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**Postmortem Care: A Ritual Created by Medical Subculture**

Leia Franchini

*Pacific University*

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Postmortem Care: A Ritual Created by Medical Subculture

Abstract
American culture primarily functions within a scientific belief system, where all phenomena can be explained via the natural sciences, and death is the end of biological life. If death is the termination of life, death is also the cessation of the "American Dream." Subsequently, death becomes an act of deviance and is confined to the medical institution. Traditional American rituals associated with the human corpse have been lost. Healthcare providers are now the primary caregivers to the dying and the corpse. Since death rituals are no longer supplied by American culture, this thesis argues that medical professionals have created their own rituals in the form of medical procedures. This research seeks to understand how postmortem care, a scientifically based medical procedure, is ritualized by healthcare providers to normalize and assign meaning to death in a culture where dying is deviant behavior. Data for the study was gathered qualitatively via participant observation and interviews. The analysis of the data relies heavily on the discipline of thanatology, as well as incorporating theories of symbolic anthropology and social interactionism.

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Postmortem Care: A Ritual Created by Medical Subculture

Leia Franchini

Supervisor: Cheleen Mahar Ph.D

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Abstract

American culture primarily functions within a scientific belief system, where all phenomena can be explained via the natural sciences, and death is the end of biological life. If death is the termination of life, death is also the cessation of the "American Dream."

Subsequently, death becomes an act of deviance and is confined to the medical institution. Traditional American rituals associated with the human corpse have been lost. Healthcare providers are now the primary caregivers to the dying and the corpse. Since death rituals are no longer supplied by American culture, this thesis argues that medical professionals have created their own rituals in the form of medical procedures. This research seeks to understand how postmortem care, a scientifically based medical procedure, is ritualized by healthcare providers to normalize, and assign meaning to death in a culture where dying is deviant behavior. Data for the study was gathered qualitatively via participant observation and interviews. The analysis of the data relies heavily on the discipline of thanatology, as well as incorporating theories of symbolic anthropology and social interactionism.
Introduction

Six thirty in the morning, half asleep and clutching my coffee, I walk into the fluorescently-lit hospital. I navigate my way through the maze of hallways and stairwells to my unit, surgical telemetry\(^1\). The night shift nurses and CNA’s are scurrying around trying to finish their end-of-shift charting.

“Hey Leia, I assigned you the comfort care patient\(^2\), I hope this is ok with you.” I shrug my shoulders as I collect my patient assignment and duty phone from the charge nurse, “I’m ok with comfort care – how close do you think they are?”

“They’ve been comfort care for the last three days, so who knows. I thought you would be able to handle the situation, but if at any point you need to talk, let your charge nurse know”

Seven o’clock, I had completed reviewing my patients’ H&P’s\(^3\) as well as the most current orders\(^4\) submitted by their attending physician and surgeon when the CNA\(^5\) I was replacing asked, “Ready for report?” She looked and sounded exhausted. We made our way to an empty room where Karen informs me of pertinent information for the care of my patients, including, but not limited to how they transfer, behavioral issues, complications, and personality quirks. Finally, she details the status of my comfort care patient. “The patient is non-responsive. We suspect his pain has increased when he picks at the blanket with his hands. He needs turned pm\(^6\). Patient’s only family is his son, who isn’t handling the transition to comfort care. He

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\(^1\) Surgical telemetry, a post-surgical unit that includes heart monitoring for patients with histories of cardiovascular complications.

\(^2\) Comfort care patient refers to a patient that is actively dying and medical staff responsibility is to keep them comfortable through the dying process.

\(^3\) History and physicals – background information on medical condition of patient.

\(^4\) Physician orders essentially direct the care of the patient for recovery and include details on diet, exercise, medications, tests and procedures.

\(^5\) Certified Nursing Assistant.

\(^6\) Medical abbreviation for “pro re nata” meaning “when necessary.”
doesn’t understand why we are still medicating him, and why his breathing is still labored even though we have him on oxygen.”

“Wait, I interrupt, he is still on oxygen? Why and what’s the flow rate?"”

“Yes, Karen continued, he is on oxygen because the son insisted that he remain on oxygen, and the nurse has it set at a minimum of one liter. Like I said, the son is incredibly anxious and not handling the situation well, good luck.”

“Sounds like it should be a fun day,” I comment, as Karen and I walk back onto the floor.

The first thing I did was walk to my comfort care patient’s room. Mr. Smith was lying there, jaw slacked and eyes half-open. His skin was pale and clammy to the touch. I peeked at his legs and feet and notice some mottling, but his nails and lips weren’t tinted blue. I watch him breath for a little, and notice that his respirations are rapid, and shallow. His son wasn’t in the room, so I decide that would be the best time to provide some hygienic care. I wash Mr. Smith’s face and swab his mouth with a damp toothette while introducing myself to him. I check his chart to see the last time he had been turned and noticing that it was around six thirty. I make a mental note and leave to introduce myself to my other patients.

My day flew by as it usually does. I offered bed baths, helped patients to the bathroom, changed linens, ambulated patients, monitored vitals and helped with dressing changes. Every hour I would walk in to Mr. Smith’s room and check on him. I would swab his mouth with a damp toothette, or the nurse and I would reposition him in the bed. Each time, I would count

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7 Flow rate of oxygen references liters of oxygen delivered per minute
8 Coloration of the skin changing to a bluish, blotchy appearance due to the decrease of blood circulation. Usually begins in the lower limbs and progresses upward
9 As the dying process progresses, the senses of sight, smell, touch will gradually decrease, but hearing is understood to be the last available sense to the dying patient.
10 Ambulate is the medical terminology for walking
11 Measures of various physiological statistics including, but not limited to, blood pressure, temperature, heart rate, respiratory rate and pain scale
12 Wound bandages.
his respirations and monitor his pulse. I hadn’t seen his son all day, so I was preparing myself for sitting with Mr. Smith when his time came. Finally, in the early afternoon, I walked out of a patient’s room and see the charge nurse standing in Mr. Smith’s room. She calls me in. “Leia, I think he is close, do you mind staying with him? I’m going to go call his son and let Lisa, his nurse, know.” I nod my head.

I stood by Mr. Smith’s bed and took his hand. It was cold. I noticed his nails were now cyanotic, as well as his lips. He was exhibiting Cheyne-Stokes respiratory rate. As I study Mr. Smith’s face, I noticed that I could see his pulse in his neck. Leaning close I whispered to him, “It’s ok Mr. Smith, I’m here to sit with you till the end, whenever you’re ready to let go, I’ll be here.” A couple minutes later, he let out a breath and the pulse in his neck disappeared. He was gone. Both Lisa and the charge nurse walked into the room. I let them know he was gone. Lisa listened to his chest and nods her head. The charge nurse looked at the clock, and said she would let the doctor know and document the time of death. Lisa and I decided to start postmortem care, and hopefully we would be done before the son arrived since he had let the charge nurse know over the phone that he was half an hour away.

While the nurse removed Mr. Smith’s IV sight, central line, and oxygen, I began giving him a bath, shaving him and changing the soiled linens. We worked quickly but carefully, while continuing to address the patient in much the same way we would if he were still alive.

“Mr. Smith, I’m going to remove your catheter, this may feel uncomfortable, but it shouldn’t hurt.”

“Mr. Smith, I’m going to remove your IV, you’ll feel a slight pinch.”

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13 Tinted blue.
14 Shallow breathing where respirations are staggered between ten and sixty seconds.
15 Medical procedure that involves cleaning the corpse, protecting the corpse from damage and removing medical paraphernalia.
16 Central venous catheter or a catheter placed into a large vein in the neck, chest or groin.
“Mr. Smith, I’m going to shave your face, we can’t have you looking scruffy, now can we.”

“Mr. Smith, I’m going to turn you on your side and change the soiled linens underneath you.”

Lisa and I worked quickly, and we were almost finished when there was a knock on the door. Lisa checked and it was the charge nurse with the son. Lisa let them know that we had to change the linens, and the son could come in. But instead, the son insisted on standing in the room and watching. As soon as the son stepped into the room, both the nurse and I fell into an awkward silence. I had never had family watch postmortem care and found myself upset that the family insisted on watching. I felt as if some sacred moment was being violated.

Lisa and I quickly finished the care, trying to turn the patient without letting his head and limbs flop in unnatural directions. At one point, Mr. Smith’s head bumped the side rail as Lisa and I tried to change the linens, and his son reprimanded us, “Be careful!” I was frustrated. How dare this family member sit in on postmortem care! This was what separated me from him, a medical professional from a lay-person. The son, who had no knowledge or experience of dealing with a corpse, was reprimanding me in postmortem care. I didn’t see him offering to cradle the corpse in his arms while Lisa changed the linens! I was offended. Once we had finished, I gathered all the supplies and mess and quickly left the room.

