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**A RITUAL INVESTIGATION OF SUDDEN DEATH EVENTS IN AN  
URBAN UNITED STATES EMERGENCY DEPARTMENT**

by

**MARY ELEANOR MITSCH**

**DISSERTATION**

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

**DOCTOR OF PHILOSOPHY**

2012

**MAJOR: ANTHROPOLOGY**

Approved by:

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Advisor

Date

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## **DEDICATION**

I dedicate this research  
to my husband John and our sons John and James,  
the men in my life whom have taught me  
about love and family.

You have supported and nurtured me through this  
labor of love.

You have shown me every day that family is  
always about the living. I am grateful each moment  
for each of you.

I dedicate this work to our Jessica,  
whose sudden death event inspired this research.  
We live each day in anticipation of seeing  
your face and hearing your voice.

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## **Chapter 1**

### **Prologue**

This is the story of how I learned about death as a social act and a ritual process (Hertz 1960). In this auto ethnographic dissertation I will discuss how as a person, nurse, anthropologist and parent, I came to study the cultural meanings of rituals in sudden death events in an urban emergency department (ED).

Death in my large Catholic family was a social event. My mother was one of eight children. My father was one of six children. Each of these branches of my family had many extended family members. I was the fourth of five children. There were many rituals surrounding death. When a family member died we all went to the funeral home for two days of viewing and the third day was the funeral mass and then a funeral luncheon and of course another day off of school.

### **My Grandfather's Story**

When my favorite grandfather was in his later years he assured all of us that he would die on a Sunday so that all of his grandchildren (there were at least thirty of us) would get a full week off of school. He died on a Sunday night. The social and ritual process of death began the moment he passed away. People had to be called, funeral arrangements had to be made with the church and the funeral home. Ordinary life was suspended as we were thrown into ritual space. Then on that Monday after he died, our extended family were all together at our home, telling stories, cooking, and crying. On Tuesday, all day viewing at the funeral home, praying. Wednesday all day viewing at the

funeral home, praying. Thursday, prayers very early at the funeral home, saying final goodbyes, closing of the casket, funeral procession to the church, funeral mass, procession to the cemetery, graveside service, praying the burial (witnessed of course), eating at the luncheon, (after prayers before eating, more stories, laughing, crying). Friday, the final day of being all together, laughing and telling more stories about my grandfather, the weekend to rest and back to school on Monday. We laughed a lot at my grandfather's funeral. He loved to tell us jokes; he would have wanted us laughing, celebrating his life. My father's family dealt with most things with humor. My mother's family was much more serious about all things. She would many times come into a room and tell us that we were being too loud. She would say at least once each day, "Lower your voices, after all this is a funeral. Be more respectful." On her side of the family death was more serious, something that was treated with more respect and sadness, but the rituals were otherwise very similar.

These were the specific events of my grandfather's wake and funeral. How do I remember all of these details? I remember these details because this pattern was the sequence of events of everyone's wake and funeral in my family. This was our ritual process. It was also a social event. It was normal for us. Everyone would be at the funeral home all day, even the smallest child. We would take our board games and our cards. All of our cousins would be all dressed up and we would lie on the floor in a separate room, play and be together. We loved to be together. When the priest would come to say the rosary, another Catholic ritual one of my sisters would come to get us and we would go in to say the rosary with the grownups. We would get called in to see perhaps a certain

relative that wanted to see us. We would go in and out of the viewing room, touching, looking at, and staring at the deceased, wondering if we could discern the rise and fall of the chest in respiration. One or another cousin always claimed that the body was breathing. We would even kiss them if we were really close to the person. We could go in and out of any room that we wanted, as we wanted. We weren't banished from any room; we just were not expected to be in with the deceased each and every moment. In a large family we did this so often it seemed normal; death was expected, very sad, but part of the cycle of life. Moreover, because we were a religious family, life, we believed continued after death. We talked freely about seeing our loved ones again soon in another place that we called heaven, a beautiful place where we would all be reunited after death. A place where there was no pain, no suffering. This was our shared belief. My mother was a nurse; she explained early to us that people got sick, and that they sometimes got so sick there was nothing that the doctors could do, and that even though we were praying for them, they died. I learned that death was inevitable. I was fortunate in my family; people who died during my childhood were old. I had no idea what all of this was preparing me for.

I followed in my mother's footsteps and became a nurse. In nursing school as a student nurse I had very little or no experience with patients who were dying. I remember learning about how to "save" people and it was certainly implied, if not stated, that when people died it was because a member of the healthcare team had probably made an error or had not worked hard enough or long enough to "save" them. The only other explanation was that people had not listened well enough to the instructions that we

had given to them, or that they had chosen the wrong hospital whose team was not up to date on the latest research and techniques necessary to “save” a life. I started my nursing career carrying this awesome responsibility and tremendous stress.

Death presented itself early and often to me during my first nursing job after graduation in a busy medical surgical unit in a large urban hospital. I remember going home each day exhausted and wondering why it was so different from what I had learned in school. I wondered each day if I had chosen the right profession. It was so different from what I had expected it would be. I wondered if I was going to be able to do it. I was overwhelmed, and I had been underprepared by my nursing education. I was new and usually with an experienced nurse who helped me with policies and procedures that were written and those that were not written. I also learned that some policies were handed down to others by hospital oral tradition. Some policies made sense to me and others did not make sense. However, one day I was alone and I had to make a decision where there was no policy and I found myself making that decision based not on my formal education, or on oral tradition, but on what I had learned so well so many years prior to that day. I made that decision knowing that death was about family, tradition, culture. Death regardless of where it happens involves ritualistic and social activity. It can open people to the deepest mysteries of being human. The next story of a married couple demonstrates among other things the power that death has to dislodge people from habitual ways of being in the world.



## **The Couple's Story**

I remember one story involving one couple in particular. I was twenty one and single. I remember them as being "older". They were probably in their 40s. I admired the tender way they looked at each other. They were devoted to one another. The woman had a terminal cancer. I do not remember which one. Her husband was by her bedside day and night, day after day. I do not remember any other visitors. They were in a private room all the way at the end of the hall in the corner. They had a lot of privacy where their room was. Private rooms at that time were very rare and very expensive; they were never covered by insurance. They did not use their nurse call light very often. We went into the room only when we had to; I remember feeling like we were intruding if we stayed longer than we needed to stay to complete our tasks. Late each evening the husband would go to the cafeteria for dinner or coffee. He was never gone long. He only left her side for food.

This particular night I was coming on for the night shift. The other nurses were starting report and the nurse in charge told me that the husband was in the cafeteria and she asked me to go down and check on his wife. She said that the patient had been very lethargic all evening and her vital signs had been very low. The nurse said that she had been in the room a lot that evening and the husband had been hesitant to leave his wife's side. He knew that the end was near. I went into the room to check on her. She was dead. She appeared to have slept peacefully away. I went up the hall and told the nurses. They wanted to continue giving report and asked me to stay at the elevator to watch for her husband so that he would not go right to her room and find her by himself. After making

sure she looked peaceful when he entered the room, I went to stand at the elevator to wait for him.

When he got off the elevator he looked at me and I knew that he knew what I was going to tell him. I told him that while he was gone I had checked on her and that she had died. Silently we walked down the long hallway together and into the room where he just stood and looked at her. I asked him if he would like some time alone with her. He answered, yes, and then he asked me if he could get into bed with her. I told him, yes. I told him to take all the time he needed. I also told him that I would close the door and when he was ready he could come out to the nurses' station and we would let him know what to do next. I left him there and went back down the hall.

When I got back to the nursing station, they asked me where he was. I told them that he was in bed with his wife. I was so touched by it all. They were horrified that I had left him in the room alone, and they said something to me, "Is he some kind of pervert that he wants to get in bed with her? What if he does something kinky to her? Why would you leave him alone with her?" I remember saying, "They are married and we have left them alone together for weeks? What are we afraid that he could do to her now?" I was flabbergasted. I was also angry that they had ruined this moment for me. I can still see the three or four women standing there looking at me like I was the crazy one.

