

A missing link? The role of mortuary staff in hospital-based bereavement care services



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Abstract: In this paper we argue that anatomical pathology technologists (APTs) have been overlooked as a key group of healthcare practitioners who play a role in bereavement care. Drawing on an ethnographic case study of a mortuary team in a large urban hospital, we examine the technical and emotional components of the APT role, including how the concept of patient care is utilised in the mortuary. We argue that their work with other healthcare practitioners and professionals illustrates how APTs offer a 'bridge' between the immediacy of a death, after-death care and subsequent viewing of the deceased person, thereby providing a vital and under-acknowledged service for bereaved people. We conclude that through education and the promotion of mortuary activities APTs are developing a 'community of practice' that moves beyond an outdated perception of 'dirty work' towards a more enlightened vision of mortuary settings and APTs as important components of hospital-based bereavement care services.

Key words: Anatomical pathology technologists, bereavement care service, community of practice, hospital mortuary, ethnography, dirty work.

A small number of published accounts have examined the organisation of mortuaries and the role of mortuary staff around the world (see Cahill, 1999; Gassaway, 2007; Timmermans, 2007; Brysiewicz, 2007; van der Geest, 2006; and Horsley, 2008). To date, comparable insight into UK mortuaries and the staff who work within them is missing. The closest available is arguably a series of interviews with pathologists about their work (see Armstrong, 2008), although these are as much biographical accounts of the pathologists themselves as what they practice. What exists on 'behind the scenes' of the contemporary UK mortuary has come from observational photography (Grant, 1999) and an autobiographical book (Williams 2010), neither of which empirically or theoretically address the way in which mortuary staff manage both deceased and bereaved people. Elsewhere, the projects in the Kings Fund Healing Environments for Care at the End of Life (2008-10) (Kings Fund, 2011) highlight the impact and significance

of the hospital mortuary viewing room upon the memories of bereaved people. However, the professional practice and identity of those who work almost exclusively within mortuaries, 'anatomical pathology technologists' as they are called in the UK (APTs), is largely invisible in this and other existing literature. Moreover, their broader contribution to bereavement care in the UK to date has not been articulated.

This oversight is despite the fact that there is considerable Department of Health (DH) guidance on good practice in hospital mortuaries and ways in which mortuaries and their staff ought to be integrated into wider bereavement care services (see DH 2005; 2006; 2010a; 2010b; 2010c) A few years earlier Fauri *et al.*, (2000) advocated the benefit of bereavement care services in acute settings; elsewhere cases have been made for integrated bereavement care services in hospitals (see Walsh *et al.*, 2008; Walsh *et al.*, 2013). Within recent end of life care policy mortuaries are mentioned in the National End

of Life Care Programme (2011a) guidance *What to do when a person dies*, and the ability of mortuary staff is acknowledged briefly in the document *Guidance for staff responsible for care after death (last offices)* (National End of Life Care Programme, 2011b). Clearly, policy and guidance intends the creation of an integrated bereavement care service which includes mortuary staff as part of a multi-disciplinary team. Despite this, a DH report (2010c) concluded that the majority of bereavement care is currently provided through hospices and palliative care services, with hospital bereavement services the result of 'local champions' (p2) rather than a systematic incorporation into healthcare services. The need for detailed empirical evidence on how APTs contribute to bereavement care partly underpinned the rationale for this small-scale study.

Set within this context, this paper reports the findings of an ethnographic case study of a mortuary and bereavement care services team in a large teaching hospital in the UK. Drawing on interviews with APTs and the wider bereavement care team, we consider the contribution of APTs to bereavement care services, including the technical and emotional components of the APT role, such as the reconstruction of the deceased person following post-mortem and their interactions with bereaved people. We argue that APTs provide a 'bridge' between the immediacy of a death and any subsequent viewing of the deceased person, and that this is a vital service for recently bereaved people the value of which is beginning to emerge. We conclude that through education and the promotion of their activities, APTs are developing a 'community of practice' that moves beyond an outdated perception of 'dirty work' in a mortuary, to enable a more enlightened vision of the work of this setting as an essential component of hospital-based bereavement care services.