As we always do, we allowed the son private time with his father. However, two hours after Mr. Smith’s passing, the son was still sitting in the patient’s room. The nursing staff was once again placed in an awkward position. We recognized the son’s need to grieve, but there was also a need to get the body to the morgue and free the bed for incoming patients. While we sympathized for him, we were also responsible for providing care to other patients and finishing
the care of Mr. Smith’s corpse, which required getting the body to the morgue. As horrible as it may sound, we were glad when the son left because we were able to return to a normal flow of nursing.

Lisa and I returned to Mr. Smith’s room to bag-and-tag\(^{17}\) the corpse. This time, rather than being solemn and somber as we felt we had to be during postmortem care, we were more chipper and began laughing at random. We shared stories of our first time providing postmortem care. We stripped the body, signed the toe-tag, bagged the body and transported the patient down to the morgue. Our job was done, and laughing at the awkwardness of the whole situation, we returned to our work and caring for our remaining patients.

As I drove home that night, I thought about the events of the day. I reprocessed the feelings I experienced while providing postmortem care, and then transporting the corpse to the morgue. Why did I feel as if the son had intruded when we provided postmortem care? Part of me felt an attachment to the patient, and even though Mr. Smith was dead, it remained my duty to protect his privacy. Postmortem care is a very exposing procedure. The body is stripped, orifices cleaned, wounds re-bandaged, medical paraphernalia removed. I felt as if the son was violating the patient’s privacy, and preventing the patient from dying with dignity. It was my job to protect the patient from such violations, and the son had defied my authority in this situation. Secondly, postmortem care was a procedure that only medical professionals carry out. It was my chance to reestablish my position as a medical professional, and determine what the death of this patient meant culturally in the medical realm.

If postmortem care was my way of normalizing death and reaffirming my medical professional identity, how many other medical professionals utilize postmortem care or other rituals to cope with the death of a patient? How do healthcare professionals “deal” with the

\(^{17}\) Fill out toe-tag, body bag-tag and personal effects tag and place body in body bag.
emotions associated with losing a patient, whether expected or not, through their work? Do they create rituals out of medical procedures, such as postmortem care, or do they use other methods?

This work takes its lead from these experiences, and investigates the rituals that emerge for medical professionals around the experiences of death and dying.
Literature Review

The Institutionalization of Death

Contemporary American society has removed death from the home and placed it in the medical institution; it is no longer the responsibility of the family to care for the dying, but the responsibility of physicians and nurses (Leming and Dickinson 2007). Michael R. Leming and George E. Dickinson (2007) detail the shift within American society from acceptance to the rejection of death. “Death took place in the home where the dying person was surrounded by family and friends. Today in the 21st century, death more likely takes place “offstage” in institutions – hospitals, nursing homes, and other extended care facilities” (Leming and Dickinson 2007:248). The institutionalization of death has resulted in a loss of meaning and rituals associated with death and the preparation of the corpse for burial. This creates a challenge for physicians and nurses who are no longer socialized to find meaning in death (Leming and Dickinson 2007). Without societal rituals to assign meaning to death, healthcare practitioners must develop their own rituals and meanings for the dying process.

Thanatological research has focused on bereavement among doctors and nurses and the treatment of the dying patient. However, researchers have failed to explore the ritualistic medical procedures healthcare practitioners utilize when confronted by death. Taylor and Francis Group (2006) argue that rituals developed within the medical subculture serve to normalize death in a subculture where dying is a deviant behavior. “Such meaning-making processes result from a normal and adaptive mourning process that every caregiver experiences as a result of encounter and coping with losses both in one’s personal life and throughout the care of the dying and the bereaved” (Taylor and Francis Group 2006:656). But researchers have failed to recognize
medical procedures involved in postmortem care as a ritual developed in the medical institution operating as a coping mechanism for nurses and doctors. My research will examine the rituals nurses and physicians utilize to find meaning in death.

**Physicians and Death**

Social science research presents medical school as the "rite of passage" laypersons must complete to become physicians. Medical school "transforms laypersons into something else — physicians" (Leming and Dickinson 2007:176). As the medical student transitions into a physician, they develop attitudes that influence their behaviors toward medical situations, especially death. What does it mean to be a physician and relate to a dying patient? Robert A. Burt (2002) explains that physicians must remove compassion from their perspective when medically treating patients. Desensitization begins the first year of medical school in anatomy lab. Students learn to "reimagine this person as a collection of organs, muscle tissue and the like" (Burt 2002:90). Not only are students taught to dehumanize the patient, they are socialized to combat death; to seek a cure for the disease. Death becomes the enemy (Burt 2002). Physicians are trained to anesthetize their emotions in order to fulfill medical ideology which focuses on curing diseases and prolonging life. "Death is consequently seen as a professional failure" (Kamerman 1988:63). Medical students are taught how to succeed in healthcare. But often medical training leads to feelings of unpreparedness, and a sense of failure and guilt that accompany the death of a patient (Saunderson and Ridsdale 1999). Although physicians recognize death as an unavoidable part of the biological life cycle, they never fully recover from the death of a patient, due to the lack of socialization on how to deal with the emotional impact the death of a patient may have on them (Hendin 1973).
Nurses and Death

Nurses' attitudes towards death are opposite from most physicians; however, their behavioral responses are the same. Most nurses do not view death as a failure (Leming and Dickenson 2007), rather, it becomes a challenge to their professional and emotional wellbeing. They are expected to meet the mental, emotional and physical needs of the dying patient and the patient’s family, without jeopardizing their role as a professional, and harming their own emotional health (Mendel 1981). They are "called on to perform the impossible: to give completely, yet never lose - as pure vessels of compassion, to provide an endless supply of generic love" (Russ 2005:141). Similar to physicians, nurses feel the need to desensitize themselves, not because they view death as a failure, but because they must take on the responsibility of providing emotional support to the patient and to the grieving family (Ufema 1991).

Desensitization

Research has already shown that physicians and nurses enervate their emotions and exhibit callous behaviors towards the dying patient and family. But at what point do they become devitalized? "Somewhere between the entry as a student into a health profession and the practice of that profession - subtle changes occur in attitudes concerning dying and reactions to death" (Castles and Murray 1979:21). Castles and Murray (1979) argue that such changes occur when confronting death. "I can't remember a death that was peaceful, beautiful or transcendent. Death here is usually a noisy, hurried scramble through a harsh industrial environment" (Austin 2008:232). As the primary caregivers to the dying patient and then the corpse, healthcare
professionals are subjected to witnessing the dying process that the average American no longer experiences.

The eyes glazed and half closed, jaw dropped and mouth open, cold and flaccid lip; cold, clammy sweats on head and neck; respirations hurried and shallow or slow and stertorous with rattle; pulse irregular, unequal, weak and immeasurably fast; prostrate on back, arms tossing in disorder, hands waving languidly before the face or grasping through empty air, or fumbling with bedclothes (quo. Worcester 1961:36, Castles and Murray 1979:236).

Dying is not an easy transition and it becomes the responsibility of medical staff to assist the patient through the transition. They are called upon to provide the meaning of death to the dying, even when they don’t possess that meaning themselves. Nurses and physicians are confronted by the practical unpleasantness of dying that contradicts societal fantasies of a peaceful death. They are expected not only to understand death, but also to share its meaning with others, and assist the dying through the experience. It is this expectation, fueled by their fear of failure in professional competency, that results in the emotional numbing of the healthcare provider.

**Postmortem Care as Procedure and a Ritual**

The duty of the healthcare provider does not end with the patient’s death. The physician and nurse must inform family, funeral homes, and lawyers that are connected to the death, and ensure that the body is presentable to society. Postmortem care, a medical procedure, imitates the qualities of a cultural ritual designed to inform society of a death while addressing the physical, perhaps spiritual, needs of the corpse. Although it is founded in biological and scientific explanations, it becomes an aesthetic ritual for the emotional wellbeing of the professional. "As nursing students, we learned to wash the body carefully, protect orifices and pad certain areas to
prevent bruising. The rational for these actions was generally presented as 'showing respect for the deceased" (Pennington 1978:846). Medical personnel place the body in a position depicting societal expectations of peacefulness before rigor mortis sets in (Pennington 1978). After the bereaved family views the "sleeping" corpse, the body is wrapped in a plastic bag and stored in the morgue. Postmortem care is the ritual in which healthcare providers find symbolic meaning in death, while simultaneously fulfilling their duty to society and the patient as the caretakers of the dead.