I was the outcast here. My action had shoved me outside of proper behavior according to the culture of this nursing unit. I had violated a sacred taboo. One of the nurses insisted I go get him. I told her, no, he would be out soon. We all looked at each other. It was a

standoff. I was not one of them, that I would never be one of them. But most importantly, I knew that I no longer wanted to be one of them.

Now, at 55, I wonder while I am writing this if I would have summoned the same courage to stand up to them, knowing now how miserable those nurses would make my life. I was so idealistic and naïve. That night they started making my life there very hard. I generally had the hardest assignment and no one would offer to help me. I had very few friends there and from that night on had even fewer.

### **The Anthropology Story**

Soon after that time, I requested a transfer to the maternity unit. Following that transfer I had a wonderful, long and extensive career working and teaching maternity nursing in urban areas. In the maternity specialty, nurses were exposed to perinatal loss in classes and clinical experiences in nursing school. As a result they were better equipped to handle death and dying on the job when they came to the maternity units to work. Where I was working many nurses were certified as grief specialists and gave high quality care to patients in this field of nursing. Perinatal loss was better researched leading to recommendations for guiding practice and care when these deaths did occur and rituals to help the families grieve well were freely practiced.

I found my work in urban healthcare very challenging. I was very committed to health care for women in urban areas. My husband was transferred often, and we moved several times in a few years, and I began to see some other challenges in my practice. I was working with high risk pregnant women and knew that their babies were healthier if

they attended prenatal appointments. It was well known to maternity nursing that transportation to and from clinics was often listed as a barrier when women are trying to access quality health care. But knowing that, I wondered why the women who lived literally across the street from the urban hospitals and prenatal clinics did not come for their prenatal appointments. Why wouldn't women cross the street for what I thought was high quality health care for them and their babies? I wondered if it could be related to issues of culture. Again, I found my nursing education and practice lacking complete answers. I wasn't ready to give up on my nursing career, because I loved nursing. But I wondered if the discipline of anthropology would be able to shine some light on this topic and others for me. I began to look into the idea of pursuing a PhD in medical anthropology. I applied and was accepted.

I loved my anthropology classes. I found the discipline challenging and the ideas new. The students in my classes were mostly younger than me and I found the whole idea of school at my age quite refreshing. I took one class at a time while I raised three children and taught nursing full time at another university. Life was very full, just the way I liked it.

The discipline of anthropology was changing me just as I had hoped. I was looking at almost everything in a new and different way. Nothing was as it appeared at first glance: Everything had a story; everything had a context. The years passed very quickly. I was moving through my coursework. I was immediately using my anthropology theory into my teaching in the nursing classroom and I felt that I was a better nurse because of my doctoral work. I was feeling very blessed.

I turned fifty. I was wondering, as so many women do at that age, what the theme would be of the second half of my life? What area would interest me enough to spend years of my life doing a dissertation? Did a subject exist that would keep me interested and engaged in writing and thinking about for several years? I took an End-of-Life Issues course and it brought back all of the issues that I had thought about earlier but had let go of for many reasons. Now I had the time to think about those important issues again in a new and different way. I had had the privilege of working with people who were dying, but now I had the absolute luxury of time and was able to study death as a social phenomenon. I was energized and I was hooked.

During that time I also had some deaths in my close circle of family and friends, and those experiences were enhanced by the evolving hospice movement. I had time to reflect on those deaths. I was most intrigued and impressed by the work that the nurses did in hospice care. Using my newly gained dual perspective, I examined the work that these nurses did not only from the viewpoint of a nurse but also from the viewpoint of a social scientist: What was the meaning of work to hospice nurses? I entered into my yearlong advanced methods class and began a two-semester research project where I interviewed hospice nurses with questions about this very subject. What did their work mean to them? Was there such a thing as a “good death”? This time was profound for me. The nurses and the stories that they shared with me were very important to my personal and professional life. For the hospice nurses and the families they cared for during this time, death was indeed a social and ritualistic event. They told me stories of patients’ families bathing loved ones who were dying, being in bed with loved ones and

many other dying rituals. The preparation for a “good death” was much like the preparation for birth that I was used to, working with families in labor and delivery nursing. Hospice nursing was unique in that the hospice team and the family knew that the loved one was dying. A “good death” could be prepared for; in most cases there was time to get “ready” for the death event.

The two semesters flew. The research was satisfying and fulfilling. It was my last course before my qualifying exams. I knew I was in the right place. I had ideas for my dissertation. I sent in my final project via email. I was very proud of my work. It was May 4<sup>th</sup> 2006. My students were attending Baccalaureate Mass on the campus where I taught. I picked up my cap and gown and walked across the campus for the procession. It was a beautiful evening. I was very excited to be done with my course work. I couldn't have been happier.

### **Jessica's Story**

After a reception which followed the Baccalaureate Mass, I returned to my car where I found my cell phone ringing. It was about 9:30 pm. It was my husband calling to tell me that my 24-year-old daughter had been in a car accident on her way home from work. She was actually in the ED of the hospital where she was employed. He told me to come right home. I drove home and got into his car in the driveway, and we drove off into liminal space.

We drove the fifteen minutes to the hospital, and I started making phone calls to ask people to pray for us. I am on several prayer lists and I called each of them. All of the people I called asked if they should come. I told each of them not to, because I did not

know what was happening. I told each of them that when “I get there, I will see and then I will let you know what I need”. I did call one of my friends, Martha, who held an executive position there at the hospital; I knew that I would need a physician referral at that hospital. As a family we had our doctors at another hospital and I thought I might need some advice. She told me that she would come. I told her that I would appreciate that. I also told one other family to come. Our families had a long history of being together in tragic circumstances and I thought I could use their support. I did not want a lot of people. I also asked John to call Jessica’s two brothers but to tell them they did not have to come to the hospital, because I wanted to know what was going on first; my sons hated hospitals, and I did not want them there if they did not need to be there. My husband was able to reach each of the boys, and they waited to hear more from us.

We actually came upon the accident scene on our way to the hospital. The police had it blocked off. The expressway was closed, and taking the posted detour was being rerouted this way. Now the police were detouring everyone yet another way. John got out of the car to tell them who we were so that they would let us through. I remember looking straight ahead. A policeman came up to my window and asked me if I had heard what had happened here. I said that I knew that the accident had been very serious. He looked at me with very sad eyes and told me, “Good luck.” I remember thanking him. John got back in the car and they moved the barriers and we drove through. I remember looking straight ahead. I remember only flashing lights.

After we made it past the accident scene, I called Jessica’s brother Johnny who was in Lansing and told him that he needed to come. Johnny had been celebrating a

friend's 21st birthday and he was going to call someone to get him. I told him to do that. I called a friend of mine and asked her to go to my house and get my younger son Jimmy and bring him to the hospital. She was a beautiful, loving, and comforting person, and I knew that he would come with her.

A few moments later we arrived at the ED. John pulled up and I got out of the car. He told me that he was going to go park. I went in and there was a woman waiting for me. "Mrs. Mitsch?" Yes, I said. I am sure that she introduced herself to me, but I heard her say was that she was from Pastoral Care. She asked me if I was alone. I told her that my husband was parking the car. She asked me if there was other family that she could call for me. I told her that all of my family was back East. I asked her where Jessica was. She told me that Jessica was having a CAT scan done and that the doctor would talk to us in the family room. I remember thinking two things, that she was still alive (they do not do CAT scans on dead people), and that I did not want to go to the family room; they only give very bad news in the family room. I did walk with her though and when we got to the family room there was a ladies room across from the family room and I went into the bathroom. I vomited. I washed my face, looked into the mirror, pulled myself together and went out to the hallway. John was there in the hallway with the pastoral care person, I took my husband's hand and we went into the family room.

