important factors (i.e. emotional hardiness through habituation, impact of training, and use of black or gallows humour), no reference was made to the issue of embodiment.

Disembodiment becomes problematic when nurses allow the pain and suffering of patients and relatives to be perceived as less real. The inter-subjective relationship is severed in such denial. Remaining embodied compels the nurse to examine and confront the nature of contact with patients and relatives, to offer comfort, and choices, which could limit emotional and physical pain. "Only the nurse's conscious attempts to remain embodied while inflicting pain enables caring relationship and differentiates the act from torture" (Schroeder, 1992:212). Morally ambiguous acts, which fail to consider the wishes of the relatives, could be prevented if nurses were to "re-inhabit" their own bodies to practice from an embodied frame.

Howard (1994) adopted an introspective position by questioning the manner by which as an operational police officer he engaged with sudden death encounters. "My training then was to enable me to deal with the practical side of the matter, collecting the relevant information and completing the correct forms. The bereaved were then left to cope as best they could. Nothing had prepared me for the emotional reaction and the feeling of complete inadequacy that I experienced on each occasion...Following one particularly stressful incident that involved a young family, I took stock of what I was doing, and more importantly, what I wasn't doing. I felt that as a professional person I was letting people down and this at a time in their lives when they were at their most vulnerable. On a purely humanitarian level I felt I was letting down my fellow man..." (p.1). This reflective account of one police officer's embodied deathwork led to a postal survey of policies and practices relative to sudden and traumatic death despatched to all 43 police forces in England and Wales. 82% of respondents agreed that the police service should do more to assist the bereaved. A

range of recommendations was proposed from leaflet production to training implications, which would improve support for the suddenly bereaved. An important question is whether the very 'human' element of deathwork can be taught, and the emergency disciplines commented that it is more about being sensitive to an individual's plight that helps one to cope rather than any amount of training.

Cathcart (1990) highlighted ways in which police officers could offer a human, caring service by first, providing choices over whether to see the body even when a formal identification is not required. Second, providing immediate relatives with transport to the receiving hospital. One mother reported, "I remember thinking how thoughtful it was of them to provide two officers to ensure a safe journey to the mortuary and then home for two obviously distraught parents." (p.2260). Diamond and Watson (1990) reported on their involvement with the Foundation for the Study of Infant Deaths in which an analysis of 388 questionnaires by parents of infants who died revealed the nature of police contact. Favourable comments were linked to kindness, a sympathetic manner, and helpfulness whilst multiple officers attending the scene linked to unfavourable comments over intrusive approaches. Although the glowing comments concerning police involvement are heartening, it would appear that there still exists a need to ensure best practice becomes universal.

Interestingly, reference to the role of the woman police constable (WPC) possesses a gender specific relationship to deathwork. Young (1994) described how women were marginalised by a gender hierarchy across the whole of police history, where the status attributed to 'hard' male constructs and symbols is then set against a negative range of classifiably 'soft' categories, prescribed as female qualities necessary for women's work. Such women's work renders the WPC as a conceptual problem to male prestige, 'structurally invisible' within male dominated police space and being allowed in only with reluctance. Such asymmetry directs women police officers to those areas considered less important and even unwelcome by male colleagues who consign them to tasks with little or no status such as welfare of the elderly, women

and children, and this is perceived as a correct extension of their domestic role. Deathwork is one such role.

The linking of spirituality to a religious dimension is strong when expressed through exclamations such as "*Yeah, there but for the grace of God*" (PC para 160). In this statement a sense of luck is verbalised, which gives gratitude to a higher power for having escaped the suffering and destiny observed in another. It is usually expressed following 'close shave' encounters with misfortune, but often it is used as a cliché for 'it could so easily have been me or mine'. This cognition hits home when emergency personnel consider risky situations in their own lives or in the lives of immediate family and friends.