**Qualitative Versus Quantitative**

Thanatological research has favored the qualitative approach with interviews as the primary method for gathering data. Wolfe and Jordon (2000) explain the difficulty in studying healthcare proceedings: "Many end-of-life and bereavement caregivers are unfamiliar with the methods of social science research. Some even seem to fear and loathe them as an intrusion on the clinical process, a threat to long-cherished beliefs about their competence as practitioners" (Pp. 581). Perhaps this is one reason that little research has been produced on the ritual of postmortem care. Russ (2005) conducted participant observation in the hospice setting, and was successful because she appropriated the role of a healthcare worker before working as a researcher. She built trusting relationships between her subjects and after sharing an experience of death was able to gather the majority of her data. Saunderson and Ridesdale (1999) were the only researchers to utilize a quantitative approach. They created a survey of open-ended questions that was sent to physicians in the surrounding area and then coded for significant data. Biographies written by physicians and nurses, although not academic research, also contribute pertinent information to the literature, as they often detail procedures that would never otherwise be observed.
Methods

Study Conduction

This is a qualitative, pilot study conducted as an undergraduate senior thesis in the discipline of anthropology. It is an ethnographic study of nursing staff on a surgical telemetry ward at Salem Hospital, and how this staff utilize *postmortem care as a ritual* for assigning symbolic meaning to, and normalizing, death in medical subculture, a culture based on denying the possibility of death, and based on saving and prolonging life. Data was gathered during one year of participant observation as a certified nursing assistant. Additionally, five semi-structured interviews were conducted with nursing staff, ranging across their experiences of postmortem care, education and professional training, and nursing roles on the ward.

The data was analyzed utilizing an open coding system, identifying themes and trends, followed by a closed coding system to select pertinent quotes. The study was approached utilizing grounded theory.

Informants

Barbara Knight is a registered nurse (RN) with a bachelor’s of nursing degree (BSN). Her primary role is a floor nurse, providing direct patient care. She is currently in school to obtain her master’s of nursing (MSN) and nurse practitioner license for primary care. She is currently in her third year of nursing, with a previous career as a real estate broker. She entered into nursing with several years of volunteer experience in the medical field before becoming a nurse.

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18 This method provided a means of establishing a trusting relationship between informants and researcher while gaining a better understanding procedures, behaviors and experiences on the post-surgical ward.
19 Research is conducted and then a hypothesis is formulated during the analysis of the data.
20 All names have been changed to pseudonyms to protect the confidentiality of informants.
Jennifer Carol is an RN with a BSN\textsuperscript{21}. She works as both a floor nurse, providing patient care, and a charge nurse, overseeing other nurses, managing the operations of the ward, and acting as a resource. She is currently in her third year of nursing, and had worked as a certified nursing assistant (CNA) while in school.

Kara Smith is also an RN, and holds two bachelor degrees in biology and nursing. She is one of the Assistant Nurse Managers (ANM) of the surgical telemetry unit, and she also works as a charge nurse and occasionally a floor nurse. She is currently in her fifth year of nursing.

Cassie Anderson is a certified nursing assistant (CNA) and certified unit clerk (CUA). On any given day she will either work on the floor providing patient care under the direction of floor nurses, or she will work at the nursing station managing the clerical duties of the unit and supervising the telemetry\textsuperscript{22} monitors under the direction of the charge nurse. She has worked as a CNA for four years, with nine years of experience as a medical assistant in California. She is currently applying to nursing school.

Zoe Hernandez is a registered nurse currently pursuing her bachelor's of nursing. She holds degrees in art, physical science, general teaching and business. She works as a floor nurse providing patient care, and has worked as a nurse for four years with previous careers in funeral directing and retail work.

**Changes to the Project**

Originally, the project intended to explore how both physicians and nurses utilize postmortem care as a ritual; however, it became apparent that physicians do not really take part in postmortem care in any meaningful way. While they may participate in calling the “time of death” at traumatic incidences, they do not prepare or interact with the corpse. In order to

\textsuperscript{21} BSN stands for Bachelor of Science in Nursing.

\textsuperscript{22} Telemetry is the continuous electronic monitoring of a variety of physiological functions, but the surgical telemetry floor monitored cardiac functions.
develop a complete story about how physicians interact with corpses, the study would have extended to analyzing first year anatomy classes at medical schools and interviewing physicians on their experiences in medical school. Although an interesting facet of study, this would have been too extensive for the time constraints of this study. Physician interviews were therefore excluded. The experiences of certified nursing assistants was added for two reasons. Participant observations were under the role of a CNA, providing an alternative perspective to the viewpoint of an RN. Secondly, it became apparent through interviews that CNA’s are the primary providers of postmortem care on the unit, even though many of them denied being educated enough to hold any such position.
Analysis

We save Lives! Although Some May Die

You lay before me,

No heartbeat, no breaths, no life.

When I first encountered a corpse like you, I had to remind myself,

You are dead.

Now I try hard to remember,

You were once alive.

You were once a soul with dreams, family, personality, a history;

Now I look at you and I see a dead body²³.

White-washed walls, linoleum floors, fluorescent lights, monitors everywhere beeping, a smell of sterilization, the blur of individuals in scrubs rushing past you, and endless number of rooms filled with sick people. "Priority page, code blue, adult, building B, room 5523." You don't know what that means, but you are certain it can't be good, as nurses around you rush off to some unknown destination. Here you stand, in the midst of a hospital floor, uncertain of your role. Where do you go, where can you stand or sit, what can and can't you touch? You are filled with uncertainty. All you want to do is find someone familiar, even if it is your family, friend, or acquaintance that is staying as a patient. You manage to find a desk. It must be the nurses' station, since there are monitors everywhere, people in scrubs rushing in and out, talking in hushed and hurried voices, typing on the computers, and making phone calls. "Can I help you?" a woman in blue scrubs asks. You tell her the name of the patient you are there to visit and she

²³ Every poetic entry was written by Leia Franchini
tells you which direction to go. Recognizing the look of momentary panic on your face, she smiles and offers to walk you to the room. You quickly accept. You have never met this woman before, but you are comfortable with her. She doesn't seem overwhelmed by the sounds, smells, and all the sick people. In fact, she seems quite at home, busy, but not distracted by the electronic paging through the loudspeakers going on all the time. You reach the door of the patient you are visiting. There is a red stop sign on the door stating, "See nurse before entering." The woman, obviously a nurse, hands you a mask. She helps you put it on while explaining that it is a precautionary measure being taken to protect the patient from becoming even more ill. You hesitate to enter the room, but the nurse opens the door and guides you in announcing your presence to the patient. She shows you where to sit, what tubes to avoid, and assures you that the visit is much appreciated. As your visit progresses, several nurses and technicians enter and leave the room. They smile, introduce themselves, carry out their business and leave. The patient, although quite sick, seems to be in good care. Who are these people, that they can come day after day to a world of sick and dying people, some pleasant, others shouting demands and throwing things, and still walk into rooms with smiles on their faces? They offer words of encouragement, while receiving none in return. They repeatedly explain the patient’s illness, medical treatments being provided, and progress towards discharging home. Nothing seems to faze them. They are nurses.

They didn't all used to be as confident as they may appear in the beginning. Watch closely and you may spot a new nurse. But how do they develop such confidence? How do they no longer fear illness and diseases? How are they not overwhelmed by the lights, sounds, and smells? How do they know where to sit, stand, what to touch, what not to touch? Every nurse enters the healthcare field as a lay-person, but they are slowly integrated into the subculture of
medicine. Nursing school and clinical training begins the integration process, but that is not what initiates them into the world of medicine. If you were to ask a nurse how they handle all the aspects of nursing, they would most likely shrug their shoulders and say, "It’s my job; I work to save lives." Such a statement embodies the ideology of nursing and all of medicine. Healthcare is a culture composed of nurses, physicians, technicians and support staff that all share a common goal. They seek to better the lives of the community by improving society’s physical, mental and emotional wellbeing. Ultimately, they walk into the doors of their clinic, hospital, nursing home, thinking "Today I am saving lives." But even this mindset is not enough to integrate a nurse into healthcare. Rather, it the exact opposite idea. A nurse will not be able to have confidence in what they do, or in their abilities to save lives, until they have lost a life. Until a nurse can accept that patients, even their patients, despite all medical interventions, will die, and until a nurse can learn to let go of such deaths, they will never fully integrate into medical culture as a nurse.

"When I first started as a CNA, I carried my deaths with me a lot. And I had a conversation with an older nurse in one of my clinicals, ‘cause I was talking to her about a patient that passed away, and I used the phrase that I lost them. And she stopped me and she said, no you didn’t. They expired and that's ok. She goes, you cannot carry that with you, otherwise you will not make it through two years of nursing and you will be in counseling (Carol 2010)."

Nurses walk a fine line in balancing the emotional requirements of their job. They absolutely must be able to connect and become personal with their patients in order to effectively treat them; however, they must also learn how to disconnect and let go of their patients when they die. Many of them learn such skills through their experiences with death, and carrying out a medical procedure known as postmortem care.

