OPENING THE WINDOW:
DEATH AND THE SUPPORT WORKER

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INTRODUCTION

The first time I ever saw a lady who’d passed on…they were washing her and everything, and I’ll always remember, the one thing that got to me, was the fact that the auxiliary opened the window and she went “go on” and then she shut the window.

Healthcare Assistant

Workers in healthcare settings are regularly called upon to confront the death of others as a normal part of their working lives. They are not alone in this respect. Many examples can be found of work roles which involve dealing with death and dying, most obviously in funeral services, cemeteries and coroners and on a broader scale in the emergency services: fire, police and ambulance. In these instances, however, the worker manages death and dying in a relatively brief timeframe and in relation to someone who they have had little if any contact with in the past. For healthcare workers, whether in a hospital or community setting, death is likely to be a more personal experience: such workers are likely to have been looking after the individual over an extended period and consequently developed a deeper relationship with them.

Amongst health workers in various settings, hospital healthcare assistants represent a group for whom the experience of death is likely to be particularly acute and affecting. In contrast to the care worker in a nursing home, responsible for older people for whom death is the typical outcome of a stay, the hospital healthcare assistant is caring for patients across a range of ages, with death an ever present but unpredictable possibility. This paper explores how the healthcare assistant (HCA) in a hospital setting views and deals with death as a routine part of the labour process. It is divided into four main parts: the first explores the literature which contributes to an understanding of worker engagement with death at the workplace; the second proposes a set of research questions and presents the methods used to address them; the third sets out the findings; and the final part discusses them.

Death at the workplace: dirty and emotional

While scholars of work and employment have paid limited attention to employees who deal with the dead and the dying, two steams of literature have some relevance to this domain of interest. The first relates to dirty work and the second to emotion at work. Workers who deal with death have typically been classified as dirty workers. Dirty work was originally defined by Hughes (1958: 122) as ‘physically, socially or morally tainted’ work, while Ashforth and Kreiner (1999: 415) describe physical taint as occurring where ‘an occupation is…directly associated with garbage, death, effluent and so on’ (emphasis added). Indeed it is striking that Hughes’ (1993:89) early use of the term ‘dirty work’ is in the context of German concentration camps: ‘I found myself asking…how could such dirty work be done amongst and, in a sense, by the millions of ordinary civilized German people’ (emphasis in text).

Research on ‘tainted’ work has often concentrated on the degradation of the labour process for those undertaking it. Dirty work has been presented as socially stigmatised, leading to a research focus on the cognitive consequences of such social approbation for the post holders’ sense of self worth and identification with the occupational role (Kreiner et al, 2006). More tangible constraints associated with dirty work have also been highlighted, particularly acute in the case of those undertaking physically tainted work. Physically tainted workers are more likely to be dealing with real dirt than those in socially or morally tainted roles where the dirt
assumes a more symbolic form: the socially tainted interact with the ethically questionable ‘Other’; while the morally tainted, are themselves that ‘Other’ (Jervis, 2001). More tangibly the working conditions of the physically tainted worker have also been presented as especially degraded. Stacey (2005), for example, points to the overwork, added responsibilities, risks and low pay associated with home care work in the United States, while Thornley (1997) draws attention to the under valued nature support work in the UK healthcare sector, captured by her description of such workers as ‘invisible’.

At the same time, dirty work has been seen to generate important rewards for those undertaking it. These have sometimes derived from socio-cognitive processes described by Ashford and Kriener (1999) as reframing – changing the meaning attached to an occupation – and recalibration – altering the valence of a work role. Thus post holders might develop a shared view of their work as ‘heroic’ in the face of broader social judgements. Such benefits are not, however, solely based on cognitive adjustments. Despite the assumption of stigma in much of this literature, there are dirty work roles which are generally seen in a positive social light, reflected in the public goodwill often directed at those in nursing and the emergency services. The benefits associated with such roles are also reflected in the dignity derived for such work which is often only glimpsed when the workers themselves are asked how they feel about their work. Despite the constraints on care working, Stacey (2005) highlights a range of gains articulated by care employees, including the practical autonomy associated with their work, the ‘useful’ care skills acquired and the simple pride connected with undertaking care work.

For the physically tainted employee dealing with death and the dying, the consequences of such work are likely to revolve around the emotions unleashed. James (1992), for example, views emotional labour as intrinsic to caring work. A definition of physically tainted work which brackets the handling of death with the management of ‘garbage and effluent’, is too crude to account for the distinctive emotional experiences of those who deal with death as well as effluent and garbage. Thus, the engagement with death amongst many types of healthcare worker, along with the associated human effluent, is likely to lead to a working life which contrasts sharply not least in emotional terms with that of say a refuse collector or street sweeper, whose remit remains limited to the handling of garbage and effluent.