Another statement at risk of becoming a well-worn cliché concerns the following, "*...they had the best possible chance of survival only it wasn't meant to be*" (NB para 371). This phrase is readily spoken to relatives when a patient has died despite sound resuscitative conditions (i.e. witnessed collapse, immediate bystander CPR, and early paramedic intervention). The suggestion is that a higher power has control over selection criteria for death and the concept is duplicated albeit in a reversed context in the statement for survivors, 'It wasn't your time' or, 'You must still have work to do here on earth'.

During sudden death encounters religious rituals are handled in one of two ways. First, responsibility for the religious dimension is devolved to another individual, a religious minister appropriate to the denomination of the patient. Second, emergency personnel perform religious rituals during contact with the dying or deceased person. A list of religious ministers is found in the Sister's Office however, they do not attend every case and there are a number of reasons for this. First, the nurse needs to be receptive to the need to ask the relatives if a religious minister is required to attend. Failure to consult relatives may be because the nurse has not asked the relative specifically. It is often asked "Would you like me to call anyone to help you through this?" However, this does not necessarily mean a religious minister and unless this is

specified the relative may not perceive a need to request attendance. Also, the nurse may not wish to be alarmist by suggesting a religious minister attends given the positive outcome of some resuscitations, which demonstrates that the nurse is judging the value of a religious minister's presence at the point of death and not in the period leading up to death. Of all the deaths attended I have never seen a religious minister attend the patient before a sudden death in accident and emergency. This is not to suggest that there is an omission to care on the part of the religious minister, or the nurse merely that the severely restricted timeframe for response disallows attendance coupled with the lack a designated nurse to care for the needs of the relatives. Attendance is much more likely to be after the death pronouncement and even then, only when a specific request is made by relatives for a religious minister to attend.

Sobriety and reverent silence is observed as a characteristic of the post-death resuscitation room milieu. With the exception of open prayer, speaking is limited to monosyllables and utterances below the breath of relevance to the duties being performed during the laying out procedure. When open prayer is spoken it is usually a religious minister who performs the prayer and emergency personnel welcome this devolved duty. *"Yeah, recently I had a sudden death and em, I asked them (relatives) if they wanted a priest as it was during the day so (name) came and he was lovely. He came in and said, "Now what do we call her? Gladys? Right Gladys..." you know, and he said a prayer over her and it was lovely and the relatives really appreciated that you know, it was really nice"* (NB para 427). Occasionally individual emergency personnel may initiate their own personal prayer, or may recite a whole prayer in their thoughts whilst performing procedures. *"...when I'm doing it (laying out the body), I say a prayer"* (NC para 314). The following extract from Huyler (2000) provides a reflective account of his experience as an emergency department physician whilst attending an autopsy. Huyler described in detail how the torso, an empty vessel on the stainless steel table regained its identity as 'person with a soul' through the mortuary attendant's reciting of the Lord's Prayer mid way through a post mortem. "And there it was, blue-black, the full size of my thumb, held in the pathologist's tweezers. The blood clot. "Would any of you mind if I say a prayer?" The attending looked solemn,

stern, but the anger I had seen was gone. Surprised, we simply nodded as he bowed his head and spoke.

Our father who art in heaven
Hallowed be Thy name
Thy kingdom come, Thy will be done
On earth as it is in Heaven.
Give us this day our daily bread
And forgive us our trespasses
As we forgive those who trespass against us.
Lead us not into temptation
But deliver us from evil
For Thine is the kingdom, and the power
And the glory forever.

We all said Amen, and he lifted his head, opened his eyes. He looked calm and excited. There was silence until the pathologist, an uneasy witness, cleared his throat. "Well", he said. "I should really get back to it." (Huylar, 2000:23). Often emergency personnel work in pairs or teams and an assumption is made that the other individual(s) may not wish to participate in 'collective' prayer though this may vary in different regions of the U.K. where religious affiliation is stronger. A dualistic culture exists in the accident and emergency environment whereby speed, disengagement and precision are juxtapositioned to soul, spirit and transcendence.