Study context

The policy context of bereavement care highlights the significance and lasting impact of bereavement care immediately following a death in hospital, and the need to include the care of the deceased person in any pre-death planning decisions. Guidance on good practice in hospital-based bereavement care services followed the launch of the DH Pathology Modernisation Programme in England and Wales in 1999, subsequently underpinned by the National Pathology Service Improvement Programme (as part of the NHS Improvement – Diagnostics scheme). In 2013, the UK Association of Anatomical Pathology Technologists (AAPT) formed an alliance with the National Bereavement Forum highlighting bereavement care as a recognised part of health care delivery at this post-mortem level. Despite this progress, reasons for the lack of formal recognition of the APT role in bereavement care are multifaceted, not least owing to the stigma associated with working with the dead, and here we explore some of these tensions with a particular focus on bereavement care.

A brief history of the APT role shows that it was not formalised until 1962 when it came under the remit of the Royal Institute of Public Health. Prior to this, there was limited health-related organisational interest in the training of APTs (Burnett, 2004). Most of the mortuary staff working in hospitals were employed as mortuary attendants, assistants or porters and trained on an *ad-hoc* basis by pathologists and more experienced attendants. In efforts to standardise mortuary work and promote good practice, the *Handbook of Mortuary Practice and Safety* was introduced in 1991 by the Royal Institute, (now called the Royal Society for Public Health following a merger with the Royal Society for Health in 2008). Updated in 2004 by Burnett, this publication identified the APT's job as relating to '... all matters pertaining to the deceased while the body is in the mortuary and... to assist the pathologist during post mortems as well as to ensure the smooth running of the mortuary' (Burnett, 2004, p5).

Seven hundred APTs currently work in NHS, Local Authority and Public mortuaries around the country¹. Since 2003, the AAPT has represented APT members and campaigned for wider professional recognition of the occupation, partly as a response to the development of the Healthcare Scientist role within the NHS (DH, 2010a; 2010b). There are also two qualifications for APTs provided through the Royal Society for Public Health (RSPH): the Certificate and Diploma in Anatomical Pathology Technology. These are accredited by the Royal Society for Public Health, but not compulsory for practice.

At the same time, theoretical perspectives on grief which inform the needs of bereaved people and expectations about the delivery of services to support them continue to evolve. Many bereavement theories have advocated that viewing the body of the deceased person is a key component of facing the reality of death as part of the process of grief resolution (Worden, 1991; Parkes, 1986). Indeed, Worden's seminal work on grief positioned this acceptance as key to 'letting go'. However, the work of Silverman and Klass (1996) shifted this thinking to include a recognition that bonds continue after death and the process of letting go is **not** an essential feature of 'successful' grieving. The role of viewing the deceased person is therefore not clear and empirical evidence suggests that any benefit is varied. For example, a recent study by Chapple and Zieland (2010) into the usefulness of encouraging relatives to view people following traumatic death revealed a diverse range of reactions both from people who chose to view the body and those who did not and the impact of this on the bereavement process. However, their data revealed that people view the deceased person for a myriad of reasons – the main ones being to say goodbye, to make sure there has not been a mistake, to retain the caring role, and out of a

¹ The organisation of mortuaries is highly localised, with some based in hospitals and others in standalone facilities.

sense of obligation. Indeed, people may not want to view the deceased at all. The authors concluded that there is no substantive evidence to show the helpfulness or otherwise of viewing, thus, regardless of the competing perspectives of what grief resolution might mean, viewing can help some bereaved people to face the reality of loss and equally facilitate continuing bonds between the living and deceased.

The sociological literature on the dead body suggests that those professionals involved in viewing typically take pride in the presentation of the deceased person. Further, Hallam, Hockey & Howarth (1999) interpret this as follows, '(M)orticians work to produce a visual representation of the living person which corresponds to a remembered image of the embodied self of the deceased' (1999, p126). They also suggest that this type of work enables an extension of the relationship for bereaved people by attempting to make them look lifelike and recognisable as the deceased person (see also Harper, 2010). In this way, the professional who is involved in post-mortem care also develops a relationship with the deceased person. Later, as the data show, even when no-one wanted to view the deceased person in the mortuary, the APTs regarded it as important that the deceased person should look presentable so that their dignity was respected; highlighting the perceived intrinsic value of their work.