In exploring this added emotional dimension to dirty work involving death, it is clear that emotion has emerged as a contested influence upon the labour process. Discussion has revolved around whether the use or stimulation of emotions degrades or enriches working lives. Early debates in the sociology of work saw worker responses to the expression of emotion at work as heavily constrained and indeed structurally determined by the mode of capitalist production. Hochschild’s (1983) notion of emotional labour was predicated on the commodification of feelings in service work with employees expected to act out emotions according to organisational feeling rules. The result was not only negative economic consequences for the worker in the form of exploitation, but psychologically damaging outcomes in terms of burn-out, guilt or estrangement. Subsequent discussion, however, has placed much greater emphasis on a residual degree of autonomy for the expression of emotions albeit within the context of ongoing structural constraints. Korczyinski (2002), for example, noted Hochschild’s (1983) failure to distinguish between the objectively alienating features of capitalism from the subjective employee responses to it. Bolton (2005a) developed this point by stressing the discretion available to workers in managing their emotions in response to different motivations: pecuniary, prescriptive, presentational, and philanthropic. It is an approach which opens-up the possibility that in expressing emotions the consequences for workers are not necessarily or solely negative but might fulfil a range of individual and social needs.
In summary, debates on dirty work and emotion at work overlap in important respects. Dirty workers, in particular the physically tainted, often engage with death along with garbage and (human) effluent, a feature of their work which is likely to require or stimulate a distinctive emotional response. This raises the issue of whether the expression of such emotions is the source of degradation or enrichment. Within the dirty work and emotional labour literatures, views vary on likely outcomes. There is, however, an important stream within both which suggests that any evaluation of such outcomes needs to draw on the views expressed by the workers themselves. This paper draws on the views of HCAs in a hospital setting to explore how and with what consequences they engage with death and dying as a routine part of their working lives.

**RESEARCH APPROACH**

**The healthcare assistant role**

With varying degrees of explicitness, nurses are often referred to as dirty workers (Bolton, 2005b) and those working alongside them as HCAs, are no less engaged in tasks which justify a similar designation. Traditionally, the social organisation of work (Sudnow, 1967) has ensured that nurses and support workers rather than say doctors are responsible for dealing with the immediate and direct aftermath of death as it relates to the body. There are, however, grounds for suggesting that it is the HCA who has increasingly taken on the physically tainted tasks associated with direct patient care, a development which might be expected to have distinctive consequences for their engagement with death and their emotional responses to it. This should not be seen as a new development. The importance of the assistant or auxiliary in dealing with the emotional labour associated with death in a healthcare setting was highlighted by James (1992) in her study of caring work in a hospice. As she notes there is ‘almost an inverse of status and skill in emotional labour…young staff-nurses relied on the four older auxiliaries who were described as being the backbone of the unit’. James implies that this reliance derived from the background of the auxiliaries as well as the structure and nature of their roles: ‘Reasons that so much of the emotional labour lay with the auxiliaries were that emotional labour takes and requires considerable knowledge of the patient as a person.’ Nonetheless, significant changes in the character of the healthcare workforce, and especially in secondary healthcare, have furthered and reinforced the HCAs involvement in dirty and emotional work.

The HCA role is a longstanding one within the nursing labour process, emerging and developing in harness with the nurse role over the last century or more. With such an extended history, the role has unsurprisingly been structured, used and managed in subtly different ways over the years, in part captured by the different occupational titles still attached to it: healthcare assistant, auxiliary nurse, ward assistant and clinical support worker. However in recent years increased weight has been placed on the HCA role. Initially this can be traced to a re-organisation of nurse training from the early 1990s which, in replacing an on-the-job apprentice model with one based upon ‘classroom’ learning, removed student nurses from the ward and left the HCA as the only source of hands-on support for the registered nurse. The importance of the support role was deepened by pressures for a broader re-structuring of the healthcare workforce in the context of various public policy developments. As a means of dealing with statutory requirements to reduce junior doctors’ working hours, along with a drive towards up-skilling as part of an ongoing professionalisation project, nurses began to move from the provision of the most basic nursing
tasks as a means of taking on more technical and specialist tasks (Doherty, 2007). The HCA was not only left as the main source of support for the nurse on the ward, but this support focused on providing the bulk of the direct and personal patient care. HCAs now undertake most of the intimate tasks associated with personal care. This requires them to spend more time with patients than other members of the ward team, often leading to the development of a relatively close relationship, and in the event of patient death raising a distinct set of questions about how they view and cope with it.

The HCA’s increased engagement with dirty work, in particular death and its emotional consequences, assumes added interest given the nature of the individuals taking-up the HCA role and their preparation for it. The HCA role is largely unregulated. Despite considerable public policy debate on this issue, at present anyone can take-up the role with only a minimal, criminal record check. Trusts sometimes impose their own entry requirements in terms of a desired NVQ level or relevant work experience, but these are at the discretion of the hospital and often applied loosely even by the trust. HCAs will undergo mandatory training as part of a typically one or two week induction course; however, this pales against the three year pre-registration programme undertaken by nurses.

It is open to debate as to how the unregulated nature of HCA employment might affect the HCA’s engagement with death. The low barriers to entry might allow individuals with worldly experience and tacit caring skills to more readily take-on the role. While HCAs have diverse backgrounds (Kessler et al 2008), many will have been employed in a care context, often residential homes, with others having undertaken care responsibilities for children and other relatives in a non paid, domestic context. This caring experience might better equip individuals for dirty and emotional work than the formal training received by nurses. On the other hand, the very absence of regulation and formal preparation might encourage individuals to take up the role for whom dirty work and especially an engagement with death is an extreme personal jolt. It remains an open empirical question as to how those performing close personal care within a relatively unregulated work role respond to dying and death.