The doctor was in there alone, sitting in a chair. I remember thinking that he looked 13 years old. I also remember feeling sorry for him because he looked so sad. I knew that he hated to be the one to tell us what he was going to tell us. He took a deep breath, he looked down took another deep breath, looked up, and said, "She was



completely down at the site. She had no vitals when they got to her. She wanted to come back to you. Her heart started right up. She had some movement at first but now there is none. We know that her spinal cord is severed. We just do not know how high and she can't breathe on her own. She had no blood pressure when she got here" -- I remember calculating that in my head what 15 minutes with no BP meant-- "She has several skull fractures that we can see, and she has very severe head injuries. I have sent her for a CAT scan and I am sure that we will only find more bad news. I am very sorry. Do you have any questions?" I asked the doctor why she didn't go directly to University Hospital. The doctor responded, "We couldn't take her with absent vital signs past one hospital to go to another." And then I asked him, "Can you transfer her now?" And he shook his head.

He then told us that after the CAT scan she would be transferred to the Surgical Intensive Care Unit (SICU). They had called in the neurosurgeon on call and he would be in to see if surgery would be an option. He again asked if we had any questions. We did not. He told us again that he was sorry. He stood up and he left.

That left us with the pastoral minister. She asked us if we wanted anything. I told her that I wanted a priest and I wanted to see Jessica. She told me that she had called the priest and could not reach him. She was the pastoral minister on call. She did not know if I could see Jessica in the SICU because the visiting hours in that unit were over.

I then looked towards the doorway and saw two people standing there, my friend Martha and a person there in scrubs. Martha introduced the person in scrubs to me as the manager of the unit where Jessica worked. The woman's name was Pat. Jessica had

worked in Pat's unit until 8:00 that night. Her car had been hit on her way home from work. Jessica had worked at this hospital. She had been hit leaving work. Apparently she was at work late. She stayed late to finish some paperwork for a patient who was a new admission who had come in and needed a procedure early the next morning. She had left work late. She was hit and came into the ED and was unrecognizable from her injuries. Jessica was in scrubs and her car was registered to her. They called the unit where she worked and asked if one of them could come and identify her. The staff there called her manager at home and she came in from home and identified her and then they called us.

That is how Pat came to be with us now. We had never met her before this evening. They were working on getting us into the other unit, the SICU, where the visiting hours were over so that we could be with Jessica. Apparently, the nurses were very strict about enforcing visiting hours in the SICU. I was horrified about that. I was begging my friend Martha to use all of her power and influence to help us. She calmly and repeatedly told us that she was "working on it" and would help us. Martha was also trying to get us a priest. I needed Jessica to have the Catholic healing ritual of Anointing of the Sick, which could only be administered by an ordained priest. This is a very important ritual for Catholics, especially Catholics who are in imminent danger of dying.

At some point during this time I was given a clean urine cup filled with Jessica's jewelry. I do not remember who handed it to me. I do remember thinking: Oh, my God, her jewelry is in a urine cup? When I worked on a maternity unit, we lovingly placed items in a beautiful small silk bag for the mother. But a urine cup? Had I left the planet?

Eventually, we left the family room in the ED and walked over the SICU waiting area. We got to a large waiting room, and a resident came to talk to us. He told us that she had returned from the CAT scan and was in the room and that we could see her. He said that they were waiting for the neurosurgeon. He kept clearing his throat, putting his head down, and could not make eye contact with us. He asked us if we had any questions. I was absolutely numb. I could think of nothing. My mind was blank. Martha asked what the CAT scan showed. I remember thinking, what a good question. He said that he did not have the results. I remember thinking he lied to us just then. There also was a police officer in the waiting room. I remember wondering why they had let her in. Why was it that she was allowed in, but I wasn't? I was Jessica's mother. The police officer was talking to someone; I can't remember whom. John went up to her and told her who he was. He asked her if she had any information about the accident. She told him that a man went through a stop sign and hit Jessica. She said that he was coming from a golf outing. He did not appear to be drunk and they did not smell alcohol, but they had sent him to be tested at the university hospital. She said that she was angry because he had a lot of points on his license, and even if he had just gone through the stop sign, he would have lost his license. I had to walk away from her. She was so angry she was shaking. She was pacing back and forth in front of us. Her anxiety made me more anxious.

I know now that she had seen what happened to Jessica. It must have been horrible for her to see Jessica and then see us. I went to sit down. It was soon after an SICU employee came and told us that we could see Jessica. I never saw the police officer

again; I would have liked to have thanked her. I just couldn't that night. I couldn't stand being near her.

Martha walked John and me up to the ICU window of Jessica's room. She was holding onto my arm. John was on the other side of me. I looked in the window at my daughter in the bed. Jessica's head was wrapped in a towel and her face was swollen and bruised. She did not look anything like herself. I remember trying to catch my breath and at the same time saying out loud horrified "is that her face"? Martha calmly answering that there was a lot of packing around her face and most of that was bruising which of course would go away. She was on a ventilator and that was all I remember seeing, a lot of people doing different things, activity everywhere, Martha on one side of me talking softly and John on the other side saying nothing.

I remember Martha asking me if I was ready to go in. I nodded my head and we walked in the door. None of the nurses looked up. I remember saying, "She is not here," and John saying "Where is she?" "She is all around us but she is not in this body." I knew that she was not in her body, but I felt her all around me. I moved past Martha and maneuvered my way through the IV lines and tubes past people and up to her bruised and very swollen face. I leaned down and kissed her... She just did not feel like my Jessica. "Oh, Jessica," I whispered. I breathed onto her face. I stood up and made room for John to kiss her. I tried to look at the nurses. The room seemed so dark. Martha was now across from me on the other side of the bed, and she asked me to lean towards her. She had a washcloth and she wiped my face. I realized later she must have wiped blood off of my face. I moved down the bed and gave John the space by Jessica's head. I reached

down and picked up her hand and almost immediately placed it softly back on the bed. “Her hand feels dead,” I said to the nurse directly across the bed from me. She answered me. “It feels like that sometimes when the arm is broken and we think her extremities could all be broken”. I looked at her arms. They looked so perfect lying on the bed. I looked again at her face, but I could hardly stand to look at her. She had a tube in her mouth connected to the ventilator, and her fabulous blond hair was pulled back by packing and a towel, saturated in blood. Her eyes were so swollen and they were surrounded by black bruising. Jessica was so blond and she would bruise and get swollen so easily. Her eyelashes were so long; they were caked with blood. There was blood covering her closed eyes. I asked for a 4 x 4 gauze pad to wipe her eyes clean. I assumed that the blood had come from the cut on her forehead where the packing was. Martha opened a clean pad for me. I gently wiped her eye orbital. As I wiped, the blood immediately returned. I drew in my breath, I kept breathing in, because breathing out was so much work. I looked at the nurse again and said, “That blood is coming from her brain.” She nodded and looked down. I put my head down. I asked for a priest. Martha told me that she had called another friend of ours, Martie, also a nurse, and that she was going to get a priest. I relaxed. I knew that Martie would take this very seriously and I would get a priest in time. John told me that Jimmy was in the waiting room. He wanted to wait for his brother Johnny to get there before he came in to see Jessica. More of our friends were out there with him. I told John I thought that was okay, and I told him that Jessica was not really there anyway. I thought it was fine for him to wait for his brother.

Jessica would want it that way, the two of them together. She knew how hard this would be for them.

One of the nurses then came in and said that one my friends Mary Ann who was in the waiting room wanted to come in and pray over Jessica but that if she came in one of us would have to leave. I was so insulted. My daughter was dying and they were sticking to some policy of only two visitors at a time, a common ICU visitor policy, but I just said that I would leave. I knew how to play the game. I knew that I was not leaving, but I wanted to see Mary Ann, and I wanted her to pray over Jessica. I knew at this point they would have to throw me out. One of the nurses who overheard this conversation, I think, was trying to help me. She told me that Jessica's feet were very warm and that perhaps I would like to come to the bottom of the bed and touch them. I did and did feel very comforted by that. Jessica and I had painted our toenails together watching *Grey's Anatomy* the Sunday before.