Religious rituals are more likely to be observed in accident and emergency when emergency personnel are aware of the need to ask the question. Remarkably, one nurse commented, "*I've never thought, "What if he's a certain religion?"*" (NC para 51). It is acknowledged that specific ethnic groups may wish to observe their religious beliefs through the enactment of specific rituals however; a distinct lack of awareness of the needs of a multi-cultural society exists among emergency personnel (Green, 1989; McGuinness, 1986). Other wards in the hospital retain the body for one

hour prior to performing last offices and transporting the body to the hospital mortuary. A single room is used to harbour the body and the nurse may put a vase of flowers at the bedside and arrange the room neatly by removing any excess clothing or crockery, and personal effects. A number of informal rituals exist in nursing practice that have yet to be fully explained. One relates to the refusal of flowers from relatives that are mixed red and white, which symbolise 'blood and tears', another relates to the presence of a bird which has entered the ward through an open window which symbolises an impending death. The bird is apparently about to take the spirit of the deceased with them. A green coloured counterpane is considered unlucky and some elderly patients may refuse to have one on their bed. Clearly these practices have no real place in modern day practice yet they continue to be spoken about to the next generation of 'wannabe' nurses. Such issues are potentially the material of archives of nursing folklore and would provide a rich area for psychosocial nursing research. A similarly spiritual dimension specifically related to the 'freeing of spirit' guides nursing practice and is manifested in theatrical gestures such as opening the window where the body lies. *"Well they used to say open the windows to let the soul depart and things like that. Some people believe it and some don't...it's just when I started my training that was what everybody did and I just continued. If the soul is going to go then it's going to it's fair enough"* (NB para 447). The assumption is that there is always a window in the room where the body lies. One accident and emergency department had no such window, so when asked about the mechanism for spiritual escape, the assumption being that the soul possesses a cognitive ability and desire to depart, one nurse commented, *"No we open the door!"* (NB para 455).

In conclusion, the concept of spirituality has been discussed drawing on issues relating to relationship and embodiment and questions whether the paramedic and police services also operate from an embodied frame in which concepts of relationship are central to effective service delivery. Religious ritual was also explored within the chapter revealing that some of the practices of emergency personnel are shaped by their personal belief frame and this impacts on the humanitarian service provision.

CHAPTER THIRTEEN

Conclusion

Sudden death has been explored from a sociological perspective and in so doing it is assumed that the phenomenon could be explored. Exploration of the phenomenon 'sudden deathwork' was achieved by collecting data, which primarily identified the procedural base. By drawing on Sudnow's (1967) approach to the identification of the procedural base to deathwork in the US hospital setting it was possible to establish what sudden deathwork in the UK accident and emergency setting is. Thick description of the procedural base highlighted the manner in which emergency personnel managed sudden deathwork exposing the complexities of working with such an abstract concept. By exposing the procedural base to sudden deathwork the phenomenon has become more tangible and hopefully will be better understood. Additionally, the procedural base to sudden death speaks volumes about what sudden death is and the accident and emergency milieu in which it is manifested.

Death trajectories have been explored in relation to death within the US medicalised hospital setting of the nineteen sixties (Sudnow, 1967) and later from a single case perspective (Glaser and Strauss, 1970) with associated death literature by Glaser and Strauss (1965; 1967; 1968; 1971). It is important to note the significance of these classic texts in shaping the very focused work on sudden death trajectories and particularly in providing a route to the discovery of the most appropriate way to develop insights regarding the phenomenon. Timmermans (1996; 1997; 1997b; 1998; 1998a; 1999; 1999a) reported on specific dimensions of sudden death trajectories in relation to the techno-scientific script, questioning the ethics of resuscitation in relation to beneficence and non-maleficence for both the patient and their relatives. Social value and social death as self-fulfilling prophecy were considered to shape resuscitation outcome due to a standardised and pre-inscribed default mechanism to resuscitate, one which may be extremely worrying to health professionals practising in an era of heightened awareness of litigation. The two

dimensions, death and sudden death trajectories provided a foundation for this study to investigate practices in rich detail enabling a thick description of the accident and emergency sudden death milieu to emerge.