In a subculture where the focus is to cure and prevent diseases, while simultaneously prolonging life, patients that are diagnosed terminally ill or die unexpectedly represent contrary evidence in direct opposition to the ideology of medicine. The patient, whether they want to die
or not, is a deviant actor in the social landscape of medicine. And yet, healthcare professionals, because they hold themselves to a high standard of treating all patients regardless of their condition, force themselves to interact with the deviant patient. As a result, medical personnel must find ways to normalize the deviance of death, especially nurses, who are the primary medical professionals interacting with patients.

Postmortem care addresses the deviance of death in a ritualistic manner by attaching symbolic meaning to death for the culture of sustaining life. In general, medical procedures can be understood as rituals that normalize socially unacceptable actions and behaviors necessary for diagnosis or treatment. For example, a male patient would allow a physician to examine their prostate by inserting a finger into the anus and probing the edges of the prostate gland. This action, although still recognized as awkward for the patient, is not considered a sexual behavior because it is a medical procedure symbolizing professionalism separate from sexuality. All paraphernalia utilized in the procedure support and uphold the ideology of the medical procedure. Latex gloves are worn separating the personal interaction of skin to skin contact. The patient wears a hospital gown, allowing the physician to depersonalize them and maintain the professionalism of an M.D. The words exchanged between the patient and physician are scripted by medical institutions and ingrained on the physician. All actions of the physician are methodical and minimal, and they are performed as an athlete performs a pre-game ritual. In the same manner, postmortem care is a ritual in medical culture that normalizes death and the handling of a corpse.

The literature explains that death, within American society, is confined to medical institutions. So, it makes sense that the medical field, a subculture with its own language, rituals, and socially acceptable rules, would create its own form of death rituals. Henry Orenstein, an

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24 See appendix II
anthropologist in Southern India, explains that only human societies have created rituals of mourning when another human being dies. "In nonhuman societies rather little attention is given to the dead, surely less than is devoted to the living [...] in human societies some form of mourning or ceremonialism at death is virtually, if not wholly, universal (1970:1371)." There is a general understanding that all cultures have death rituals; however, it is the variation within death rituals that not only unify a culture but also make it distinct from another culture. Death for an individual is the end of socially recognized life; the human leaves the world of living culture, and enters into an invisible reality where they no longer manifest cultural symbolism. Rather they enter into an imperceptible society, detached from cultural influences. While the individual may no longer actively participate in the manifestation of culture, the body remains part of the living realm and interacts with the living through death rituals. "Cultural meanings of death are not static, originary, or fixed in predetermined structural oppositions. Rather, they are themselves composed, authenticated, and even disrupted in lived space (Aggarwal, 2001)." The body becomes the center of death rituals, and symbolizes a bridge between the reality of death and the reality of life. Rituals develop around the corpse as a means of transcending and immortalizing cultural practices. Though the dead don’t actively participate through language, their body participates as a prop or symbol in death rituals, thus manifesting cultural immortality (Hertz, 1960). Therefore, postmortem care is the death ritual of medical culture which unites nursing professionals, reifies and immortalizes medical culture and the practice of saving lives.

Death in the medical field is divided into two categories: expected deaths and unexpected deaths. Expected deaths are often termed by healthcare professionals as "comfort care deaths," wherein the patient is diagnosed as terminally ill, and beyond all medical interventions. In such cases, the physician makes the determination with the family and the patient to cease all medical
treatments\textsuperscript{25} other than those that may ease the pain and discomfort of dying\textsuperscript{26}. For the most part, the physician’s job is complete; but, the responsibility of the nurses increases. Nurses become responsible for educating families and patients on the dying process. They must explain what physiologically occurs, why the patient quits eating, or drinking, or breathes sporadically, while simultaneously offering the family and patient independence by allowing them to direct their comfort care. If a patient is not able to speak for themselves, the families become responsible for determining whether a patient should be repositioned in bed, receive medication for pain, be kept on oxygen and much more.

"Once they are to the point where they are no longer interacting, then the patient’s families direct the kinds of care we give them as far as pain medication, if they want them turned, some families don’t want them turned, some families will ask for periodic vital signs ... it’s just up to them what they want to do (Carol 2010)."

Oftentimes, such decisions are overwhelming since the family is inexperienced with death. The nurse then takes on the role of advisor, suggesting when to medicate the patient for pain, or remove oxygen so as to not drag out the dying process. When a patient dies as a comfort care patient, the nurse’s roles gradually shifts from caregiver of the patient to caregiver of the family. This is a necessity that will be discussed later in the paper, but for now, we need to recognize that comfort care patients are those that are expected to die, and are being made comfortable while they die.

Unexpected deaths refer to individuals that die with DNR orders\textsuperscript{27}, referred to as “DNR deaths,” or are full-code\textsuperscript{28} patients, termed “traumatic deaths.” The death can be a result of

\textsuperscript{25} Including but not limited to x-ray’s, CT scans, MRI scans, invasive procedures, and vital signs.
\textsuperscript{26} Oxygen can be given (though it slows the dying process), pain medication, wound dressing changes, turning in bed and more.
\textsuperscript{27} Do Not Resuscitate - the patient and/or power of attorney state that in the instance of death, they do not want to be resuscitated. All comfort care patients must have DNR orders to accompany comfort care orders.
\textsuperscript{28} All medical interventions are to be taken to revive the patient in the instance of death. Patients are by default full-code unless they sign DNR orders.
complications related to their admitting illness, or from unrelated causes such as unknown heart conditions. DNR patients enter the hospital with the signed documents stating they do not wish to be resuscitated via CPR or other methods if they should die. Full code patients do wish to be resuscitated and all medical interventions will be implemented to revive the patient including CPR, medications, and electric shock of the heart. It is when these interventions fail that the patient has died, and only the physician can announce that the patient is dead.

All three forms of death, comfort care, DNR, and traumatic, affect nurses in different ways. However, all deaths, with the exceptions of autopsy required situations, result in the performance of postmortem care. Postmortem care normalizes death, allows nurses opportunities for emotional detachment, and initiates new nurses into medical culture, a culture in which the focus is on saving lives, even though some patients may die.

29 “Time of death” in a full-code situation is called at the time CPR and interventions are stopped. Officially, the patient doesn’t die until the supervising physician determines that the patient is beyond medical interventions.

30 Autopsy can be requested by family at any time, and is required if a patient dies twenty-four hours post admittance or post-surgery.
Cold Hearted Grief

Am I a calloused soul?

No, I just cannot grieve.

I don't have the memories, the love, that your family had.

They must grieve.

All I have is your body;

It's not my place to grieve.

Nurses, depending upon their medical emphasis, are exposed to death in different levels. For example, oncology\textsuperscript{31} nurses are more likely to deal with death than surgical nurses. As previously stated, the focus of this study is surgical nursing, wherein informants demonstrated an impression that they are not allowed to grieve.

"With my first death I cried in the supply closet. But I don't think it is appropriate to grieve in front of family. It is our responsibility to comfort the family and allow them to grieve, so we need to be separate from them when we grieve; it's not our family that died (Smith 2010)."

Nurses are actively involved in the dying process and are required to provide intimate care to the dying patient. Somehow, they disconnect emotionally from the patient, so at the point of death they don't grieve. Desensitization is a necessity for the nurse as their caregiving role shifts from the patient to the family. It becomes the nurse's responsibility, as one who is familiar with death, to be the emotional support for the survivors. They must find ways of easing participants from the conditions of brutality that surround a corpse to a position of peace and tranquility.

"So I usually turn my attention immediately to the family. Usually their [the deceased] jaw drops, I try to get their jaw positioned up, so I'm helping the family

\textsuperscript{31} Branch of medicine associated with diagnosis and treatment of cancer.
not look at the person differently. I don’t want them to see a corpse; I want them to see their family member (Knight 2010).”

Nurses don’t have time to grieve; they must care for the family.

Many feel it is not their position to grieve, because it is not their family member that has passed away. They believe they have no vested interest, no emotional involvement with the patient, as the family would. Therefore, they are only allowed to offer condolences and support to the family. However, nurses do have a vested interest in the patient. According to medical ideologies, they were supposed to prolong the patient’s life. So how does the nurse come to a point of neglecting this vested interest in a patient, disconnecting from the situation and not grieving at the time of death?

A patient diagnosed terminally ill and beyond medical treatment is placed on comfort care. In this situation, the nurse begins to distance themselves emotionally from the patient. With the living and curable patient, the nurse is actively involved in their life, their stories, and trying to get to know the patient. However, once on comfort care, the nurse gradually shifts their focus from the patient to the family. This is especially true once the patient becomes unresponsive. Patients, as they approach death, decreasingly need the care of the nurse.

“The patient no longer needs me (Smith 2010).”