Method

The views of HCAs on their engagement with death and dying at the workplace were gathered as part of a broader project on the structure and consequences of support worker roles in secondary healthcare. Concentrating mainly on the HCA role, it adopted a case study approach which covered three hospital trusts located in different parts of the country: a southern trust, a midlands trust and a northern trust. The southern and northern trusts were large teaching hospitals: the southern trust with 1500 beds, a total budget of around £500 million and a workforce of just over 9,000; the northern trust with 3,000 beds, a budget of £750 million and a workforce of 15,000. The midlands trust was a district general hospital with a budget of around £250 million, 700 beds and a total workforce of some 4,600.

The data presented in this paper were mainly gathered by interviewing sixty-one HCAs from general medical and surgical wards in these three trusts during 2007-8: thirty on two of the southern trust’s three sites; sixteen on the midland trust’s one site; and fifteen on two of the northern trust’s six sites. As part of the interview process, HCAs were asked to fill out a short pro forma which generated structured information on their backgrounds. Reflecting the general make-up of the HCA workforce the overwhelming proportion of those interviewed were women. The pro forma data indicated that significant majorities had children and partners. As already implied, individuals took up the role with diverse backgrounds, although for many the gateway into the role was work in another caring context, whether paid employment in a residential home or unpaid caring work in domestic context. The
representativeness of the HCAs interviewed should be treated with some caution. Typically, at least two HCAs were interviewed per ward with the total full time equivalent HCA ward complement ranging from around 6 to 10. Ward sisters chose the HCA for interview, but they were asked to provide a mix in terms of age and experience; the pro forma data suggest that some variation in these respects was achieved.

The interview schedule included a question on how HCAs coped with death on the ward and their first experience of engagement with it. This was then linked to a more general discussion about how they dealt with their emotions at work: HCA were asked whether they had ever become attached or close to a patient and how they had managed such situations, a question which often led onto a discussion about a patient who had died. HCAs were also questioned about what they most liked and disliked about their job, in a few instances prompting references to aspects of death on the ward. As part of the case study research, focus groups were conducted with previous trust patients and HCAs were observed on the wards. Some reference is made to the findings from the focus groups and observation, but the paper mainly concentrates on the interview material.

**FINDINGS**

At the time I didn't think it was real. What happened was [nurse’s name] had said to me “oh this lady’s really unwell” and...she asked me if I minded sitting with her; because she didn't have any family with her or anything, and she said that she could possibly die and how do I feel, you know, if I feel uncomfortable about doing it then don't do it, but she thought it would be a good learning opportunity. So I went and sat with her because I didn't mind...and as I was stroking her hand she did die and it was like it weren't real really. And I helped clean her and, and then when they wrapped her up...in the sheet, the thing that got to me most was actually covering her face, you know, wrapping her head up. And...I kept looking because I kept thinking I could see her breathing, and I was thinking “oh”. Anyway I finished that shift...at three o’clock and...I had an appointment to try on wedding dresses and my mum was meeting me in the shop. And I went in and I was fine, I didn't feel upset or anything, but then when I started talking about it and I told my mum, I just burst into tears. And I just explained to her that it was when I wrapped the lady’s head up that that's, that's what really got me really. I don't know why.[North_HCA9]

The structure of encounters

This HCA from our northern case study trust is quoted at length not only because she provides a particularly rich description of her engagement with death, but because in doing so she highlights a number of key features associated with the structure and nature of such an encounter. In general, she illustrates the direct link between physically tainted dirty work - dealing with death -and emotion- in this case the distress caused and reflected in the ultimate shedding of tears. More specifically, the quote suggests that an HCA’s engagement with death tends to comprise three related elements: shape, context and management.

In terms of shape, the northern HCA’s story indicates that an engagement with death and dying is often an episode comprising a series of identifiable stages. These stages might be distinguished as a prelude to; engagement with; and aftermath of death. They are likely to underpin any such engagement, although their form and substance are likely to vary. In the case of the northern HCA, the shape of the encounter with dying and death was relatively
self-contained, complete and compressed. It is equally plausible to envisage a much more fragmented and extended encounter with possibly different emotional consequences.

Cutting across these stages is the context for the encounter. It is clear from the northern HCA that any encounter with death is framed by a distinctive configuration of local circumstances. These might relate to the individual HCA (the personal) or the social conditions in which she finds herself (the situational). Combining shape and context, helps unpack the elements of the encounter described by the northern HCA in the following way:

<table>
<thead>
<tr>
<th>Situational</th>
<th>Personal</th>
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<tbody>
<tr>
<td>Prelude</td>
<td>First encounter with dying (hence reference to a ‘learning opportunity’).</td>
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<tr>
<td></td>
<td>Supportive nurse who asks if comfortable sitting with the patient.</td>
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<td></td>
<td>The patient is alone with no family present.</td>
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<td></td>
<td>Holding the patient’s hand when she dies.</td>
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<tr>
<td>Engagement</td>
<td>First time undertaking last offices.</td>
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<td></td>
<td>Last offices carried out immediately after death and after being with the patient when she died.</td>
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<td></td>
<td>Adverse reaction to wrapping the body and covering the face.</td>
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<tr>
<td>Aftermath</td>
<td>To be married in the near future.</td>
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<tr>
<td></td>
<td>Able to recount experiences to mother which takes place in a wedding dress shop.</td>
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The value of this two dimensional framework lies not only in unpacking and describing an encounter with death, but in providing a means for understanding its management by the HCA. The northern HCA had a particular way of coping with her engagement which in part involved detachment from the situation- she presents the episode as ‘unreal’, indeed in the telling it has a dream-like, even nightmarish, quality with the imagined breathing of a dead body – as well as an explicit display of emotion with her crying on a recounting of her experiences to her mother. These responses might be seen as related to the shape of the encounter- all three stages quickly followed on from each other and were closely entwined- and the context - the first time experience of dealing so directly with death and dying juxtaposed with her preparations for marriage.