I did step out of the room but stayed right in the hallway looking in through the window. Martha stepped out, and so did John. I stood there watching the staff working so diligently to save my daughter. I was certain they were doing an excellent job with her. I verified with Martha that I had heard that Jessica's spinal cord was severed and that she was paralyzed, and she said yes. Then she said this "Start to think about organ donation" I said, "Yes. Something good must come of this." John said, "What did you say?" Martha said "I was just telling Mary about all of the miracles that happen here at .... I also know that Fr John is coming". I received a call then from my friend Fr Jim. I had called every priest I knew on the ride there and for some reason could reach no one that night. I told

him that Jessica was very ill and that we were waiting for the neurosurgeon. He responded "I am coming". After I got his call, I turned my phone off. I was hoping that he would pick up my message. I was waiting for him to call back. I was too exhausted to talk now to anyone else. Mary Ann came in to pray over Jessica. I told her to pray and hold Jessica's feet, the only part of her that still felt like her. She did that and then she stood with me. No one asked anyone to leave.

Martha came to me and told me that Fr. John, our parish priest, was there. I went to him. I was afraid to let him right in to see Jessica. I wanted to prepare him to what she looked like. I started to talk to him and Martha said something to me; I don't know what she said to me, but I remember thinking we should hurry. I remember trying to get him close to her, taking him up close to her on the left side of the bed with me I led the way and he came with me, up close to her head and face, maneuvering him again past the tubes, IV's and lines. I remember concentrating on trying to stand up straight...just wanting to lie across her or fall on the floor screaming. I wasn't sure what to do, but I knew I could not really do what I wanted. I was so afraid that they would ask me to leave. I felt like I was on stage and they were watching me and I had to do the right thing. I just didn't know what that was. How does one act when one's life is shattering in front of her? I could hear Fr. John praying, and my entire body started to shake. I felt his arm go around me. I fell into his side in relief. He understood. His arm tightened around my waist as if to say, Go ahead and lean on me, I have you. But he said out loud, "Pray with me, Mary." He started the *Our Father* and I did pray. The memory of that prayer rushed over me and brought me back to a place that I knew and had been before. He knew that.

He prayed louder. I have no recollection of him actually anointing her face or body, but my husband remembers him anointing Jessica. I wish I had those memories. I know that they would comfort me. I so desperately wanted her anointed and I had continually asked the nurses for a priest. I do not know if Jessica would have wanted those rituals but I had to have them for her and for our family. It was what I knew of death. It was my learned and lived experience.

Fr. John finished the ritual of anointing and as the prayer was ending I heard someone say “Mrs. Mitsch?” I turned towards the door of the room and saw a man in scrubs. “That is Dr. T.,” I heard someone say. The man motioned to me to follow him. I followed him to a small room down the hall. The room had several chairs and a table in it. There were dirty coffee cups and newspapers on the tables and the wastebaskets were full. I remember thinking the room was filthy. I sat down between John and my friend Martha. Dr T. leaned back on the table, and said something like this: “I wish I had something else to tell you. There is nothing we can do for her. There is no hope, no thread of hope, no surgery, and no miracle. She will not survive. I came here so that you did not have to hear this from a resident.” I know that he kept talking. I just saw his lips moving. I never heard another word. On my right I felt my husband moving beside me and I knew that he asked him a question; I know Dr T. answered him, but I never heard the words. It was as if I was deaf, I was in complete silence.

Then I heard an alarm. I heard Martha speak softly in my left ear. I was sure that it was Jessica. That was her alarm. I said to Martha that I didn’t know what to do. Martha said, “Let’s get up and go into the hall and make a decision. She took my arm and



I went with her. My vision was so limited I could only see about one foot to either side of me. I had no peripheral vision. My husband followed me and we went out of the room. Mary Ann told me later that she and Fr John were with us. I have no recollection of them being there. I went into the hall and there were several doctors in the hall waiting for us. They ask us what we wanted to do. I said to Martha, "Tell them to stop." She turned to the doctors and said, "You can stop." Then I told them to keep her on life support if they could use her organs. The head resident shook his head then looked down, and then the doctors walked away.

I continued to hold on to Martha and my husband, and we headed to the waiting room to tell Jimmy. On my way to the waiting room I could hear my friends praying the rosary before I could see them. I can't explain the comfort I felt at that moment. I walked in and stood there and said, "She did not make it." One of my friends, Mary Beth, said, "Oh, Mary," and got up and hugged me. I turned. Jimmy was in a private room just next to the larger room. John was going in there and I followed him. John told Jimmy, "She died, Jimmy," And Jimmy answered, "Oh, shit! Oh, my God, Dad!" John and I sat down on the floor with our son. We were completely silent. What was there to say?

I have no idea how long we sat there. John got up and said that he wanted to go to the ED and try to meet Johnny before someone else told him. I think maybe Jimmy went with him. I got up and went back to the larger room. I cannot remember anything except the door opening and my friend, Fr Jim, coming in. I remember getting up and falling into his arms. I whispered, "Do you know? -- I couldn't say it out loud -- And he said, "I do." And I said "God has me confused with someone else." He did not answer. Fr John

got up at this time. I had forgotten all about him. They greeted each other. Fr John said, "I got here just in time." I remember saying softly. "Don't be ridiculous Fr. John. She waited for you." I really believed that. She died right after we were done praying. Fr John said he felt that way too, that it was why he was talking louder, because he could feel her spirit leaving the room; he wanted her to hear him all the way out. I know that she stayed because she knew that it was so important to me that she was anointed.

All of my friends were sitting there. We sat back down. I guess that someone said that we could come back in. Martha and I got up and I remember leaning down and taking Fr Jim by the hand, taking him in with me. I remember walking down a very long hallway between the waiting room and Jessica's room. My peripheral vision was almost gone. The hallway was like a football field.

I can remember two things that happened on the way to Jessica's room. Fr Jim, who had his arm around my waist supporting me, asked me, "Mary, what are you thinking?" I said, "Nothing. My mind is blank." I remember trying to think of something and being absolutely unable to think of one thing. I asked him, "What are you thinking?" and he said, "Jessica is with Jesus." I couldn't think of a response. I also remember a nurse stopping me. She told me that she had to tell me how very sorry she was. She had worked with Jessica and she wanted me to know that we had raised such a wonderful young woman, that Jessica was such a joy to work with. I remember telling her that Jessica was our first child and that in so many ways she had raised us, and that I appreciated her telling me what she had told me.

The three of us -- Fr Jim, Martha, and I -- went back in to see Jessica. I remember when I went in that she looked the same as she did when she was on life support. That verified for me that I was right about her spirit. When a person dies, they look very different. Call it by whatever name you would like, I will call it a soul. When the soul leaves the body the body looks very different. I had noticed this difference in patients when they died in my nursing practice. The connection between a mother and a child is difficult to describe here at this moment. When I first saw Jessica her soul was gone, her heart was beating because the drugs were telling it to, and the ventilator was breathing for her, but her soul was gone from her body which was why her hand felt dead. There was no longer that spiritual connection between my beautiful daughter and me. I did not even know that the connection was so palpable until it was gone. It was always there, until that night when it was no longer. However, I did feel her all around me in the room. I would have to learn a new way to spiritually connect with her.

I was overwhelmed by a desire to get into bed with her. The bed she was in the room was very narrow. I asked Martha to help me to move her. We moved her to the other edge of the bed. I removed my shoes and I crawled into bed with my beautiful child, who had snuggled with me for years and who just the weekend before had sat at the bottom of my bed and told me about her evening out with her friends and how much fun she had. I nestled into her body and closed my eyes. I was still holding Fr Jim's hand with my right hand. It was as if I couldn't let go; I was afraid if I did I would fall into a darkness I would never get out of. I lay with her and I asked if they would ask my friends to come in and pray. I could hear people gathering around us and praying. I asked my

friend Sharon to make sure the nurse who had stopped me in the hallway was invited in with our friends. I felt like the nurse was one of us now. I have no idea if she came. I never opened my eyes. I listened to those voices praying for me, my friends were praying for us. I was hoping that God was listening. I was wondering if I was ever going to be able to get out of that bed. My mind was blank and full at the same time. I was numb. Shouldn't I be screaming or crying? No, that just wasn't me. Jessica would hate that. I was with her now. I would never get to do this ever again. It was time to be grateful and in the moment. I practice an hour of contemplative prayer each morning for two years prior to this night. While I lay with my Jessie, God carried me into a contemplative state of mind.