But families become more and more dependent on the nurse. As a result, the nurse will shift their focus of care to the family, and seek to aid them in dealing with the death of their loved one. So when the patient dies, the nurse has already disconnected emotionally from the patient and bonded with the family. They are able to provide the emotional support for the families without being overwhelmed themselves.

"Dealing with the family is a lot of work (Hernandez 2011)."
They have dissociated all investments they had in the patient, allowing them to fulfill the new role of caregiver to the grieving family. If, indeed, they feel any grief, it is sympathetic grief for the family.

While the nurse does not grieve over the patient, they still feel grief; sympathetic grief for the family. However, they also feel that it is unprofessional to express sympathetic grief. How nurses grieve can be better understood by applying Goffman’s dramaturgical theory (Sandstrom et al. 2010). Goffman explains that there exists a front stage, wherein role performance takes place as it does in a theatre. In the front stage, the individual performs or portrays the self they feel themselves to be in that scene, much like an actor wearing a mask (Sandstrom et al. 2010). So, a college student in a classroom will present the studious, intelligent being they identify as in college. But when they return home, to high school, they may change the way they speak, dress, and walk to present the friend they understood themselves to be in high school. The same phenomenon exists in nursing. Nurses, in the hospital scene, when presented with an audience of other nurses, physicians, patients and patient families, perform the role of a professional nurse. They will utilize a medical and professional script, dress in accordance with the dress code, even walk in the manner a nurse walks (determined and hurried). But backstage is where the self is able to cease all performances. In the backstage, true identity exists and is developed. Nursing backstage is any location separate from the audience of medicine. It exists in the break room, outside the hospital, and when they are not wearing their scrubs or name badge. While they may present a different self, whether as mother, daughter, or friend, they can no longer present their nursing self.

If nurses must grieve, it must occur backstage where it does not tarnish the presentation of nursing professionalism. Grief can only occur when all nursing responsibilities have been

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32 See Appendix II
fulfilled, such as postmortem care, comforting the family, paperwork and transporting the body
to the morgue. Grieving before such requirements are completed, even if backstage, would
reflect poor nursing. A nurse is on stage until all responsibilities are complete, or the
performance is finished.

"I usually make sure everything is done, then take a few minutes to myself in the
supply closet. With my first death I cried in the supply closet (Smith 2010)."

It is also important to recognize that the deaths of patients, and any grief or coping that
must take place, is not exclusive to the primary nurse. Healthcare ideology stresses the ideology
of the team, and thus the care of a single patient is the responsibility of the entire healthcare
team. As a result, nursing staff adopt a pack mentality, wherein when a death occurs on a given
floor, all the nurses on that floor are affected. When a wolf is injured, the rest of the pack will
protect and care for the injured pack member. Nurses will act in the same manner. If one nurse is
grieving, or had "a tough day," the others will work to encourage and support that nurse.

"I dunno, I think it depends, because you don't have to partake in postmortem care
to think about that stuff especially because there are other patients that you don't
do postmortem care on but you know they passed away, but you're not the one
participating, so I dunno, I just think about ... um ... I don't wanna sound crazy, I
think about them and their families (Anderson 2010)."

Gustave Le Bon proposed in his theory of collective behavior that crowds or people in groups act
as one unit or individual and formulate responses to ambiguous situation (Sandstrom et al.
2010). 33 So, if we approach nurses with the understanding that they operate with a pack
mentality, or a collective consciousness, it follows logically that if one nurse experiences a death,
all nurses on that unit experience the death. While the primary nurse adopts the grief of the
family, the rest of the nurses on the unit adopt the grief of the primary nurse, fulfilling the role
called for by the pack mentality, and providing backstage support for the primary nurse. So then,

33 See Appendix II
the rest of the nurses, while they are not required to care for the corpse or the family, care for the nurse involved in the dying process.

"I usually carpool with another nurse, and so she and I would always treat the other to ice cream if we had a tough day or a death (Smith 2010)."

What is experienced by one nurse is collectively experienced by the other nurses.

Consistent with the theorem of the pack mentality, if a nurse threatens the ideologies of medical culture or the healthcare team, they are ostracized. Zoe Hernandez had been exposed to death at a young age, when she accompanied her older sibling to crime scenes and observed while he photographed the scene. Also, one of her first jobs was as a funeral home director and mortician. Such experiences caused her to develop a different mindset from the other nurses regarding death.

"I've dealt with death enough that I don't really need to cope with it, it's part of life, dying is part of life, so I don't think I'm as affected as other people cause I've done it so much (Hernandez 2011)."

Although she may seem detached as a nurse should, she does not adopt the grief of the family, and fails to fulfill her care giving role as a nurse. Many of the nurses, even though they don't feel grief at a death, feel that it is a necessity to process at least the idea of mortality and the grief felt by the family.

"um, no (laughs) sometimes you don't think about it right afterwards, sometimes you wait a day or two and then you think about it. . .you have to (Anderson 2010)."

Zoe Hernandez violates this ideology. She doesn't feel the need to reflect on the deaths occurring on the floor, so the other nurses view her as being in a dangerous position of denial. At some point, she will not be able to continue to deny her emotions, and could have a breakdown or not succeed in nursing. Therefore, she endangers the health of the nursing team and is ostracized.
There are exceptions as to when a nurse is allowed to grieve, but they are confined the backstage arena. It is acceptable for a nurse to grieve after their first death. It is expected. Stories of their first deaths and their grief unite nurses, and further lend credibility to the collective conscious of nursing. Without grieving at their first death, nurses are unable to participate in sympathetic grief for the families, and the collective grief for their coworker. It is also acceptable for a nurse to grieve after a traumatic death. Nurses grieve traumatic deaths because they are not provided with time to disconnect from the patient.

"There's been a couple times, especially after the code, where I just had to cry. I had to leave the room crying and get myself composed, come back and then have a conversation with the doctor about what happened (Carol 2010)."

Compound the situation with a sense of guilt at the unexpected death of the patient, and it becomes a necessity for the nurse to grieve, even before they fulfill the roles of supporting the family.

"I struggle with my one code, the traumatic code. I still feel like that was a failure for me that I didn't recognize what was going on when he had such high anxiety and I should have seen some of the signs earlier. And so that's a hard thing. But I also know that we did as much as we possibly could to help him (Carol 2010)."

In these instances, nurses must include in their grief a way of processing what occurred, whether it is through discussing the event with another nurse or with the physician. They need to know, that despite the outcome, the patient at some point was beyond all medical aid. If even for a split second, the patient was terminally ill and beyond medical interventions, then as with comfort care patients, the nurse is able to accept the death.
So Dies Innocence

Oh corpse, did you know that when you died you would become a teacher?

Standing before you are two students.

They say they want to see, feel and be a part of nursing.

Well, it’s time you show them the not-so-rewarding part of nursing.

They stand back from you, corpse, 

Trying to hide the fear.

But I see it; I was once like them.

I envy their naivety, their innocence.

But soon they will be like me; I have to make them like me.

Or they will never succeed.

So dear corpse, let’s force them to face mortality,

To come as close to death as they can without dying themselves.

They will either walk away stronger, or they will fail and never return.

Stories of first time experiences with death and postmortem care all involve key elements of fear, awkward experiences with the corpse, and a need to be taught by another individual what to do. Both nurses and CNA’s receive some form of death education either during school or clinical training; and yet, they still remain unprepared for their first encounter with a corpse.

“uh, well you were kinda briefed on it [. . . ] I think what stands out is when you are in the class and [they] are trying to give you a hearsay visual about what you are going to encounter. They let you know there is going to be a lack of coloration, coloration is gonna be different. If you see um the back side of them darker, that’s normal. They try to, try to give you, that, what’s really stood out, what to expect (Anderson 2010).”
Cassie Anderson explained that she was “briefed” on what to expect when viewing a corpse; however, she was not taught how to emotionally handle her experience or how to interact with the corpse. As a result, her first time experience with a corpse and postmortem care was fraught with fear and uncertainty.

“I was pretty intimidated by going in there by myself because I wasn’t sure how I would react, if I would react, so I asked somebody to go in and help me (Anderson 2010).”

Both nurses and nursing aides are verbally taught what a deceased body may look like and the physiology of death; and yet, because they are never shown a corpse or receive demonstrations on postmortem care, they are uncertain when approaching a corpse of their responsibilities. Their ideas of death remain informed by American media. They expect the body to be cold to touch, or stiff from rigor mortis. There exists a disjunction between what American culture says they should experience and what they actually encounter. They are unable to make cultural understandings of the corpse.

“The first time I saw it, it was surreal, it was hard to tell, like that’s a person and they’re dead [. . . ] I had to tell myself over and over. I dunno, its hard telling you how your brain, you, because you know they’re human, but they’re not really there, so it’s kind of bizarre (Hernandez 2011).”

Nursing staff are unprepared for their first encounter with a corpse resulting in shocking first-time experiences. For example Jennifer Carol shared her first time dealing with a dead patient.