The framework provides a means of further exploring in greater detail the nature and consequences of HCA encounters with death and dying. The stages of the encounter are used to structure the discussion, with consideration given to how a range of personal and situational factors shape the experience and management by the HCA.

**Prelude**

The prelude stage typically relates to close encounters with a dying patient. Such encounters were not core or a regular part of nursing roles on the ward: over recent years patient stays have become ever shorter, lasting days rather than weeks. However, those patients admitted and staying have tended to be more acutely ill than in the past. Moreover, the HCA is the member of the ward team most likely to deal with such patients in a direct and sustained way. For the terminally ill patient ‘TLC’ (the euphemism used when medication for a terminally ill
patient was withdrawn), removes the basis for any regular contact between nurse and patient, leaving the HCA as the main care provider. At the same time, there are situational differences which affect the HCA’s encounter with the dying patient:

**Situational.** These situational differences often revolved around the patients’ condition and circumstances: their age, length of stay and support. Again the configuration of these factors was crucial. Certainly the emotional distress was heightened where the dying patient was young:

A few years ago somebody who was relatively young, in their 40s died, I fortunately wasn’t here for the incident but I helped lay him out and that was, shocking is probably too hard a word, because I didn’t know him, but that was unusual and that was probably something else to deal with. [South_B2_HCA2]

Sometimes I feel really sad, especially when the young people die; I cry. [Mid_B_HCA15]

A young feller who’d got that many problems and, and he passed away eventually and it was terrible. But, you know, we just have to try and bring the shutters up and carry on really.[Mid_B_HCA3]

Odd occasions you still think about it depending on what situation that patient has died in…If they’ve gone to sleep or it’s been a patient that is terminally ill, it’s easier because they’re not suffering anymore…If it’s a younger person and if they’ve had a really bad bleed or they’ve haemorrhaged …and then you have to clean them and lay them out, that I think about afterwards, because it’s not the fact that they’ve died, it’s the fact that they’ve had to suffer and you go home and you think that is an awful way to die.[North_HCA10]

Old age did not, however, always dilute the emotional response, which was often more closely related to how long the patient had been on the ward and the intimacy of the relationship:

‘If they’ve been with you a long time and pass away or something, it can be quite sad…sometimes you can’t help your feelings.[Mid_A_HCA7]

I know you shouldn’t really but sometimes you do get attached to patients. You shouldn’t really because if they die I get quite emotionally, well I obviously don’t show it but you get sort of like quite emotional. But some of the patients are on the ward for weeks, sometimes months, you know, you can’t help but get attached, can you really, you know.[South_A1_HCA24]

It depends on how much you’ve looked after that patient and how well you’ve got to know that patient and how well you get on with them, because obviously you get on with people in different ways. So no, some days you do get very upset.[South_A1_HCA12]

The suddenness of the death also had emotional consequences. A number of HCAs mentioned that it was their immediate contact with the patient before death and its unpredictability which prompted a sharp emotional response, often sadness or shock.

I’d been in that morning and I’d said to her (the patient) blimin’ hell you look ever so well today…And I was chatting to her, she was fine…then I just finished giving my last dinner out and the crash alarm went off…She was in the chair and she’s just slumped and they tried to resuscitate her a couple of times. I mean she was a good age, she was ninety four I think. And I felt awful because I sat there and thought I’d just been speaking to her literally just over an hour ago and she was fine…that was the last time that I properly had a cry.[Mid_B_HCA10]
We had this little man that was on the ward; he must have been on the ward for months and months and he used to be a bit of a wanderer, and then they used to have to sedate him to stop him wandering about. And he’d still get up and walk, and he fell on his face one day and he was covered in bruises. And then two weeks ago I was like feeding him with his supper, and we put him back to bed and he just died, and it was so quick, you know, and I just felt like a lump in my throat, you know. And I went home and I just couldn’t stop thinking about it and I thought well I suppose that’s life, you know, it’s a hospital, isn’t it, you know.[South_A1_HCA24]

In addition, HCAs consistently noted how the perception of a patient dying alone prompted an acute and intense emotional response:

The thing I don’t like is I don’t like to see a patient die on their own…I should be hardened to this after thirteen years, but it really cuts me up if I think you know oh he’s died on his own.[Mid_B_HCA1]

Personal. These situational, patient-related factors assumed particular resonance for the HCA when linked to personal circumstances. Thus, the HCA’s response to a dying patient was sometimes informed by a dying or caring experience from beyond the workplace, for example, a recent, vivid or affecting family death or illness. The HCA’s emotional reaction to the patient in these circumstances was more intense, in certain cases leading to some reluctance to engage, but more typically to a heightened level of empathy:

There was this one time, like [the patient] was in the same condition as my mum, and then she passed away, then I just felt okay and I walked out.[Mid_A_HCA5]

It never gets any easier but you learn to cope with it different, and that’s the only way I can put it. It’s like after I came back to work after my daughter died, I mean she was twenty-three so I found that, well obviously really hard, and when I first came back to work I could not deal with a dead body.[Mid_B_HCA6]

Anything that I can do I will do to make that time easier…I know because, you see, my mum died in [ward name] a few years ago and I can remember the time, it was a horrible time and I can remember never really seeing anybody when my mum was dying. But then that’s natural now and I can see that because if someone’s dying and they’re not to have any care except for TLC then, you know, sometimes there’s not a lot of the time that you see a staff nurse, it’s the HCAs that you’ll see.[South_B1_HCA28]

I’ve actually worked with people that have had cancer, you know, and quite a lot of older women, you know, they’ve actually just been told and maybe they’re eighty or ninety. And obviously that upsets them so I just sat down, I just sit down and just say “well actually, you know, I lost my daughter”. When I say that she was twenty-four, they just said “oh my goodness”, you know, that they’ve lived their life, you know. [South_A1_HCA24]

In addition, there were HCA’s with personal dispositions, unrelated to background circumstances which lent themselves to contact with the dying or encouraged the dying to seek such contact with the HCA.

That’s what makes it worthwhile just like, you know, just knowing that you’ve made someone’s last moments comfortable or you’ve reassured the relatives and they feel supported by you. Because obviously sometimes, you know, like if someone’s dying and there’s no one there, I don’t like people dying on their own so I will go and sit with them and, you know, the families are usually, you know, really grateful for that if they can’t get in.[South_B1_HCA28]
I'm not hard-faced but death is a fact of life and whether it be young, middle aged, old or past a hundred, one day or other everyone is going to die. It's not nice, I don't thrive on it but my personality, I tend to be able to be quite approachable to people who do struggle with it and they always come up, can I have a chat with you, and I just sit there and listen.

**Engagement**

**Situation**

Deaths on wards were quite rare: during over 200 hours of observation across 37 separate shifts, there were only two where deaths occurred and one with a near death event, in the form of a cardiac arrest. It is noteworthy, however, that such events were uneven and unpredictable: on one shift two deaths occurred in quick succession. Moreover, most of our HCAs were able clearly to recount their first engagement with death despite the passing years, a testament to the deep impression it made. As with the northern HCA, engagement with death usually revolved around last offices, a process which initially tended to generate strong emotions in the form of shock, sadness and distress.

The situational factors underpinning this first encounter again emerged as crucial in generating and modifying these emotional responses. Most important was the level of support available. There was little formal help from the trusts in dealing with last offices, with any guidance informal and derived from the ward team. Where such informal support and guidance were not forthcoming, the first experience of last offices could be quite harrowing, prompting at least two HCAs who had been strongly affected in this way to voluntarily ‘shepherd’ new HCAs and indeed nurses through the process. The provision of informal comfort and aid in dealing with last offices did not necessarily prevent the expression of emotions. Indeed, it was noted by certain HCA’s that nothing could prepare you for an encounter with death. However, the provision of support from the ward team could help provide a more controlled and managed environment for an HCA’s first engagement with death:

> I ask [new HCAs] to come in with me [to last offices]...But there’s one thing I always say to them “if any part of that time that you don’t want to do anything and if you think I can’t do this, just tell me”; I let them go out, I’ll get somebody else; because it’s not a nice job and not everybody can handle it. [Mid_B_HCA1]

> The first time I ever laid a body, I was thrown in at the deep end. They didn't know whether I’d done it before and I was just put with another auxiliary and it was like that needs doing, go and do it. But then I broke my heart after, and then they came up to me and said “well are you OK?” And I thought well I’d never done it before. So if we’ve had new auxiliaries start, I will always say to them you've got to do it eventually but if you just want to come in and sort of observe, and then if you need to go out you can go out and I’ll do it with somebody else. [Mid_B_HCA6]

**Personal.** HCAs varied in whether they were equipped and ready to engage with death at the workplace. This form of preparedness was affected by the range of background factors already alluded to in dealing with prelude or dying stage, such as an experience of death in their private lives or indeed in previous employment. For those without such an experience dealing with death could again provoke shock or fear, and there were instances where HCAs felt pushed into coping with it before they were personally ready:

> It was a shock because I’ve never had to deal with that last office before...I was a bit frightened to touch the patent, you know [although] I knew they wasn’t going to hurt me or nothing. [Mid_A_HCA13]
I thought I’d never seen a dead body before, but [the nurse] was like pushing me in to doing it, thinking because I’m a healthcare I know what to do, and get on with it. So, and I went in there and I said, you know, “I haven’t seen a dead body”. So, and then she said “oh just touch it!”…but I felt pushed then in to wrapping up the body and I didn’t want to, I wasn't ready. [South_A1_HCA22]

At the same time, there were again HCAs with dispositions which lent themselves to a positive and emotional rewarding engagement with death. These were HCAs who brought a particular meaning to this stage. The meanings attached to death encounters are dealt with below. Nonetheless, it is worth noting that for some HCAs last offices represented an important extension of the care and a form of closure on the process.