I have no idea how long my friends prayed the *Our Father*. At some point I got up and I put my shoes on. I started to worry about Jessica going to the hospital morgue. I knew that this would be a medical examiner case. I remember looking at my friend Cathy and saying, "I do not want Jessica to go to the hospital morgue." I remember this incredible sadness on her face. She said nothing. I couldn't think....so I decided to do something.

I asked Martha for some water to bathe Jessica. I asked all the women to help me. It was time for the next ritual. I wanted to bathe her and cover her with lotion. Where was her purse? I knew my daughter: her favorite lotion would be in her purse. Her purse was located and they gave me some of the lotion from the hospital. I made some remark that she must have stolen that awful lotion and I was not using that on her body. No, look again. I know that she would have some great lotion in her purse. Sure enough, she did. I

was so proud. *Aveeno Baby<sub>tm</sub>: Lavender and Vanilla Calming Comfort Lotion, Helps calm babies before bedtime.* A brand new tube, barely used. Perfect.

Twelve women, two generations of women, my friends and her friends, began to bathe her. I started wiping her face, but I could not spend much time there. Her face was so damaged, her neck and shoulders had little marks almost like crosses, and I realized that they were from flying pieces of glass. The little crosses were all over her otherwise perfect body. I gently bathed them down to her breasts realizing she would never breastfeed a baby; she would never have a baby. I was beginning to feel myself panic. What will I do? What should I do right now to pull myself together? I always sang to my kids when they got panicky. Singing always helped Jessica. “I know this sounds crazy,” I said, “but I think we should sing.” I just kept talking. Jessica always liked it when I sang to her, especially when she was a little girl, starting a new adventure, or doing something new, I think that this qualifies as a new adventure, I said. She especially liked “My Favorite Things” from *The Sound of Music* (she would ask “sing me favorite things mommy”) so we proceeded to sing it. My friends joined in. One of them, Kathleen, stated, “This is a red tent moment,” referring to the book *The Red Tent* (Diamant, 1997). I had to agree. We continued to minister to her and to each other simultaneously. When did we women get so busy that we no longer had the time or the energy to minister to each other? Had we forgotten how?

I lifted Jessica’s gown to discover that she had a pierced navel. That moment I gently reprimand her, “Jessica Marie, why did you get that piercing?” Everyone laughed. I did not know of this piercing, of course. One of her friends, Claire, stated, “She also has

a tattoo in her back that you do not know about. Do not turn her over.” More laughter. I did not turn her over. I wondered what the nurses were thinking. I knew that they were just outside the door. A terrible accident, a crazy family insisting that they get in after visiting hours, causing all kinds of trouble, laughing and singing – the nurses must have been wondering, Who are these people?

Humor. Humor had always been an important ingredient in my life. My family had used humor as a means of survival in times of hardship. Humor was also used in times of greatest intimacy, with the people that we loved the most. This was of course one of those times.

We bathed Jessica and covered her beautiful body with that wonderful lotion that she had picked at the drugstore several days before. I marveled at her and all the gifts that God had lavished on her. She in turn had so generously given those gifts to many others. I was devastated about her brain and all the damage to her head. She was a brilliant woman, working on her second degree. We had taken such good care of her. Organic baby food, cloth diapers, teaching her to be safe, saving money for private schools... all of it, all gone in a moment. We had such a short time together. Ah, but what a time. Fortunately we had savored all of it. Even tonight, each moment had been savored.

Pat, Jessica’s manager, also asked if the staff from her unit could come down and say goodbye to her. She was hesitant, stating that she realized that this was such a private family time. I knew how much Jessica cared for her “family” at work. It was a very small unit where she worked, and the unit was very close. I readily agreed, and they soon came

and said tearful goodbyes. I hoped it was all that they needed it to be. I could not stay focused on their needs, but I know that her coworkers were very important to her.

“Mrs. Mitsch? Can you come out and sign some papers?” Funeral papers. Where was John? Someone went to locate him; they thought he was making phone calls. Our sons were with him. I wanted the boys to come in and say goodbye to her. One of the nurses told me that they did not want to and that I couldn’t make them; I told her that I had no intention of “making them.” However, I was their mother and was intent on talking to them and explaining to them that research shows how important it was to hold her and to say goodbye. I explained to her that I was a perinatal nurse and this was our grief and loss research. She seemed okay with that. Our sons were back. I went to them and explained why I thought they should go in and say good-bye to her. They wanted to. I then prepared them for what they would see.

Looking back now, I know that I went back and forth that night between being mom and being a nurse. I was Jessica’s mom, but when I couldn’t stand being the mom I could be the nurse, comfortable with the tubes and the place; I could step out of the context, take myself out of the story. I was only the nurse, my shift would end, and I would go home like always, as if this was someone else’s family; I could be removed. But then it hit me -- *Oh, no, no ... this was my family, this was me, this was my daughter who was dying.* The strangers were the staff, not the family and the visitors. Everything was wrong here.

I became the nurse for those two safe minutes for my sons, preparing them for what they would see. They listened to me intently. They told me they were ready. And

then I was a mom again. John and I went with them into the room. It was just the four of us – well, five, actually, but a very different five than the five we were. I unsnapped the top of her gown and told her that her body was perfect from the neck down, that they needed to see her shoulders, and that they could kiss her hands or shoulders if they couldn't kiss her face. They each took a side of the bed and kissed her face and told her how much they loved her. They sat there for a short time and then they stood up. We walked out of that room together leaving part of all of us there with Jessica and taking a piece of her with us. We were changed forever.

They explained to me that Jessica would have to have an autopsy since it was a crime. She would have to go to the morgue and the cause of death would have to be determined. **This piece of information was the breaking point for me.... I remember taking a deep breath and taking a moment to calm myself before speaking, (I wanted to scream at this nurse) saying” I just spoke to the neurosurgeon who established the cause of death. He told me that she would never survive. How many doctors does it take to establish cause of death? I would never have stopped her CPR if there was any doubt. What are you telling me? I would like to talk to the medical examiner”.**

A beautiful woman in a lovely red suit stood up from behind the nurse's station and said, “I am the medical examiner, Mrs. Mitsch. This is a high profile criminal case. Your daughter's body is evidence, and we need to collect the evidence. You will also want the evidence in case you want to bring suit against the driver.” “I know that we will not sue the driver,” I stated. “We still need to do our job” was the response. “Please,” I



begged, “go look at her. You will know why she died. Can’t you spare her any more traumas?” She was now kinder but firmer, “I will speak to the coroner when we get there and I will let him know your feelings. I walked away knowing that when I entered the hospital -- because my daughter was not a minor, she was 24 -- as parents we had no rights. Jessica was not conscious, and it was an emergency situation, so the doctors controlled who saw my daughter and what tests my daughter had; they had all the power over her. Then, when she died, the state had all the power over her, and she became material culture as evidence for the criminal case. The state owned her now. My husband and I lost her the moment the two cars touched and she lost the ability to choose. How did that happen?

I remember turning to my friend Cathy, a maternity nurse, knowing that she would understand me. I just did not want her to go to the morgue. How can I leave her here and let someone take her to the morgue and leave her there alone? Cathy looked at me with great sadness. What could she say that would change what had to happen?

Martha spoke, “I will stay with her, and I will not leave her. I will do her care with the nurses and I will go with her to the morgue. I will stay with her until I can’t stay with her anymore. I promise I won’t leave her, Mary. “ Another nurse asked me if I would like Jessica’s clothes. I said I did, that I wanted her clothes, I wanted everything that ever touched her, I wanted everything. My friend Sharon asked her husband to get Jessica’s clothes and put them in their car. She then said, “It’s time to go Mary”.

We walked out to the waiting room to our friends who were still waiting for us and continued to walk with us through the rituals that followed. As I mentioned before, I

had many experiences in childhood where death was handled in the bosom of family, as had my husband; however, none of us had experienced death as a sudden event with a family member. Our sons, up to this point, had learned very little about death as a social act and a ritual process. They had buried goldfish and hamsters, and we had had appropriate rituals for their animal friends. They had lost one grandparent who had been ill for a long time; they had plenty of time to prepare for his death.