"I had a moment of freaking out because you know when someone dies their body releases that last breath of air comes out of them. Well I didn't know, no one had ever told me that. And um, I never went to CNA school, I'd just done enough credits through my [nursing] school that I was able to get it [CNA license] that way, um and so, [laughs], we're doing postmortem care, cleaning her up and all of sudden, she just, like, breathes. And like, I was, like, washing the side of her face, here, and I just dropped my towel and freaked out and I was like, she's not dead, she's not dead! And the CNA was like, shut up she is too, the family is outside! [laughing] I was thinking what the “F,” ya know, and so um, I learned that the body releases some of those things, but it was just really, um, I was really shocked and then it was fine ya know, finishing her up."
Like Jennifer Carol, other nurses and CNA's are unprepared for encountering a corpse. Media death, where the body has already reached rigor mortis, or is completely pale-colored actually does not occur for several hours. Physiologically, rigor mortis does not set in for several hours, and the blood slowly settles in the corpse, and the body takes time to cool to room temperature. Even though nurses may know this textual information, until they experience it as a reality, their own cultural understandings of death, founded on popular culture and media, predominates in their initial interactions with a corpse.

First-time postmortem care experiences then become an educational realm, in which the CNA or nurse must have their previous ideologies of death and the corpse replaced by medical-cultural understandings. The new CNA or RN must undergo a transition, from lay-person to medical person. The corpse acts as the teacher, removing all social myths about death and replacing them with medical realities.

Nursing staff are initially incapable of interpreting medical realities; enter the experienced caregiver. They allow the CNA or RN to be shocked by death, they allow the corpse to demonstrate death; however, the experienced caregiver must then guide the new CNA or RN in appropriate professional reactions. In Jennifer Carol's story, the CNA training her enforced the view that it was unacceptable to be surprised or "freak out" when dealing with a corpse. The family is depending on the stability of the nursing staff involved in postmortem care. The experienced caregiver must also pass along medical symbolism for death through postmortem care.

"[Name removed] was the CNA and I had never done postmortem care. He talked me through the whole thing, ya knows, remove the lines, wash the body, and make it presentable (Smith 2010)."

Without the presence of an experienced caregiver, the nursing individual is unable to navigate their first experience with a corpse. They wouldn't know how to explain what occurs with a
corpse, much less manage their own emotions or reactions to the corpse. By forcing the CNA or RN to reject American cultural ideologies of death and adopt medical ideologies, postmortem care acts as a rite of passage. Nurses are forced either to develop a “tough exterior” from which they can work without being negatively affected by death, or they will never succeed as nurses. They must undergo a rite of passage, wherein they demonstrate their ability to emotionally and mentally handle the demands of their job, and desensitize their own grief.

Unfortunately, once a nurse has fully adopted medical ideologies of death and developed “healthy nursing attitudes” towards death and bereavement, their own personal experiences become more difficult. A couple of informants expressed the pressure they felt by family to play both roles of nurse and family member when one of their own loved ones died.

“Ya know, it’s also an interesting thing to deal with death outside of the hospital and in my own life, like when my grandmother passed away, my family asked me to be there when she passed. Because they wanted someone who knew, who had experienced that [death] before ... um ... and doing postmortem care on her was a little different because she was my grandma (Carol 2010).”

The two roles of nurse and family member lie in direct opposition within medical culture. One is allowed to grieve, the other is not. Somehow a nurse must balance both roles when involving personal deaths. The nurse that shared this story utilized her experience as a way of making her a better, more supportive nurse to families when their loved ones pass away. She utilized her experience of postmortem care on her own family member as a rite of passage, as a way of transcending her own movement from a lay-person to an experienced nurse.

First time experiences, although approached with uncertainty and fear, are a necessity. The CNA or RN must be shocked by the corpse. If they successfully manage their feelings, under the guidance of another caregiver, then they succeed through the rite of passage and proceed to be seen as an experienced healthcare provider, fully integrated into medical culture.

34 See Appendix II
As postmortem care concludes, the corpse is zipped into a bodybag, and with the corpse, the innocence of a nurse is enclosed. Both are sent to the morgue, never to return to the floor.
Postmortem Care Roles

They watch as the nurse and I remove lines;

A slow trickle of blood trails down your arm, where the IV line went into your vein.

I hear a gasp.

"Remember, they will still bleed because the blood hasn’t congealed."

Lesson one, remember they are dead.

"Come, touch the body."

See, it is still warm.

Remember, it is still dead.

Observe.

Grey skin, white fingernails, a gurgling rising from the mouth;

This is what death looks like.

My interviews revealed four key participants in postmortem care: the CNA, the floor RN, the charge RN and the managerial RN.

1. The CNA. The CNA aides the nurse in observing the dying patient, while continuing to provide hygienic care that would add to the comfort of the patient. This may include, but is not limited to, swabbing the mouth with sponges, washing the face, and turning the patient in bed. Once the patient dies, if the CNA is in the room, they must seek out the nurse. Even though a CNA has seen death before, and is able to determine a lack of pulse or respirations, it remains out of their scope of practice to announce to the family that the patient has deceased. The CNA is responsible for fetching items for the comfort of the family, such as tissue, coffee, etc. Once the family has departed, the CNA takes charge in ensuring the patient is washed, linens changed, and
that the body is zipped into a body bag. Oftentimes this part of the care is carried out by the floor RN and CNA as a team. Other times a CNA will work with another CNA but postmortem care is always performed in pairs. Once the body is ready, the RN or CNA will call transport services for the body to be taken to the morgue. The CNA's role is confined primarily to caring for physical needs of the dying patient, the family and then the corpse. However, CNA's often have the undisclosed role of primary educators of postmortem care.

"And so, um, he passed during my shift, that day and I’m not even sure who the CNA was. But I remember thinking what do I do now? And then the CNA I had, had the training before and had actually performed several of them [postmortem care], so she actually did most of the work, while I pretty much assisted and paid attention to what she did. It was really one of those roles where I learned from the CNA (Knight 2010)."

The CNA is responsible for continuing the ritual of postmortem care from CNA to CAN, and then from CNA to RN.

2. The Floor RN. The floor nurse is the primary caregiver to the patient. They are the individuals monitoring the care and status of the dying patient, interacting with the family and eventually declaring time of death. At the time of death, they first act as comforter and supporter to the family. Then, usually after family has departed, the RN joins the CNA in cleaning the body. The floor nurse is responsible for removing all lines such as IV's, foley, PICC lines and oxygen. The nurse then signs the toe tag before zipping the body bag closed. These people are responsible for making sure all personal belongings such as jewelry are either sent home with family, or are zipped into the body bag with the patient. The nurse must call the physician and alert them to the time of death.

35 Intravenous sites for medications and fluids.
36 Urinary Catheter.
37 Peripheral Inserted Central Catheter.
3. The Charge Nurse. The charge nurse role is much more paperwork and task oriented. Their primary responsibility is to be a resource to the floor nurse dealing with the dying or dead patient. Oftentimes the charge nurse will take over the care of the floor nurse’s patients while the nurse carries out postmortem duties. The charge nurse is responsible for calling the donor bank to see if the patient is an organ donor, in which case the charge nurse must take steps to preserve the organs, such as covering the eyes with cold washcloths. The charge nurse also notifies bed control and the Nursing Administration Center (NAC) of the death, and follows up to make sure the M.D and all consulting M.D's were notified of the death.

4. The Managerial RN. Nurses in administrative roles, such as nurse manager, and assistant nurse manager (ANM) fulfill supportive roles for the charge nurse, floor nurse, CNA, and all other staff members that are involved with the death.

The physician's role in the death of a patient, as previously discussed, is limited for comfort care patients.

"It’s a critical value, we have to call the physician to let them know they passed. Because normally they put them on comfort care, they just wanna be notified that they passed. Of course, if it’s a trauma, they are already there, or an event like a cardiac arrest on the floor. (Carol 2010)."

If the death is unexpected, only a physician can pronounce time of death. But they do not normally partake in postmortem care.

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38 If a patient is a registered organ donor, the donor bank now calls the family of the deceased to ask for permission to harvest the organs, it is no longer the responsibility of nurses to request family permission.
39 Nursing staff that are responsible for finding beds within the appropriate ward of the hospital for a patient’s admission.
40 Team of administrative nurses who oversee all management of nursing.
They Are Not Dead Yet

We begin to wash you, corpse,

Herein is the most intimate part of my care.

I see all of you.

I see scars from the life you lived.

I trace them with my finger.

Lesson two, remember they were once alive.