Yet the fact remains that APTs are working with potentially difficult matter as the dead body can be a problematic object in any setting and represents a multiplicity of phenomena, many of which are diverse. The anthropologist Douglas (1984) has highlighted how the dead body can be dangerous and has the capacity to be both materially and symbolically contaminating. Hallam, Hockey & Howarth (1999) argue that the dead body becomes the material reality of death. While academic theorising such as this provides useful insight into the challenges presented by the dead body, the reality in a hospital environment is that it has to be managed, and the hospital mortuary is the space set aside for different forms of management. Whether it is through the safe keeping of the body, an exploration of the body to try to find the cause of death, the care of any tissue samples following post-mortem or presenting the deceased person to relatives, the ultimate responsibility for its care and safe keeping when in the mortuary falls to the APT.

Through this interaction with the dead body the job of the APT is stigmatised as dirty work given its direct and intimate association with dead people (Gassaway, 2007; see Hughes, 1962; Goffman, 1963 for discussion on dirty work and stigma respectively). This has been examined extensively in both anthropological literature in relation to the polluting nature of the dead body (see Douglas, 1984), and in sociological literature on the agency of the corpse (see Hallam, Hockey & Howarth, 1999; Harper 2010). We argue here that through these activities listed above the

APTs in this hospital were moving beyond the 'dirty work' (Gassaway, 2007) associated with handling dead bodies through fostering a community of practice.

Coined by Lave and Wenger (1991) the community of practice (CoP) model is a means through which to understand and build a cohesive body of people with experience, expertise and knowledge. Through emphasising common interests, goals and practice within a particular community of people, this approach is founded on the proposition that connecting people through learning and sharing is a constructive way of establishing credibility. As we hope to show in this paper, while not explicitly using the CoP model, the APTs in our study have been going to lengths to create such an environment within their mortuary, and there is the potential for rolling this out to hospital bereavement care services around the country.

Methodology

This ethnographic case study was funded by the British Academy and took place over a 12-month period. Its aim was to examine the role of the APT, especially the public/private interface of the mortuary service, and how APTs interpreted their occupational identity. We took a sociological approach to shed light on a largely concealed service that had not been systematically associated with more mainstream bereavement services or literature.

The ethnography involved periods of direct observation and semi-structured interviews with APTs, bereavement care officers and service managers. We sought and obtained NHS Ethics approval through IRAS and attendance at an ethics panel. A total of five days of observation was spent in the mortuary and eleven members of staff were interviewed. In accordance with good ethical practice (see British Sociological Association, 2002) written information on the project was sent to the unit in advance and given again at the interview. Signed consent to both the interview and observation was obtained at the commencement of each interview. All interviews were transcribed and sent to the respective participants for validation and all data was secured according to the Data Protection Act (1998). A simple themed analysis from codes generated by the interviews was used to analyse the data. To keep the identity of the participants confidential according to good research practice (BSA, 2002), names have been changed.

Overview of the study setting

In keeping with the ethnographic tradition, it is important to briefly acknowledge the setting in which the research took place. The study was conducted in the mortuary of a large, metropolitan teaching hospital, which served a widely diverse population in terms of economic status, age and ethnicity. On average, every week the mortuary received 25 deceased hospital patients and conducted 10-15 post-mortems (PMs).

The mortuary also served as a referral centre for specialised post-mortem examinations including high-risk cases. Staff conducted approximately two PMs per day (Monday-Friday) with the mortuary operating from 8am – 4pm; although APTs often stayed longer to either finish PMs, clean the PM room, and/or to complete and process paperwork. Additionally, the mortuary offered an out-of-hours service provided by senior APTs on an on-call rota, who were available to provide advice and assistance to hospital and external staff, such as funeral directors, 24 hours a day, 365 days per year. This might include attending the mortuary for any viewings and/or forensic/coroner PM examinations.

The study participants were part of the bereavement services provided by the hospital and the head of service had campaigned successfully for their inclusion into the existing bereavement care team. At the time of the study, working in this mortuary was: the Service Manager, the chief APT and mortuary Manager, two senior APTs, one trained and two trainee APTs. They were supported by three bereavement officers and an office manager, also an APT. Four participants were men and seven were women.