I know that’s my job and I’m quite proud actually being the last person to be able to do something like that [last offices] for them; make sure they’re okay, well in a sense, make sure that they’re alright for when you send them onto the mortuary.[Mid_B_HCA10]

I’d wanted to do [last offices]…I’ve always been interested in what they do...I know it sounds a bit weird but I have. [Mid_B_HCA2]

HCAs did appear to be personally affected by particular details associated with last offices. The emotional power of putting on the shroud and covering the face, raised by the northern HCA, emerged as a recurrent theme and a trigger for strong and unsettling feelings.

I think it’s just the way they wrap the person up and… I don’t really know if there’s another way of doing it but I just don’t like doing it, because you have to wrap them up in a sheet and...I just don’t like it at all. [Mid_B_HCA3]

Aftermath

**Situational.** In situational terms, the emotional fallout from the prelude and engagement stages was again partly contingent upon the informal supportive infrastructure provided at the ward level. The opportunity to deal with emotions following a death experience, whether through the provision of time and space for the individual HCA, the availability of a trusted colleague or access to various team members affected the ability to cope:

*Coping with a privileged colleague*: I’d go to see the Sister...me and her are a bit like each other because we both get upset...So I do sort of go to her and yes, I can relate to her and she’s very good.[Mid_B_HCA1]

*Coping in the team*: You can talk to anyone, absolutely anyone. [Mid_B_HCA10]

*Coping alone*: I just found myself a quiet, little corner to have a bit of a weep and tried to get it straightened out. There’s no point bottling it up, if you can find a quiet, harmless sort of outlet that doesn’t bother anybody else, I don’t see the harm in it. [South_A1_HCA21]

Aftermath situations were also differentiated by whether or not family members were present. For some HCAs, there was considerable emotional engagement with families, the emotions expressed by families sometimes acting as a trigger for the expression of the HCA’s emotions, or encouraging HCAs to provide emotional support for family members:

*It’s the families, if anything like that happens and I’ve got close to the family, it’s the families that make me cry and things like that because how emotional they are, and they're trying to talk to you and they can't hold it back, and it's like now I’m filling up. But yes, that’s the only bit that gets me; I sometimes feel that I have to walk away. [North_HCA4]*

*Nothing really can prepare you for the death and nothing can really prepare you for the way, you know, the relatives don’t want to go home, the way they need to be talking and*
sometimes they just need to go over it and over it, whether that be the death or just the fact that they've been given certain news and you just need to be there. [South_B1_HCA14]

**Personal.** More significant in the aftermath stage were the HCAs personal circumstances. Clearly HCAs varied in their personal preferences for dealing with the aftermath of death experiences on their own, with a privileged colleague or more generally within the team. These differences were not solely driven by personal disposition, but sometimes related to the level of support available to the HCA beyond the workplace, usually in a domestic context. A significant proportion of the HCAs, close to a half, expressed some difficulty in ‘switching off’ at the end of a working day. This difficulty was not solely related to death encounters, lying in the more general stresses associated with caring work; but it did become particularly acute in the context of such an encounter.

_Sometime you take you work home, you think about it and you're thinking about patients..._The one night I went in at ten o’clock from here thinking this patient would pass away he was really, really poorly, and then I got to work and soon I looked in to side room and he was still going. You know, you have this in your mind; he did pass way eventually. [Mid_A_HCA5]

_I do think sometimes I wonder how, I wonder if that gentleman, you know, survived the night or, I do think about things like that. [North_HCA9]

_You just kind of deal with it somehow, you go home and have a lot of tears sometimes._ [South_A1_HCA25]

For the HCA with heavy domestic responsibilities such residual workplace concerns were more readily overtaken at the end of working day. However, where they continued the availability of a supportive family member was a significant influence on the expression and management of emotions:

_I did cry because I got used to [the patient who died] and she was really lovely. So when I went home...my mum said you're going to feel emotion but remember it’s a good thing they’ve gone to rest, and she said the more you come across it the better you'll deal with it._ [North_HCA11]

**Management**

**Meanings.** It is clear that HCA experiences of death are deeply embedded in situational and personal circumstances, with attempts to manage or cope similarly tied to the nature of the episode. However while it remains difficult to abstract coping techniques, a number of coping patterns emerged. One related to the meanings attached by death encounters by HCAs. These personal interpretations served different purposes: they were primarily oriented towards helping HCAs cope with the episode by helping to generated more manageable emotions; but they could also be the basis for personal work related rewards.

The first interpretation might be summarised as patients were ‘old, had led a long life and were prepared to go’:

_They're old, a lot of them they want to go anyway, they find that I’ve had enough, leave me a lone, don't feed me, I don't want to, and I've had enough, I want to go. And it's like, there's like a few I have, patients of my own now say to me “leave me, I want to go”. And I have to accept their wish like that, I can't say “oh no, now come on, come on”, you know, I can’t do this._ [South_A1_HCA23]
You have to bear in mind that on this ward most of the people that die are elderly, so it’s really sad but there is a kind of naturalness too. [South_B2_HCA2]

I do cry, which is a lovely normal thing to do. Normally, well actually through the years you get on with things like that, you seem to, you know that they’re old, a lot of them they want to go anyway, they find that I’ve had enough. [South_A1_HCA 23]

The second interpretation relates particularly to last offices, and has already been alluded to in dealing with the body after death. It might be labelled dealing with death as an extension care. This interpretation is noteworthy in highlighting how different meanings attached to the same tasks could generate very different emotions. For some HCAs undertaking last offices was seen as one of the most ‘unpleasant’ aspects of the role.