Our relatives and friends came from Pennsylvania and we continued the long tradition of death rituals that had been so comforting to our families for generations. Our friends and neighbors here in Michigan joined in our celebration of Jessica's life. As was our tradition, we celebrated her life for one week. Our home was full of people, love, food and stories. We prayed, talked and cried each and every day. She died on a Thursday night and was buried the following Thursday. Fr Jim led 1500 people in the funeral mass of resurrection, a beautiful celebration of her life, a life full of joy and passion for living. Jimmy was supposed to take his finals that week in high school -- he was a graduating senior -- and I asked that he be exempted from all of his exams. I explained to him that it was a gift to him from Jessica. I told him I didn't care what the school decided; he would not be taking finals since the finals could not accurately measure what he had learned. Fortunately, the school agreed with my assessment of the situation.

Time passed. John returned to work and started traveling for his job within two weeks, and Jimmy graduated from high school. Johnny and Jimmy returned to their jobs

the next week. They both worked at a local golf resort and they loved to golf and found being outside very therapeutic.

I had not planned on teaching that summer so I had not signed a contract. I had planned on preparing for my comprehensive exams and preparing my dissertation proposal, which I thought would be on an end-of-life issue related to a project that I had just completed related to the meaning of work for Hospice nurses. My doctoral advisor suggested that perhaps I might want to change my topic that it might be too difficult for me to continue on this path. I remember telling her that I had no idea what I was going to do in many areas of my life. But I knew one thing for certain: I would finish my PhD, and my dissertation would, indeed, be on end-of-life issues, but I had no idea when that would be.

I bought several new white nightgowns -- everything I bought that summer was white, a sign of resurrection -- and I sat on my deck in the backyard. I had a beautiful garden, planted by my sister-in-law Joan, who came from back East twice and planted gardens each time, and I found great peace there. Some days I would pray, some days I would read books on grief -- especially on sudden death -- some days I would cry, and some days I would just sit there. I always listened to beautiful music. My sister from Alaska came three times that summer and sat on my deck with me. Time passed quickly. My neighbors and friends would visit me and bring dinner; I remember opening the door one time and being shocked that it was five o'clock. I had lost all sense of time. I welcomed any visitor, but I clung to two or three people in my life who consistently gave me hope. I did not want to go anywhere, and I did not really care to eat. I felt her with me

every minute. I had many signs of her presence and love. There were many times that I could almost touch her. I did not take any drugs; I could sleep all night every night.

Several weeks later I recalled the writing of Rosaldo (1989), Grief and a Headhunter's Rage. I had always been drawn to this work. I began to read it over and over again. I read this famous account of the sudden death of his wife Michelle and his responses to her death. Many of the events that Rosaldo had studied that seemed so distant from his personal life prior to his wife's death had taken on new meaning following her death. I realized that our journeys were intellectually similar, trying to bring meanings to sudden death. His fieldwork was in an exotic place, I was a "native" an "insider", and I realized now that this auto ethnography began during my time not in a library at a computer at a large and impressive university, but on my deck in a white nightgown.

I realized that, sadly, 30 years after I had left a nursing unit because I had broken "the rules" for letting a husband get into bed with his wife; I was breaking "the rules" this time with my own daughter. The health care system in the acute settings had not learned what I had the privilege of learning as a child, that death was a social act and ritualistic process. The formal rules were still limiting visitors, and viewing of the deceased and rituals were still not allowed. Choices were not being offered or were limited.

There was evidence of rituals in the end-of-life literature in the area of hospice and palliative care. But in the area of sudden death I found nothing in the literature related to family ritualistic activities and no literature related to how professional staff

members make meaning in their work in the aftermath of a sudden death event. I wondered whether meaning making wasn't encouraged or even allowed. Did it exist?

It is quite common for bereaved parents to have a mission. I buried my beautiful daughter Jessica and my dissertation topic was born.

### **Statement of the Problem**

Anthropologists have long recognized death as a social act and a ritual process. The ritualized process that occurs during and following death has been studied in cross cultural contexts and has been the topic of both classic ethnographies (Durkheim (1995) [1912], Hertz 1960 [1907], Malinowski 1979 [1915], Rosaldo 1980) and recent ethnographies (Conklin 2001, Kaufman 2005, Lawton 2000, Pool 2000, and Sharp, 2006). One of the most important of these classic ethnographies was written by Robert Hertz (1960) [1907]). Hertz's research conducted mostly among the Dayak of Indonesia and other South Asian societies provides a framework for cross cultural comparison (Robben 2004); this work is considered seminal in the field of anthropology, especially in the anthropology of death and dying.

In studying various aspects of death, Hertz (1960) proposed that death does not occur in a moment but is a transitional social process that occurs over time. Death and the time period immediately following death are marked by rituals that have individual and collective meanings. Hertz further indicated that associated mortuary practices were important to demonstrating the social order of the society. There were two goals to be

accomplished in re-establishing the social order following a death: first was the exclusion of the deceased individual from the society, and second was the reallocation of the roles of the deceased to others in the community. This significant ritual process was planned and laid out in a formulated way in different contexts.

Hertz's model continues to be a reference point in contemporary anthropological studies of death and dying, and his model provided a starting point for conceptualizing this research which investigated the social act of dying and rituals relating to sudden death in an urban (ED) in the United States (US).

While an extensive tradition of writings exists in which anthropologists have investigated different death rituals and their meanings in specific cultural contexts, there are still gaps in the literature. One of these gaps is in the area of rituals in the event of a sudden death. This dissertation research focused on any death that occurs in the ED. The temporal aspect of a sudden death can be very socially problematic, when there is no anticipation and no preparation. As in a more expected death, there is a corpse, survivors and a community where the deceased had social roles. There are relationships between the dead and the living and as death occurs so does a transforming experience for those involved.

In both kinds of death, sudden and a more "prepared for" death, the dying person goes through a *rite of passage* van Gennep (1960[1909]) and enters into an area of *liminality* Turner (1967, 1969, 1982, 1987). This rite of passage involves a key transition from life to death and crossing a threshold where the dying person cannot cross back. The liminal time is considered a temporary time, although of varying duration. Similarly, it

is important to contemplate how these major theoretical concepts relate to the social transitions of the family and other mourners as well. For example, the mourners also may have no idea where they are going, how they will exist within the social order without the deceased but sense that they cannot move back. In studying the social aspects of death in sudden death, it is therefore important to realize that liminality is still a highly relevant concept. With the key ideas of rites of passages and liminality in mind, there is a need for further anthropological investigation of the question of what the social act in sudden death is and what related rituals exist in a specific cultural context.

In the highly death adverse U.S. culture, the idea of death and especially sudden death is seen as “unnatural” in the predominantly biomedical healthcare system where the approaches to care are heavily premised on a heroic and curative outcome. Consequently death is seen many times as a medical failure as opposed to a human life course event. Therefore conducting this research in an urban ED in a large U.S. metropolitan area is a significant place in which to further study the concept of sudden death as a social act and a ritual process. The ED is a setting where the heroic use of technology is utilized routinely to save lives; death in this setting is particularly sudden and unexpected.

### **Purpose**

The purpose of this dissertation research is to study the context of sudden unexpected death in an urban ED. An auto ethnographic approach will be utilized by the anthropologist, who is a nurse and a bereaved parent. Some of the patients may be transferred to the Intensive Care Unit (ICU) and die there, but this study will be limited to

the deaths that occur in the ED. The questions that I have are these: What kind of social act is death when the context is sudden? What rituals exist when the death is sudden death? What has meaning to the family at a time when their family member has died suddenly and without warning? How does the organizational culture and related power dynamics of the setting affect the possibility of ritualistic activity? How does the culture of the ED affect the making of stories and how does this experience stay with the staff members and the bereaved after the event?