Application of the temporal dimension enhanced the overall quality of the research as compared to the use of a 'freeze frame' approach. Merleau-Ponty's (1962) and Glaser and Strauss's (1968) use of a temporal dimension shaped the way in which the data collection was conducted to harness not only actions central to sudden death but also to compare them with previous incidents in the same and different groups and also in different settings. Rich detail of happenings, which were both similar and contrasted with others were revealed and helped explain variations in the way sudden death was managed.

Of significance was the ability to position myself as a researcher at the edge of my own society. This marginal process enriched the data collection and analysis by being able to operate within and out with the culture, using reflexive processes to engage with the 'happenings' and by disengaging at a meta-cognitive level in order to grasp the essentials of 'what was going on' and formulate constructions. May's (1997) aspiration for the ethnographer to literally 'stroll around' was facilitated by the different ways in which access to the accident and emergency culture was achieved and it was most helpful that the conditions, which would assist the research were laid in previous years.

Internal consistency within the content of the thesis provides a relatively accurate rendition of events and discussions. Many examples of sudden death related scenarios were integrated into the analysis and personal narratives harnessed and that can be traced back to the original speaker or group and relate to their personal involvement in sudden deathwork. Young (1995) declared his own endeavour to secure accuracy as far as possible following research on his own 'tribe', following thirty years of 'on the street coppering' he was confident that his ethnographic accounts could provide

authentic detail, which is potentially more valuable than crime statistics that are invariably “bodged” anyway.

Dominant discourses have shaped the way research is executed and it is important to consider how such discourses have impacted on this study. The use of an ethnographic approach within an inductive frame exposed an under-reported aspect of emergency care provision usually hidden within a private/public binary opposition. The particular design used is a strike against modernist medicalised dominance to embrace a liberating discourse whereby the researcher has engaged in an embodied sense within the culture and hence, with the phenomenon. To observe and then to declare specifically what sudden deathwork is and not what one would like to believe it is required the deconstruction of a range of events. Insight into the inhibiting ‘chains’, which constrain researchers who maintain a dual identity, further helped the last aspect along. There is an ethical obligation to report what is being said and seen as accurately as possible to declare what sudden death is so it was necessary to take my nursing ‘hat’ off and put my sociologist ‘hat’ on in order to think sociologically and to reveal before me practices and procedures, which I preferred not to expose for example, that nurses’ laugh at sudden death just like their counterparts in other emergency disciplines. Similarly, revealing how paramedics become frustrated when nurses do not listen effectively to the patient history when transferring patients into the resuscitation room. Further, police officers were known to become highly irritated by what they believe is obstructive behaviour by nurses when they are seeking patient information in the course of their enquiries. The use of a feminist frame helped reduce the dominant discourse to reveal those intricate complexities usually hidden within emergency personnel practices.

When emergency personnel read this they may not be entirely happy with the ‘warts and all’ product and attention should really be turned to the range of possibilities for informing practice. It is precisely this blinkered vision that results in a failure to question practice, and is compounded by situating much of what constitutes sudden deathwork within the ‘non-accountable’ range of emergency personnel activity. Such

activity is rarely reported on and absence of formalised defensible documentation may be the reason why emergency and healthcare services have experienced problems such as: the human organs inquiry; the bodies in the chapel; the body left at the scene; and, most recently the machine washing of a dead baby. Inappropriate care conditions will remain unreported and unresolved in the absence of defensible documentation but also because blinkered vision exacerbated by dominant empirical discourses may fail to expose the minutiae of what is actually 'going on'.