[The most unpleasant part of the job] at first, was like washing, you know, the people who had died. I couldn’t do that, well I could do it but I used to think “oh gosh, this is terrible”. [Mid_B_HCA4]

However, those HCAs who viewed last offices as an extension of care, indeed a final closure on the care process were able to present it as an ‘enjoyable’ part of the job:

I enjoy doing it, that’s an awful thing, isn’t it, but I think it’s the last thing that you can do for somebody if you’ve looked after somebody for a long time. [Mid_B_HCA6]

I really enjoy doing last offices… It’s the last thing you do for the patient, the last bit, if you do it right, it’s dignified. [Mid_B_HCA2]

I do like to do it and people find that really, really strange. And I’ve said if I’ve looked after a patient for x amount of weeks or x amount of months, then I think laying the person sort of to rest is the last thing that you can do for them. [Mid_B_HCA6]

A third interpretation might be described as the need to care to the family after the death of the patient: caring was seen as extending beyond death not only in dealing with the patient after death, but also in providing for the remaining friends and family members. For instance, the ‘tidying up’ associated with last offices was sometimes presented as being more for family’s than the patient’s benefit. Indeed, there were instances where HCAs transferred their direct care from the patient to the family members in the immediate aftermath of the death.

We’ll make sure they’re all presentable, then their family’ll come in and sit a bit and obviously they’ll want to say their goodbyes and stuff. [Mid_B_HCA10]

I have had comment on the way that I sort of dress the room, and I always treat it as though that could be my relative. And I would like their relatives to come in and find a room how I would like to find it – everything cleared away, no scattered things, the locker dressed, flowers, and I will dress that room how I would expect to walk in and find my relative. [Mid_B_HCA6]

It was good to be able to make sure that you looked after them from after they passed away, I was glad to know that I was there to, you know, make sure everything were ready, they were clean for the family to come look at them. And it’s awful but it’s quite nice to know that I made them, at such a horrible time for their family to come and see them, because a lot of families do want to come and see them after they’ve passed away… And like there was one family that came in and I sat with them and I had a cup of tea and they were OK then. [North_HCA13]

Finally, there was a bundle of interpretations, in the form of coping devices, in dealing with death related tasks, particularly related to last offices. These might be characterised as imparting imaginary features or qualities to the deceased. Thus HCAs noted how they were
able to deal with the situation by continuing to talk to the patient, by imagining the patient could still see or feel or by assuming that the patient was simply asleep. In one of our focus groups an ex-patient recalled the example of an HCA who coped by singing to a patient who had recently passed away, also an instance of last offices being undertaken as an extension of care:

I just imagined [the deceased person] was asleep and I was fine. [Mid_A_HCA-14]

Laying patients out there’s part of that I really hate and that’s when they cover their face up with a sheet… I’ll talk to them right up until the time they pass and then I’ll apologise when I pull it over. [Mid_B_HCA1]

I know it sounds daft but I still talk to them as though they still alive; it’s how I deal with it. I just sit there and oh well them asleep, I’ll just carry on. I know it sounds daft bit it’s the only way that I can properly get my head round it. [Mid_B_HCA10]

We just treat them the same as if they were alive because you never know, they might be listening. [North_HCA14]

I cope because when we’re washing someone or laying them out, I talk to them as though they’re asleep…I tell them what I’m doing, because you just suddenly can’t start undressing them and sort of pulling people about just because they're not able to speak or hear you, and I just feel comfortable by, by saying to that person what, what I'm doing. [North_HCA8]

Feelings and Displays. Another management theme is associated with the traditional ground for emotional labour debates, felt and expressed emotions, and in particular the relationship between the two. There was a difference of view amongst HCAs as to whether the emotions felt became muted and tempered with experience. For some HCAs there was a ‘hardening’ over time, a stifling of genuine feelings; while for others the emotional difficulties of dealing with death were ever present.

[The patient] passed away and [the Sister] in charge said “have you ever done one” [last offices before] I said “no”. She says “come on, you can come with me”…She did take me under her wing, she was very good. And I cried all the way through it. That’s really bad isn’t it but I got over that and the second time wasn’t so bad… I mean one Christmas we had eight deaths and my job Christmas afternoon was laying people out. [Mid_B_HCA1]

You don’t get hardened to it you just protect yourself from it a little bit…I mean there’s been a couple of time when I’ve had to run off the ward and cried and bit and then come back…It’s hard; it took a while to get used to. [Mid_B_HCA10]

The first time that happened I was really upset, that really, really upset me and the first cardiac arrest…but you kind of get used to it. [South_B2_HCA4]

There was a more general agreement that whatever the emotions felt, they were not appropriately expressed on the ward, especially in front of family members.