The specific aims of the study were to:

1. Identify and describe the meaning of social rituals to families and healthcare staff involved in sudden death events in an urban ED
2. Discover the organizational culture and power structure involved with the formal and informal rituals in a sudden death in an urban ED
3. Analyze the data collected regarding the social rituals and organizational culture in sudden events in an urban ED in the U.S. to contribute to the anthropological literature on death and dying and ritual processes

### **Background and Significance**

Several theoretical frameworks will be used to understand the social construction of sudden death in the urban American ED setting. Robert Hertz (1960 [1907]) studied the emotional and social aspects of death by studying primarily the funeral rituals of the Dayak culture. In describing how rites and rituals were socially constructed, he identified several key headings: the corpse, the soul and the survivors. The goals of the funeral ceremony were to: bury the dead, give the soul access to another land and end mourning for the living, and allow them to enter back into society. Hertz compares death to other



rites of passage such as birth and weddings. In all of these events the idea is separation from one state and integration into another place in society. This initiation requires that all involved engage in rituals to insure safe transition from one place to the other.

In the social practice of death rituals, mourners recognize that the deceased had a role in society and that role cannot be ended in one moment. Society has made an “investment” in this person and there is recognition of the “collective consciousness” of acknowledging death as a community event. The funeral practices and burial rituals were used to mourn the deceased and to transform the deceased into an ancestor. This ritual process allowed mourners to say good bye to the soul whose journey was to another place and to end the formal mourning time for the living. These death rituals are social processes that involved a transition for all involved. The deceased person joins previously deceased ancestors and the community having fulfilled mourning obligations says a final goodbye to the dead.

Related to these ideas of Hertz, van Gennep (1960[1909]) refers to important events in a person’s life where separation and integration occur to be “a rite of passage”. Van Gennep relates his theory specifically to times that involve a developmental transition in life, such as birth, puberty, marriage and death. Van Gennep refers to three stages that make up the “rite of passage” namely separation, transition and incorporation (reintegration). Progressing through these times in one’s life creates a change in the status of the person. Each stage has its specific ritual activity. In death events, the person is separated from the community through death and transitions away from that community that the deceased participated in when alive. During this transition time, normal rules of

the social order do not apply. This liminal stage mediates between one social state and the next, during this time there is a change of status for the individual in society. During the reintegration time, all must enter into their new social statuses.

Victor Turner (1967, 1969, 1982 and 1987) developed these ideas into the limin or liminal time. Turner describes the liminal period for the dying as the transition from life to death, a threshold where the dying person and their family have crossed over and they cannot cross back. They have no idea of the future or even of the very next moments. This limin is a time of anti-structure and creativity, where both sense of time and boundaries can become blurred. In the ED setting the time of transition or the liminal time may involve receiving devastating news concerning the condition of your family member, perhaps learning that they have died or even viewing the body. This time could be extremely short, even minutes. In the ED setting in which this research was done the boundary between life and death is largely organizationally constructed by the hospital teams and their policies. As I experienced and observed, the families are in shock and could be quite powerless in this time of chaos. In this dissertation research, ritual theory about death was used including classic theories of Hertz, van Gennep and Turner to think about not only the dying but also their families and the staff members who care for the dying. What rituals are important to the bereaved families? What rituals will give meaning to mourners in each stage of this rite of passage?

Death in the ED can be seen largely as a secular ritual. Secular ritual can be used according to Moore and Myerhoff (1977) to analyze organizations and events and ceremonies that take place within an organizational culture. The secular ritual process is

a collective ceremony that has social meaning. This meaning can be highly personal. Like all forms of social ritual, secular rituals are used to give structure and order to social reality. The important aspects of rituals well known to anthropology are also present in secular rituals, and the formal properties of secular rituals described by Moore and Myerhoff are as follows:

1. Repetition: either of an occasion or content or form, or any combination of these.
2. Acting: a basic quality of ritual being that is not an essentially spontaneous activity, but rather most is not all of it is self-consciously “acted” like a part in a play. Further, this usually involves doing something, not only saying or thinking something.
3. “Special” behavior or stylization: actions or symbols used are extraordinary themselves, or ordinary ones are used in an unusual way, a way that calls attention to them and sets them apart from other, mundane uses.
4. Order: collective rituals are by definition an organized event, both of persons and cultural elements having a beginning and an end, thus bound to have some order. It may contain within it moments of, or elements of chaos and spontaneity, but these are in prescribed times and places. Order is the dominant mode and is often quite exaggeratedly precise. Its order is the dominate mode and is often quite exaggeratedly precise. Its order is often the very thing which sets it apart.
5. Evocative presentational style: staging: collective rituals are intended to produce at least an attentive state of mind and often an even greater commitment of some kind; ceremony commonly does so through manipulations of symbols and sensory stimuli.
6. The “collective dimension”: by definition collective ritual has a social meaning. (7)

These properties will be further explained and used to analyze the social act of death and the ritualistic process that occurs with the staff and the families involved in a sudden death event in the ED setting. This ethnography researched secular rituals in the chaotic ED setting. The interviews with the staff and the family members involved in sudden death events elicited the meaning making from the sudden death experience in the ED as a collective social event and ritualistic activity.

**Death in the ED**

There are 500,000 sudden deaths a year in the United States (Turakhia and Tseng 2007). Sudden death occurs under many different circumstances. Most of these victims are taken to the hospital and resuscitation (CPR) attempts are made to restore life. Derse (2001) states that CPR attempts are usually unsuccessful and provide data that for every six patients who have CPR, only one survives to be discharged from the hospital. CPR was historically used for people who experienced unexpected reversible cardiac arrest and now is routinely started on people who have a cardiac arrest. Derse also speaks to the education and orientation of the physicians in the ED stating that they are trained in resuscitation and not in the art of caring for the dying. Derse concludes with the hope that the education of physicians will include those patients and families who are in need of end-of-life care in the context of sudden death. Like Derse, other physicians have voiced similar thoughts. Let us consider this quote by Kenneth Iseron (2000:75) a physician colleague of Derse reporting on the context of sudden death in the ED “Unexpectedly they (the families of the deceased) become our newest patients. The question we must ask ourselves is; are we prepared for them?”

Literature exists in clinical disciplines such as social work, psychology, medicine and nursing related to sudden death and caring for the survivors when the death occurs in the ED (e.g., Adamowski et al 1993, Carr 2003, Cassel and Dernel 2001, Derse 2001, Kaul 2001, Mortlock 2005, Scott 2007). There is some evidence in this literature that suggests that healthcare delivery personnel in emergency departments can assist families by offering choices and opportunities to engage in protocols considered to assist grieving

for families experiencing a sudden death event. However, there are still major gaps in the research; which are mostly related to the difficulty in reaching this highly vulnerable population of family members in the ED environment. New and different kinds of understandings of this underexplored research domain are needed. For this reason, I contend that it is necessary to more fully explore sudden death as a social event and ritualistic activity.

### **Contemporary Ethnography on Death and Dying**

Anthropological methods, particularly ethnography, can contribute to important new understandings. An in-depth ethnography, such as this one can hopefully lead to new knowledge of the social conditions promoting good death or obstacles that prohibit a good death in sudden death events in this context. Such knowledge would increase the understanding of this shared social experience and most likely improve healthcare around sudden death in the ED. Ethnography creates the environment for in-depth study and can facilitate a positive rapport with the study participants, both the staff and the family members of the deceased involved in sudden death events in the ED. For these reasons, ethnographic research is an important method to understand this shared social experience.

Having indicated that ethnographic methods are well suited for studying complex death and dying related topics in high tech biomedical settings, I will next review several recent ethnographies that address related issues and settings (Kaufman 2005, Pool 2000, Lawton 2000, Timmermans 1999 Chapple 2010). My aim was to build on these contemporary ethnographies related to death and dying in specific hospital settings and

addressing, in varying degrees of detail, ritual processes relating to particular dying trajectories.

One very important recent ethnography dealing with death and dying in ICU units is Sharon Kaufman's book entitled "...and a time to die: How American Hospitals Shape the End of Life" (Kaufman 2005). Kaufman, a gerontologist, describes in detail the medical care and ritualistic activity in ICU units in three California community hospitals. She describes how the organizational culture shapes hospital bureaucracy and the process of death in these U.S hospital units. In Kaufman's study, the trajectory of illness of the patients was typically known and could be somewhat planned, although, the timing of death was unknown. Kaufman (2005) writes that she based her project on two theories from medical anthropology.