Multiple strategies of triangulation aimed to reduce the personal biases that arose from a single researcher, single method, single theory study. However, it was necessary to compromise on these factors due to constraints on time and funding though it is recognised that such a position must be considered within the limitations of the study. In defence of a single researcher approach the benefits of being totally immersed in the data collection, transcription and analysis is on reflection, what gives strength to the research and was more likely to enrich the detail and level of insight. The use of a range of data collection approaches reduced reliance on the single method and permitted other dimensions to be included, which otherwise may not have been exposed such as the detail gained from the informants regarding paramedic and traffic officer scenarios.

The application of Schutz's use of 'relevance' was useful in that the typification of procedures within sudden deathwork was achieved such as what body wrapping constitutes or what happens when a paramedic is awaiting the arrival of a general practitioner at the scene of a sudden death. Constructions of these happenings were formulated based on common-sense understanding of its characteristics. Deviation from the typical happening introduced characteristics, which were not in keeping with other happenings and hence atypical and required reconstruction in order to describe them. As an example, during evenings, weekends and bank holidays some mortuaries were not staffed by mortuary technicians and it is the police officer who will carry out sudden deathwork and this introduced a series of happenings, which deviated from the norm requiring a new set of constructions to be formulated about what is going on.

The research essentially provides a substantive theory of sudden deathwork in accident and emergency, a description of the institutional processing of the suddenly dead but does not intend to be prescriptive however, a range of development opportunities were expressed by emergency personnel that is worthy of mention and could shape future practise. For example, it is interesting to note that toothpaste is not readily available in accident and emergency departments, and such a position is a particularly useful indicator of the objectification of the cadaver in that the procedure of cleaning the dentures is modified for a dead body. It is apparent that dead non-persons warrant 'a quick rinse' of their dentures under tap water whereas live persons would be provided with the toothbrush and toothpaste. This is not a criticism merely an observation of an accident and emergency dualism however, it is worthy of consideration in that relative's may potentially wish to kiss the deceased's mouth.

Paramedics reported on the ambulance to mortuary transfer of the dead body and expressed a need to conceal the death during that particular activity. One paramedic suggested the construction of a canopy large enough to park a reversed ambulance, which would house the ambulance out of public gaze whilst the body is unloaded, or even an ante-mortuary unloading garage with automatic roller doors. Such a facility would certainly remove death from public gaze though contributing to the continuing sequestration of death from society by affirming its continuing taboo status within Western culture.

Disallowing relatives in resuscitation continues for individuals who may actually wish to be present. It seems rather an anomaly that relatives may participate in witnessed resuscitation and actual sudden death whilst in the ambulance vehicle en route to the accident and emergency department yet then be expected to disengage when in the department. The Resuscitation Council (UK) (1996) position on witnessed resuscitation recommended that relatives should be allowed to witness resuscitation attempts and appropriately trained healthcare professionals should support them. Conversely, assuring patient confidentiality is problematic and raises legal and ethical issues surrounding the bond of trust that encourages patients to disclose personal

information to healthcare professionals. Litigation regarding the patient's right to confidentiality has not yet been brought before the regulatory bodies so the discussion remains theoretical. It would appear that a further dualism has been identified, which requires much more intense debate.

The intensely difficult method of body wrapping could be reviewed and an alternative to the sheet wrapping technique introduced, which involves abandoning the current use of a white bed sheet. As it has not been designed for such a purpose it is notably difficult to position the bed sheet whilst also allowing for total body coverage and in particular allowing for sufficient material to cover the head. Instead a 'body wrapper' could be designed, a large white piece of fabric sufficient to cover the body and which is positioned underneath the body and folded over the top to minimise effort. Edged in a velcro type tape and with a number of ties to fit snugly, the body can be secured within the body wrapper with less effort. Revealing the head when relatives arrive would still be possible in fact the head would be more easily accessible by pulling back the top triangular corner of the material and repositioning it once the deceased has been viewed.

Opportunities to enhance practise were reported by emergency personnel in relation to the way property is managed and packaged. Immediately following cot death when the tiny possessions are handed over to relatives they 'drown' in the large white hospital carrier bag and it is unusual that a more suitable alternative has not yet been commissioned. A pastel coloured laminated box, flat packed for compact storage in the accident and emergency department for easy assembly when an infant death occurs could add a touch of dignity to the occasion. As the last memory is the lasting memory it is important to handle this aspect of sudden deathwork sensitively and return some dignity to the distressed relatives.