The mortuary was principally split into two sections, the PM room and the fridge area. The atmosphere and layout of the PM room was one of clinical order and cleanliness. This contrasted with the noise and activity of the fridge area where numerous people went about their daily business. These people included doctors, porters, cleaners, and funeral directors. It was quite clear that the situation and design of the mortuary predated the inclusion of the work that took place there as part of bereavement care. For example, most space was allocated to the storage areas and PM rooms, material evidence that storage and dissection were more important aspects of mortuary work than providing services for bereaved visitors. The size of the waiting area and the comparatively small size of the viewing room indicated further that when the mortuary was designed it was anticipated that more time would be spent in preparing for and recovering from viewing than viewing itself.

The findings

As one of the first studies of its kind in a UK mortuary, the findings were wide ranging, and have been documented more fully in Komaromy and Woodthorpe (2011). Owing to the remit of this journal, here we focus on the contribution of the APT to bereavement care.

Managing emotional and technical demands

The APTs in the study displayed a high level of awareness of themselves as key personnel in the hospital's bereavement care services team. They were responsible for the reception, release and transfer of deceased patients to and from the mortuary. In conjunction with this, they were also responsible for their safe handling while there, including the management of viewings.

At interview, some of the APTs told us they were more adept at dealing with newly bereaved people while others found providing clinical information in an empathetic way more difficult. This was exemplified particularly well by a participant who reflected:

It's like an odd mixture of trying to sound sympathetic but also trying to be really clinical. (Amanda)

Another commented on the type of questions that could be asked at a viewing and the skill required in providing information that meant bereaved visitors to the mortuary would be satisfied with the service:

... sometimes you find a patient passes away in A&E for instance. [The family] come down to the mortuary, and sometimes they look at the patient [and are] like, 'Why are they looking like this? It is your fault', kind of thing. You can understand the person is bereaved at that moment, a lot of things are going through their heads. So it is just knowing that someone is happy with the service that we can give them, and if there is anything else we could do for them. (Aaliyah)

A method to manage the emotional component of their job through dealing with bereaved people was to regard, and articulate, their work as contributing to 'patient care'. In particular, this meant calling the deceased person a 'patient', and by extension those bereaved as connected to the patient and therefore requiring sensitive care. Their focus in the interviews was that their care of the deceased patient was their prime way of supporting any bereaved family members. As two participants commented,

As far as we are concerned they are all patients, until they leave our back door shall I say they are patients. They are deceased patients, but they are nonetheless patients. (Georgie)

People don't seem to understand that this person is still a patient until they leave our care, they are still a patient to us. (Lucy)

We argue that identifying the deceased person as patient rather than a body was a highly symbolic effort to 'join up' the work of the mortuary with the rest of the hospital, ensuring that the deceased person remained a patient of the hospital until they left the premises. Moreover, identifying the deceased as a patient was a frame through which viewing by bereaved people took place.

However, at the same time substantial periods of the APT's time was spent on clinical, scientific and technical tasks associated with clinical pathology work in the PM room, and where staff spent a considerable part of their day and where most of their training was focused. For example, the PM work involved APT staff in preparing the deceased person for the procedure and conducting the evisceration. When the PM was complete, the APT was responsible for

the reconstruction of the deceased person, the thorough cleaning of the PM area and the labelling, recording and despatch of the many specimens taken during the PM. All the APTs we interviewed spoke about how carefully they worked after the PMs to make the deceased person look good enough for viewing. Many expressed their enjoyment at the PM element of their job:

The best bit of my job? The post-mortems... I do love the fact that I take pride in taking care of my patients. You know, I would be mortified if I came into a viewing room and somebody had bits of tissue sticking out their nose that families could see and it is the patient care side of it.... I love also taking pride in how neat my suturing is, you know, I put the utmost effort into making sure that I do the smallest amount of sutures possible and make sure my patients are clean and dry and dignified.... the majority of it is the patient care for me. (Emma)

The APTs were clear that they actively tried to not objectify the deceased person at any time during the PM process. However, this dual role of both reconstructing the deceased patient and dealing with their bereaved family and friends was an emotionally demanding task for the APTs we interviewed and all were aware of each other's preference for PMs or viewings. Through sharing this experience and preference, we argue, they were implicitly generating a work environment that fostered empathy and understanding in the face of diverse expectations within their role. In other words, through the act of involvement within one another, they were moving towards a CoP.