[Other staff members] can see that if I’m upset I have to leave. [Mid_B_HCA12]

The control of emotions was, however, rationalised in different ways. ‘Being professional’ was presented as one justification for not displaying emotion on the ward:

You get to know all the patients if they’re in for a while and sometimes…you get quite emotionally attached…because you’ve got to know them but then… it’s difficult really and you’ve got to maintain a professional approach and keep your distance really. [North_HCA3]
Obviously a professional basis on the ward you try to control them although occasionally you can’t, and then you might go home and have a good cry, you know, a glass of wine and then start again. [South_A2_HCA12]

We’re just told we have to be professional at all times so… [South_B1_HCA14]

For others, the absence of emotional displays was a matter of respect and selflessness: as one HCA noted, death and dying were not about the HCA, but the patient and relatives, with any display of personal emotion by the HCA likely to detract from this fact:

Emotionally involved with a patient, yes, especially when they are sweet and, and if they are dying, especially on [ward name] because the first death I had on [ward name], the family were so nice, they were really lovely, so we got to talk to them as well, and when the mother died it just hit me. I was crying my eyes out, I thought “oh no”…I try and be a bit tougher, I felt that I’ve got to keep going, so I’ve got to keep doing my job, I’ve got to be there for somebody else. [South_A1_HCA10]

It doesn’t often happen that I get attached; because once you become attached you’re not able to see the full picture. [South_A1_HCA21]

There is a part of me that just thinks that to pretend that I would have the same emotions as a family member is wrong, you know, I can care without building my part because then it becomes about you, it’s not about the patient. [South_B2_HCA30]

DISCUSSION AND CONCLUSIONS

In recounting HCA experiences, this paper has sought to highlight the understated link between dirty and emotional work, and in doing so to stress that ‘physically tainted’ labour, which involves dealing with death as a routine part of working life, is distinctive and likely to engage a range of personal feelings. In a hospital setting, the comfort provided to and the intimacy developed with the dying patient, allied to uncertainties about health outcomes, might be expected to generate intense emotions within the nursing workforce. At the outset it was suggested that these were likely to be particularly intense amongst HCAs. Not only has the social organisation of hospital care placed this combination of tasks, responsibilities and consequent emotions within the nursing process, but recent public policy developments in Britain, have propelled the HCA rather than the nurse to the fore in dealing with them. In describing their encounters with death and dying, this intensity of experience has been confirmed, but the nature of this emotional engagement, whether it enriches or degrades, has emerged from the findings presented as closely related to the form, circumstances and management of the encounter.

More specifically, in seeking a fuller understanding of HCA encounters with death, the paper has highlighted a number of points. First it has suggested that such encounters are holistic episodes with a defined shape comprising a prelude to, an engagement with and an aftermath to death. The shape varies according to the integration and compression of these stages, the northern HCA providing an example of a highly integrated and compressed episode, with scope for more fragmented and extended encounters.

Second, it has been stressed that these episodes are heavily sensitive to context, comprising in part the situational but also the HCA’s personal circumstances. In short, the nature and experience of death have been revealed as highly contingent. At different stages a range of situational factors have been seen to affect the HCAs’s engagement with dying and death: the age of the patient, the presence (or not) of patient relatives and friends, the suddenness of the
death, the support available from on-ward colleagues during last offices and in coping with the emotional fallout. Equally significant are the HCA’s personal circumstances: what the individual HCA brings to the situation from beyond the workplace. Alongside personal disposition, the HCA’s experiences of caring, of illness and death in their own lives, the level of emotional support available from friends and family, the presence or not of domestic distractions, have all emerged as contributing to the perceived character and impact of the death encounter.

Third, the paper has suggested an important relationship between the shape and context of an HCA’s encounter with death and the way it is managed. The management of such an encounter has been seen as dependent on the meaning given to it by the HCA, with this meaning in turn deeply embedded in the personal and the situational: for example an HCA who has lost a young daughter is seen to engage with death and the dying in a very different way to an HCA who has not. In a more general sense, differences in meaning have been revealed as provoking very different emotional responses to death. This is clearly illustrated in the case of last offices, this same activity being seen as both ‘the most’ and ‘the least enjoyable’ aspect by different HCAs depending on how they viewed it. Thus, those HCAs who have been upset by last offices and disturbed by some of the associated tasks have been unable to impart any meaning beyond the simple (and ‘unpleasant’) physicality of process, viewing it as a literal and metaphorical clearing-up in the aftermath of death. Other HCAs have interpreted last offices as an extension of care, the final act in the care process, and been able to find closure and dignity in undertaking this process.

The management of the death encounter has also been seen as influenced by a number of widespread but relatively informal, ward-based norms. In the absence of strong and explicit ‘feeling rules’ in the three hospitals trusts, there was little to suggest that HCA emotions were managed in what Bolton (2005a) has labelled pecuniary or organisationally prescriptive ways. Indeed in such circumstances the fairly spontaneous release of emotions to the dying and to remaining friends and family members after death corresponds more to Bolton’s notion of emotional expression as philanthropy or ‘gift’. At the same time, there are ward level expectations related to the regulation of emotions, typically the importance of controlling them in a public arena, with the regular references to ‘professionalism’ as a means of justifying such control perhaps a testament to the disciplining nature of this rhetoric. Equally, such control might also be seen as manifestation of ‘gift’. The views expressed by HCAs suggested they could give by withholding. In the context of a patient’s death, the withholding rather than the display of emotion was sometimes seen as the best means of supporting and showing respect for the situation and its main actors: the patients, their friends and families.

REFERENCES