Caring for the body is the most intimate part of postmortem care. The corpse is laid bare before the nursing staff member, no longer expressing emotion, personality, or any other sign of life. And yet, they are still interacting with the nursing staff. They lie in the bed, dead, signifying the end of all culture, of life. The caregiver is asked to perform some of the most intimate care to a corpse; they must wash it, removing all soiled linens and medical paraphernalia. Such procedures require touching, turning and holding the body. They hear the last breath rush out of the body. They see the blood begin to pool in the back and buttocks of the patient. They feel the cold hands, yet warm body, of the patient. This is the last time they will change soiled bedding for the patient, only this time the patient does not express remorse for soiling the bed. The patient just lies there. Here, without family or outside lay people and without a live patient, you might think that the nursing staff are free from professional constraints, and may use the time to grieve. But that is not the case. The nurse still upholds all professionalism and does not allow herself to grieve over the patient.

Once again, Goffman’s dramaturgical model lends an understanding to the nurses’ interactions with the corpse. As a nurse provides care to the deceased patient, one might
conclude that such a setting would be a safe backstage setting. However, remember that Jennifer Carol was reprimanded by the CNA training her for her "freak out" moment. Nursing staff still view themselves as being a part of the front stage, and they feel they must maintain their professionalism. In some instances, such as Jennifer's, family could still be outside the room, setting the front stage, but there must be something within the room that is also enforcing the front stage mentality. It is the corpse.

The corpse, although dead and not interacting via independent movement or speech, continues to interact with the nurses because of nursing ideologies about the dead. Nurses recognize the body, regardless of the absence of a self, as having free agency that still demands the respect one would give to a living being.

"Because, just because they were gone, does not mean that the body is not still them. And so you have to act like they are still there, and you let them know what you are doing (Carol 2010)."

They approach the corpse with a sort of reverence that is enforced and passed down from one generation of nursing staff to the next.

"The thing I really learned was the reverence that she had for the person (Carol 2010)."

Nursing staff will then approach the body as if it was not deceased, but was instead a live patient. Somehow they learn to manage this ideology in opposition to the need to recognize the body as dead, and the need to disconnect from the patient. By allowing the dead patient to remain alive, the nursing individuals are able to normalize the procedure of postmortem care. They are able to normalize the cleaning of feces off the body, brushing the teeth, washing the face, combing the hair. The intimate care they are expected to give is no longer uncomfortable when the nursing staff address the patient as they would a live patient, or when they talk to the patient, as they would a live patient. Even the manipulating of the corpse is carried out as with a live patient,
regardless of the reality that the corpse will not move as a live body would. When turned on its side, the head will fall backwards, and then roll forward onto the face. The limbs will flop around. The body will be heavy. However, nursing staff stress moving the body in the same way one would a living body.

"You move them in the same body mechanics you move a regular, or even a person, ya know, that was not, had not died. You protect the head, you protect the limbs. If they role to the side, you bend that knee, you know, you bring the arm over, you make sure their position is still correct, um, and you do it gently, you don't jolt them, just because they've passed away doesn't mean you jolt them around. (Anderson 2010)."

Nurses will address the corpse, with or without the patient's name, telling them what they are going to do as they would in any normal medical procedure.

"Yes, we told the corpse what we were doing, but never referred to them by name. I can't treat the patient as not a patient or human, I just couldn't deal with it (Smith 2010)."

The corpse is not really dead until postmortem care is finished. Zipping the body bag around the corpse, especially the face, symbolizes death to the nurse.

"I like to start with the legs and be done so that the face is the last thing I do, you know, that's the last thing I cover up. I don't know, I guess I feel like if I start with the face first and cover it up, I'm not recognizing that person as a person. It's the finality of finishing the face, of covering them up (Knight 2010)."

Perhaps that is how they are able to maintain composure at the time of physiological death. To them the patient isn't dead until they cover the face.
I See Faces

As I wash your face, it is already committed to memory.

I will never remember your name, which is not my place; it is your family’s.

But I will forever remember your face.

You were the patient that escaped the world, that defied all technological advances, all medicine;

You were the patient that died.

To say that nurses completely distance themselves from the emotionality of death is clearly inadequate. As was previously discussed, some nurses still find it necessary to take time away from the scene for themselves, but only when their job is complete and the corpse is no longer on the floor. Contrary to medical ideology that a nurse remains unaffected by death, most nurses remember their patients that have died. But how much they remember is directly related to the emotional effect the death had on them.

All of the nurses were able to describe their first experience with death and a corpse in great detail. They were able to recall some of the most minute of details, and many remember the name and face of the first patient that died. Was this because their first experience was emotionally damaging for them? No, but it was the first time they were involved in a death, and were able to transcend their present status, and move from being a "new nurse" to an experienced healthcare professional. Along with a nurse’s first death, they also remember, in acute detail, traumatic deaths.

"I remember faces, I don't always remember names. I remember the names of my two most, of my first death and my traumatic code. I remember their names and their ages, but I don't remember the rest of them, I just see people, I see faces. I think that is part of how I disconnect. Something about not having that name
connected to that person is a little easier for me to not think about it (Carol 2010)."

Jennifer Carol touches on a profound point. By remembering faces, the nurse once again is able to disconnect, but safely. At least for the surgical nurses, this remained true for all of them. There is some obligation to remember the patients that died, or almost died, but they must also not allow the death to affect them in the future. By remembering faces, they are honoring those that died in or under their care, while sustaining their nursing identities.

"yes, I don't remember names, I remember faces, but we also don't have very many on this floor, so I do remember them all. I also remember every patient that we've coded, RRT'd\textsuperscript{41} or sent off to ICU\textsuperscript{42} and try to find out how they fared (Smith 2010)."

They remember the patient, symbolically immortalizing the patient and fulfilling their duty as nurses who sustain and prolong life.

Interestingly, during a day of participant observation, a surgical nurse expressed severe distress at a common practice on the oncology unit. The oncology nurses clip out obituaries of patients they provided care for and paste them in an unmarked book. The surgical nurse was horrified, remarking, “It is a death book!” The oncology nurses were unwittingly violating the surgical nurse’s ideology of death in medicine by producing tangible evidence of the patient’s death. The surgical nurse, while she will always remember her patients that died, erases all evidence of the death by having the room sterilized and replacing the surgical bed with another patient. Obituaries also share intimate details of the deceased that would allow the reader to ascribe personality to the deceased. The surgical nurse already worked to erase all memories of personality by disconnecting from the patient through comfort care and zipping the body bag.

\textsuperscript{41} Rapid Response Team – a team organized of intensive care nurses, a respiratory therapist, and a physician who respond to full-code situations, as well as responding to emergent situations though not code status. In RRT, a nurse means calls a Rapid Response Team to handle the patient in a declining or dangerous health status.

\textsuperscript{42} Intensive care unit.
closed at the end of postmortem care. For the surgical nurse, obituaries, and the keeping of mementos, transgresses the ritual she uses to cope with death. She is only allowed to remember their faces.
We Have to Laugh

I show my students how to “bag and tag” you.

It’s seems more like common sense,

But perhaps it is the finality of zipping the bag around your face that requires guidance.

I send my students out of the room.

They must learn how to reenter the world of the living,

After being part of the world of the dead,

Even if but for ten minutes.

Floating on the periphery of the research is the idea of black humor, where medical professionals will joke about patients or death. While it is true that healthcare professionals do laugh, it is false to assume that it is directed towards patients. Instead, they laugh at each other.

"We have had some weekends where we can laugh more, but it’s not so much about patients, it’s more about us (Carol 2010)."

Humor is used as a coping mechanism when dealing with death, as a way of alleviating the tension that can become part of suppressing feelings of bereavement, especially after traumatic deaths.

"We just end up laughing. Like the trauma patient, [another nurse] and I laughed throughout the day at stupid little things just to get through the day, because it happened at eight in the morning. But we have to laugh, not at anyone, just laugh (Smith 2010)."

Humor normalizes the operations of the floor after a death. As discreet as nursing staff may try to be, other patients on the floor and visitors are aware that someone has died. However, nursing staff don’t usually discuss deaths that occur on the floor with other patients or visitors.
First, they are bound by HIPPA\textsuperscript{43} not to disclose medical information about other patients.

Second, it would be disrespectful towards the grieving family and third, most patients don't want to hear of someone dying because they themselves are anxious about their own medical condition and fear dying themselves. Laughter and joking is a way of denying that death has occurred and affirming that the nurse's medical capabilities remain unaffected by bereavement.

"That's the other thing about humor, sometimes, patients don't wanna feel like they're in a place of death, jokes bring life into things (Carol 2010)."

Jennifer Carol makes the final point with her statement "jokes bring life into things." The nurse has to laugh, as Smith stated, if only to bring them back to a place of the living. For an unmeasured amount of time, they had to deal with the dying, whether it was a couple hours, or an entire twelve hour shift. The nurse's time is consumed preparing the surviving family for the death and separating himself or herself from the patient.