Relationships with others

The mortuary staff came into contact with many others through their clinical role. For example, medical staff sometimes came to certify deceased people in the mortuary, relatives attended for viewings and funeral directors collected deceased people. Their main contact with the public was with those who chose to view their deceased relative. It was the APT's responsibility to prepare the deceased person to be seen in the mortuary, and to be present during the viewing. If a patient had died on a ward, the protocol was for a ward nurse to meet any relatives and take them to the mortuary for viewing. However, this could be difficult as the mortuary, and by association the bereavement care services team, was sometimes regarded as a reminder of the fallibility of medicine, as Alex noted:

Often the medical world will see it [the mortuary] as a failure, a failing. Something has gone wrong and its negative, they don't want to always be reminded of that.

As the literature on dirty work suggests, an association with death could be isolating for the APTs, to the point at which

they went to other hospital departments and were treated with caution. As one APT explained:

(I)t's that whole attitude or ethos that you come to the hospital to get better and when the idea of people dying gets pushed in their faces I think potentially that's when people kind of possibly freak out a bit and go 'oh shit that might happen to my relatives'.... I mean loads of staff won't even set foot in the mortuary. (Georgie)

Further, the stigmatising effect of the mortuary and by association APTs, indicated an underlying belief among those interviewed that death should be obscured in the hospital environment, reflected in the DH guidance document *Care and Respect in Death* (2006) that states that bodies being moved to and from the mortuary require to be concealed from public view as much as possible.

To try to counter such stigmatisation, APTs promoted the visibility of the function of the mortuary, as well as the importance of patient care and continuity in the provision of bereavement care services. Similar to the invisibility of mortuaries and APTs in literature on bereavement care services, one interviewee reflected on the invisibility of the mortuary and APTs in the ethos of the hospital:

I think basically we are just a place that nobody talks about and [people think] we are just there to move patients from place to another. I don't think people actually know what we do. (Helen)

In response to this, the APTs promoted the work of the mortuary and bereavement care team by going 'out' into the hospital and participating in different forums, including formal and informal meetings. For example, APTs regularly attended meetings for trainee nurses, where they would show photographs of the APT team to discredit the idea that mortuary staff were either, what they called, 'the death squad' (Georgie) or 'morgue dwellers' (Lucy). They actively encouraged student nurses to visit the mortuary to raise awareness of what bereavement care services consisted of and how nurses could incorporate this into their practice:

We get student nurses in, nurses that have already been here, that are interested in the specific side of the education for bereavement, mortuary and bereavement, who we are, what we do, why we do it and how has that impact their work and how can they improve what they are doing, and build up relationships with us. (Steve)

Encouraging relationships with healthcare practitioners and professionals outside of the bereavement team was principally about demystifying the work that took place in the mortuary and the role of APTs, overcoming what one APT referred to as the 'CSI effect':

It's the CSI effect I think a lot of the time these days... to be able to educate other people in what we do and how

then to educate the families and help them is of great importance to us. (Emma)

Through these actions, in keeping with the CoP model, APTs were deliberately and consciously sharing best practice and building an interest in their work. Another key facet of being able to promote the role of the APT, and by extension their CoP, was through developing their professional training, status and recognition. All APTs at this hospital were required to possess or undertake the qualifications provided by the Royal Society for Public Health. While talking to them and seeing them work we noted their professional pride and high level of commitment which came in part from the senior management support and what they described as good quality staff training.

Discussion: developing a CoP

Through promoting the function of the mortuary and the work of APTs in handling both the deceased patient and bereaved visitors, the staff in the bereavement care services team were committed to establishing and making public the need for their services. They were also pioneering a new professional status by focusing on their role in bereavement care expressed through the concealed work within the mortuary setting and the safe discharge of the 'patients'. Fostering their own CoP, they were making efforts to establish, boulder and promote a cohesive knowledge base that involved both emotional and technical skill.