Sentimental order is of significance in an emergency setting and staff employs a range of emotional buffers to maintain the climate. An implicit understanding between the doctor and the nurse is tangible though there are occasions when this is likely to

shatter. The interesting point, which is worth of additional investigation is whether the implicit understanding extends to the interactions of the emergency disciplines of emergency nurses, paramedics and traffic officers. On occasions this aspect shone through such as in situations where one member of a discipline was insightful of the needs of a member of another discipline and such a study would be most topical in a climate of inter-professional working and education.

Dualism operates within the accident and emergency sudden death culture such as the paramedic dislike of death visibility in the mortuary. Visibility of death is deemed acceptable only when in the appropriate context, out with that context it adopts new meanings some of which violate pre-conceptions of what sudden deathwork should be and how it should be handled, managed and displayed.

The disabling avoidance of body handling is apparent despite the fact that dirty work is a key feature of emergency personnel role function. It has become quite clear in data from various individuals that this is one aspect of the sudden death role which would much rather be avoided however, for some individuals this takes second place behind having to deal with the intensely emotional demands of suddenly bereaved relatives. The process of handling distressed people and body handling is considered to be daunting for some as certain scenarios are ingrained in their minds and emergency personnel seem able to readily recall incidents and happenings from the distant past, which emotionally impacted on them.

In conclusion, an ethnography of sudden deathwork is presented, which incorporates the reflexive biography of the researcher and narrative accounts from emergency personnel. Scenarios described aim to build a substantive theory of sudden deathwork in the UK around the turn of the millennium. All that is left to declare is that what has been reported and described in detail is what emergency personnel 'do' so this is what sudden deathwork 'is'.

APPENDICES

APPENDIX ONE

INVITATION TO PARTICIPATE

Dear Colleague

I am a Post-Graduate student at University of Durham, researching the views of emergency personnel about the sudden death event. Your comments are valuable in understanding how emergency personnel manage sudden deaths. To gather your views and experiences I wish to invite you to take part in a taped discussion with a small group of your colleagues.

The venue is(*location*).....
at.....(*time*)..... on.....(*date*).....

During the discussion I ask that you be as open and honest as possible and that I gain your permission to publish the information gathered. May I emphasise that any issues raised during the discussion will be anonymous. I will also be available following the discussion should you wish to talk about your experiences.

To establish the number of people willing to participate I would be grateful if you would return the enclosed reply slip to the address below, no later than.....(*date*).....

On receiving your written acceptance I will contact you by telephone one day before the discussion to confirm your participation. Should you wish to know more about the discussion please feel free to contact me on the following telephone number.....

Thank you

Tricia Scott

(*Return address*)

APPENDIX TWO

FOCUS GROUP DISCUSSION SCHEDULE

- 1 Tell me what might happen when somebody dies in the department. What sort of things might you be involved in?
- 2 Tell me about those aspects of sudden death that you might find difficult or stressful.
- 3 Looking at it in another way, are there things to do with sudden death that you might not mind getting involved in?
- 4 What sort of things might you do to the deceased's body?
- 5 How might you approach caring for the relatives of the deceased?
- 6 Are there things that you don't mind dealing with?
- 7 We hear a lot about using a professional approach in (discipline). Tell me something about how able you feel you can remain professionally detached when involved in the management of a sudden death.
- 8 Following a sudden death in the department what sort of support might you receive from your colleagues?
- 9 Tell me how you cope with your emotions.
- 10 How might the design of the department affect the sudden death situation?
- 11 What about other professionals like (discipline), how might their presence affect the process of dealing with a sudden death?
- 12 What do you think are the reasons for the (discipline) attending the department?
- 13 Is there anything that anyone would like to add or clarify about the things that we've talked about?

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