At the time of death, the nurse must intimately care for the body. One could argue they enter the world of the dead, without dying themselves, and therefore need a way of returning to the world of the living, to a "normal" flow of nursing with the focus on saving lives, not caring for the dead. So, laughter helps the nurse to reenter the world of the living, to return to medical culture and to their primary goal of saving lives. Laughter demonstrates to the other nurses on the floor, that the primary nurse is not overwhelmed by the death, but is capable of coping with the death and moving along with life. A nurse that is able to laugh demonstrates that they are capable of caring for their patients, while they had to remain emotionless during the care of the dying; laughter demonstrates that they are human and capable of compassionate nursing. By sharing laughter, nurses communicate with each other that while they may have lost a patient, and they all suffered in some way or another,

\textsuperscript{43} HIPPA provides federal protection of patient's personal health information while attributing rights of healthcare control to the patient. Additionally, it provides a balance of allowing healthcare providers to share health information with other healthcare providers for patient care.
they are able to move on together and work as a team to save lives. They laugh because they have to.
Conclusion

I stare at the white, cold, body bag;
I see the outline of your body.
On the bag is a red biohazard sign,
Signifying, that what was once alive is now dead.

You were once human,
Now you are a corpse.

This was a qualitative pilot study that focused on how medical professionals utilize the medical procedure postmortem care as a death ritual for coping and bereavement purposes. Data was gathered via participant observation and interviews. Informants were nursing staff (registered nurses and certified nursing assistants) on the surgical telemetry unit at Salem Hospital. Their professional experience ranged from 2 years to 5 years. The data was analyzed using a grounded theory approach, and sought to answer the following questions: How many other medical professionals utilize postmortem care or other rituals to cope with the death of patient, how do healthcare professionals deal with the emotions of losing a patient, and do medical personal create rituals out of medical procedures?

The literature explained that ideological rituals surrounding death in American society have gradually shifted from occurring in the family home, and have become institutionalized in the medical setting. As a result, healthcare professionals are the primary caregivers to the dying and deceased, and they must find ways of desensitizing themselves towards the dying patient to preserve their own emotional wellbeing. While postmortem care is not a method of desensitization, it is a procedure that demonstrates ritualistic qualities and is the scene where
medical personnel demonstrate respect for the deceased, regardless of the deviant nature of death in medical subculture.

Medical subculture focuses on “saving lives.” Therefore, death, while it separates healthcare professionals from lay-people and unifies the healthcare team in their goals, is also an act of deviance within medical society. Postmortem care is a death ritual created by the medical subculture to normalize death and immortalize cultural ideologies of medicine.

Within medicine, nurses are the primary caregivers of the dying, and they operate under the expectation that they are not allowed to grieve openly for their patients. They must find ways of disconnecting from the dying patient, and denying any emotional investment in the patient. As a result, nurses emotionally distance themselves from the patient and attach their affections and sympathies to the surviving family. Therefore, any grief felt at the time of death is attributed to sympathetic grief for the family. If grief is expressed, it is only allowed to be expressed backstage, separate from all audiences.

Postmortem care is a rite of passage for new nursing staff. They are required to shed American media ideologies of death, and to adopt medical ideologies of death. New nurses are guided through this ritual by experienced caregivers, establishing solidarity amongst healthcare professionals and orally perpetuating the ritualistic procedure, which is not taught in technical training courses. It also serves as a ritual that signifies the official death of the patient. Nursing staff don’t recognize the patient as fully deceased until the face is covered or the body is zipped into a body-bag. The body takes on a life of its own until this moment.

Once the patient is removed from the hospital floor, the nurse must reestablish their role of healthcare provider through laughter and memories. Nurses enter into deviant behavior by participating in the dying process of the dying patient. Nurses must find ways of reaffirming their
role of medical professional and “saver of lives.” As a result, they utilize humor to normalize the care they had to provide to the corpse, and to prove that they are back in the world of medicine. Finally, they fulfill their duty of nurse and “lifesaver” by remembering the faces of their patients. Such memories immortalize the patient.

This study revealed that postmortem care is indeed a medical procedure that can be viewed as a death ritual for medical subculture; however, it is not a ritual utilized for bereavement purposes. Rather, it is a ritual that establishes the healthcare professional’s role within medical subculture and separates them from lay society. It acts both as a rite of passage for new nursing staff, as well as a ritual that unites nurses as the caregivers to the dying within medical culture. Instead of utilizing postmortem care as a bereavement ritual, nurses will project grief felt over the death of a patient as sympathetic grief for the family.
References


Appendices I

The following poem was written by Leia Franchini while conducting ethnographic research in the field of medicine.

Conversations with a Corpse

You lay before me,

No heartbeat, no breaths, no life.

When I first encountered a corpse a like you, I had to remind myself,

You are dead.

Now, I try hard to remember,

You were once alive.

You were once a soul with dreams, family, personality, a history;

Now I look at you and I see a dead body.

Am I a calloused soul?

No, I just cannot grieve.

I don’t have the memories, the love, that your family had.

They must grieve.

All I have is your body;

It’s not my place to grieve.

Oh corpse, did you know that when you died you would become a teacher?

Standing before you are two students.
They say they want to see, feel and be a part of nursing.
Well, its time you show them the not so rewarding part of nursing.

They stand back from you, corpse,
Trying to hide the fear.
But I see it, I was once like them.
I envy their naivety, their innocence.

But soon they will be like me; I have to make them like me.
Or they will never succeed.

So dear corpse, lets force them to face mortality,
To come as close to death as they can without dying themselves.
They will either walk away stronger, or they will fail and never return.

They watch as the nurse and I remove lines;
A slow trickle of blood trails down your arm, where the IV line went into your vein.

I hear a gasp.

"Remember, they will still bleed because the blood hasn't congealed."

Lesson one, remember they are dead.

"Come, touch the body."
See, it is still warm.
Remember, it is still dead.
Observe.

Grey skin, white fingernails, a gurgling rising from the mouth;

This is what death looks like.

We begin to wash you, corpse,

Herein is the most intimate part of my care.

I see all of you.

I see scars from the life you lived.

I trace them with my finger.

Lesson two, remember they were once alive.

As I wash your face, it is already committed to memory.

I will never remember your name, which is not my place; it is your families.

But I will forever remember your face, 

You were the patient that escaped the world, that defied all technological advances, all medicine;

You were the patient that died.

I show my students how to “bag and tag” you.

It’s seems more like common sense,

But perhaps it is the finality of zipping the bag around your face that requires guidance.

I send my students out of the room.

They must learn how to reenter the world of the living.

After being part of the world of the dead,
Even if but for ten minutes.
I stare at the white, cold, body bag;
I see the outline of your body.
On the bag is a red biohazard sign,
Signifying, that what was once alive is now dead.
You were once human,
Now you are a corpse.
Appendix II

Symbolic Interaction and Symbolic Anthropology Theories

The following is a brief summary of the various theories utilized in examining the data for this study.

Deviance

Deviance is defined as acts or behaviors that an individual or group of individuals partake in that may oppose the norms of a culture or society, most often eliciting negative reactions.

Deviant identity is not established merely by behaving in a deviant manner, such as speeding or smoking but relies on rule creators and rule enforcers, or members of society responsible for identifying and labeling deviant behavior. Social science theorists also argue that deviance can be a positive factor in the social landscape by identifying moral boundaries, unifying society and encouraging change within a society (Sandstrom 2010).

Within social interaction study, there exist two viewpoints for analyzing deviance. The first, the absolutist view, argues that morality and right/wrong boundaries existed before society and are independent of human manipulation. In contrast, the relativist point of view argues that morality and right/wrong boundaries are socially constructed, therefore, deviance is variable and dependent upon the society or culture. For the purpose of this study, the relativist point of view is utilized in understanding death as deviance in medical subculture (Sandstrom 2010).

Dramaturgical Theory

Dramaturgical theory seeks to explain human interactions in terms of the theatre. Scenes refer to situations surrounding the interaction, actors are the individuals involved in the interaction, acts are the segments of behaviors and role performance, audiences are individuals
that may observe the behavior, scripts include language and communication in the act and regions refer to the front and backstage of performance. The dramaturgical model demonstrates how individuals participate in creating social structures, defined roles and interpret interaction (Sandstrom et al. 2010).

**Collective Conscious and Behavior**

Collective action refers to the behavior that people groups partake in to create meaning to situations that oppose or challenge societal norms. Collective behavior, while most commonly applied to riots, demonstrates groups of people working out responses to ambiguous situations (Sandstrom 2010).

**Rite of Passage**

Rites of passages are innate to every culture and signify the progression or transition of an individual’s identity to another. There are three phases to a rite of passage. In the first phase the individual must separate from their existing identity, the second phase is the transition phase and then finally the individual develops a new identity in the third phase (Robbins 2009).