It is perhaps unsurprising that our data showed a seemingly disproportionate focus by APTs on viewing. The role of the APT in terms of caring for deceased people and the significance of this service for bereaved people in hospital seemed to be expressed at the moment of viewing. It is not the case that all deceased persons were viewed – but APTs have to assume that everyone will be viewed since it is the right of close family and friends to do so. Further, as Howarth (1996) argues, preparing the deceased person for a viewing following a death and /or post mortem was an essential feature of this part of their role insofar as the deceased person needed to look 'good'. Data from the APTs highlighted how the appearance of the deceased person was a consistent source of professional pride. We argue that in an occupation struggling to find professional recognition the viewing was the public part of their role where they met with bereaved relatives and visitors to the mortuary, and showed off the visible outcome of their work in *continuing* to care for the deceased 'patient'. This was the point their CoP became public.

In the process of establishing an occupational identity and through associating themselves with 'patient care' and bereavement services, the APTs and the mortuary practices more generally, positioned their practice as contributing to a chronological process of NHS-delivered support for patients and their families/friends. In other

words, at the interface between death and bereavement, APTs regarded their service as a vital 'bridge' between pre- and post- death in the hospital setting. In terms of continuity of care repeatedly emphasised in DH guidance and policy, we argue that APTs provide an overlooked component of bereavement services. Through nurturing their own CoP and as a result raising the profile of the role both professionally and with bereaved people, they were going some way to challenge and reduce stigmatisation associated with working with the dead body (Komaromy and Woodthorpe, 2011).

Returning to the CoP model as originally conceptualised by Lave and Wenger (1991), in which a group of people with collective interests and vision combine to form shared practice, the work of the APTs in our study fits well. We argue that within the frame of protocols and procedures, the APTs as members of the wider bereavement team were establishing and promoting a positive occupational status within the hospital through promoting good practice and their skillset to other healthcare practitioners/professionals. However, at the time of the study the extent to which this was a success in the wider setting of acute patient care was debatable, as one participant commented:

The sad thing is, sometimes I don't think we've got much of a status, because I think that in the healthcare system, nurses and healthcare assistants and doctors don't really think of APT's. They sort of think, the patient is dead, they are not patients anymore, they don't need looking after. I think some people think that our job is pointless, because you know, why does a dead person need to be cared for? I think that's the mentality of some people, but then I think that once it's explained to people they understand. (Lucy)

Stigmatised by their association with dead bodies and representing the failure of medicine and healthcare to keep the patient alive, APTs at this hospital were thus facing an uphill battle to be regarded as part of mainstream healthcare services. We argue, to evolve their emergent CoP their activity was developing in two key ways. First, in ensuring that all APTs were either qualified or studying at this hospital, emphasis was being placed on the technical skill involved in their work, evidenced through their academic study. Second, by closely aligning themselves with bereavement care services within the hospital more generally, they were promoting an integrated vision of bereavement care that included the mortuary and its staff, at the interface between the death of the patient and recently bereaved people. Within a 12 month period it was not possible to assess in this study the success of these endeavours, but we suggest that they are ripe for further exploration. Moreover, as strategies to address the stigmatisation that can accompany the APT role, there is considerable scope for these to be transferred into other hospitals.

Conclusion

While much of the emphasis on establishing the credibility of the APT role is founded on technical skills associated with PMs (see Komaromy and Woodthorpe, 2011), there remains considerable scope to cement the APT role within processes of the hospital bereavement care services and validate their membership of multi-disciplinary bereavement care teams. As this paper has illustrated, a key method by which to do this is to regard the deceased person as a 'patient' until they leave the hospital premises. We argue that through overtly connecting the patient in the mortuary to the rest of the hospital services, APTs were establishing their occupational activities as part of patient care. Furthermore, through generating good practice with bereaved visitors and sharing this with other occupational groups within the hospital, such as nurses, they were establishing a 'community of practice' that both created and validated their contribution to bereavement services.

Considerable barriers to APTs being valued as a legitimate part of patient care remain; not least their association with dead bodies and their stigmatising impact. Our study findings show that by more closely aligning and recognising APTs within hospital bereavement care services, developing a CoP that acknowledges a discrete skillset, and further recognising their important role in 'bridging' death for bereaved people may allow some of the myths underpinning such prejudice to be confronted.

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