"That medical practice and the varied responses to it are social enterprises, rooted in and influenced by cultural activities of all kinds. The second suggests that medicine as art, science and bureaucratic form is today the most powerful framework for understanding the body, the person dying and the most important, what to do" (332).

To situate her contemporary analysis of dying in these ICU settings, Kaufman (2005) begins by tracing the historical roots of death and dying over the last 2000 years. She starts with the work of the historian Aries speaking to rituals and community practices that surrounded the dying person, the corpse and the grieving. Kaufman emphasizes that during much of those 2000 years, death was not associated with doctors or treatments but with priest or religious persons. For the first thousand years, death was more recognized as a community event, not a private one. Kaufman uses this historical material to orient how death in the 20<sup>th</sup> century U.S. changed from being mainly a home based occurrence to one that mainly happened in medical settings.

Kaufman also explores in depth the themes of time, decision making and negotiation of important issues between the medical community and the families. She emphasizes two major pathways for care. In the “heroic pathway”, all of the technology is used to keep a person alive, such as ventilators, scans, and life-saving drugs. The other pathway that Kaufman explores is a path that she names the “path of the revolving door”. This is a path that a person who has a chronic illness more commonly takes. In this scenario, one would expect many discharges from and readmissions into the hospital. Each time the person returns, the condition has become more complex, and the issues of life and death more evident. The conversations between the staff and families in such situations were planned discussions that involved much planning within the structure of the organization. These prolonged discussions would not be possible in the situation of sudden death and in the ED versus the ICU setting.

Kaufman’s work in 2005 demonstrates that there is a place for high quality in-depth ethnography on death and dying in contemporary hospital settings. Like Kaufman, I understand the importance of considering the history of thinking about rituals and social events in specific kinds of hospital settings. The ED is a very different setting than the ICU units where Kaufman conducted her ethnography. The ED setting is known for its chaotic order. Things can look very calm and yet people’s lives are unraveling. When a patient is admitted to the ED whose death could be imminent the family is immediately separated and taken to the “family room”. Many times the family has witnessed the life threatening event and is in shock. There is no scheduled family meeting as Kaufman describes in her ethnography, no time for the family to prepare a list of questions. Many

times the first time the family sees the doctor in the ED the family is getting the “bad news” that their family member has died. Many times the patient is admitted to the ED treated, dies, the family is told and all of the rituals performed with the staff and family are completed in three hours. The ICU setting that Kaufman described had a different temporal component from the ED. Some of the ED staff that I conducted interviews with had prior work experiences in the ICU settings and actually pointed out some of the distinctive temporal and social differences between the settings. However, the major concepts of this recent ethnography: organizational culture, time, interactions of healthcare staff, patients and families and how the dying process is socially recognized do inform this research.

Another anthropologist who closely examined key decision-making processes around dying and death in biomedical hospital settings in the Netherlands is Robert Pool. In his (2000) performative ethnography, Negotiating a Good Death, Pool described the ritualistic activity that was necessary to be accomplished prior to a person being eligible for consideration for assisted euthanasia. He also described the rituals that were performed leading to the timed planned death of the person. All of the people in Pool’s study were terminally ill and they were fully aware of the trajectory of their illness. They were trying to maintain individual power over the timing of their death by being actively involved in the decision-making and the associated meaning making.

Pool’s study in 2000 has relevance to this research because it processually examines the socially negotiated decision making of dying and death among patients, families and involved healthcare providers. Yet, from personal and professional



experience, I know that this type of negotiated decision making that Pool describes differs significantly in most cases from what occurs in the ED context. Typically, in the ED context decisions are made in the trauma room by the trauma team and families are often segregated in separate areas, awaiting news of results from clinical protocols that have been administered by the members of the trauma teams. Thus, a need exists to study this quite different type of decision-making from what Pool reports in his ethnography.

Lawton (2000) in her book, The Dying Process, also speaks to the social issues of terminal illness and studies rituals related to hospice care in the United Kingdom. Her research chronicles patients dying experiences both in hospice day-care and in-house hospice settings. Death here also involved the dying person, the family, notions of time and organizational culture shaping the death experience. Many of the patients' bodies deteriorated to such a degree that the families said their goodbyes and asked the staff to call them when their family member's body stopped functioning. They stated that their relative had "died" already. Their family remained in a "liminal" space, for sometimes weeks after their last visit. Families stated that their relative was no longer the "person" that they loved. Lawton (2000) reflects in her last chapter specifically about the issues of liminality and time. There were patients that "stayed too long" who were ready to die. There were many conversations between families and staff members concerning being prepared and ready for death. Many of the patients and their family members felt that to die suddenly was maybe better; however, to die "too soon" could be tragic and that there would not be enough time to handle the emotional issues that may need to be finalized. In cases where things were perceived as having been well-handled, the organization gave

the patients and family members a feeling of being included in the decisions relating to their family member's "good death" experience.

Lawton's (2000) research is relevant to the proposed study as it also emphasizes the importance of time in the dying process. Specifically, Lawton considers in-depth the time needed to prepare for the death through the dying process and the time needed to intervene with the family members, so that all involved in the dying could be involved in a "good death". Death in the hospice setting is unique, because all people involved expect the person to die. In my study, the deaths all take place in the ED, as with hospice this setting is also unique however, the expectation is very different. Because of the use of technology and heroic procedures in the ED the expectation is that the person will not die. Consequently, all of the deaths were unexpected and the time to intervene with the family or at times even with the patient prior to the death in a sudden death event is very short and at most times nonexistent. In a sudden death the ritualistic activity must occur after the death, if it occurs at all. In sudden death, a major idea is that people "die too soon" and without certain important rituals taking place.

Chapple (2010) also conducted anthropological research on death and dying and writes about it in her book No Place for Dying: Hospitals the Ideology of Rescue, she discusses legal and economic issues of health care in the United States and the drive of hospitals to occupy ICU beds related to profitability. Within this cultural context Chapple also explores hospital policies and practices surrounding dying. She describes what she calls the "ritual of intensification" (205), which is the ritual that clinicians engaged in when a patient's conditions worsens and the patient's life needs rescued or has the

potential for needing rescued. She writes that the idea of “rescue” is now the gold standard to avoid death in the hospital. Rescue or the ritual of intensification is the use of technology to support life. Her research was a retrospective study where she conducted 211 interviews with clinicians who cared for patients of all ages who had died. She interviewed only clinicians; she conducted no interviews with family members.

Chapple (2010) describes specifically the difficulty of accessing the physicians, and especially the ED doctors. She describes the Emergency Departments at two of her field sites as follows:

The ED at the teaching hospital was chaotic, without possibility for me to navigate with this methodology. In the Catholic community hospital I never found an expedient way to learn about deaths that occurred in the ED (284).

I built upon this project and conducted my research with a different conceptual framework, methodology and level of access in the ED setting and for this auto ethnography it was imperative to conduct interviews with both staff and families.

Another important ethnography providing background for this study was written by a medical sociologist Timmermans (1999) involved the ritualistic activity of CPR in an ED in the U.S. His ethnography titled: Sudden Death and the Myth of CPR speaks to the myth that through the power of technology, and those who control that technology, death in this setting can be conquered. His research was an investigation that concentrated on the organizational culture and the actual experience of resuscitation in the ED. The use of resuscitation procedures writes Timmermans “means that sudden death equals premature death, a death that by definition comes too early” (4). His research concentrated on conversations with the staff members involved with the trauma.

Most of the sudden death victims are taken to the ED resuscitation room, separated from their families and CPR is started hoping to postpone death. As mentioned earlier, these measures are very rarely successful. Resuscitation techniques do not encourage a conversation concerning death. Families are in rooms away from their dying loved ones, they have hope that the resuscitations will be successful, and they have not been prepared for the impending death. Too often, there will be no parting rituals or a last chance for final moments together. Timmermans (1999) states: “sudden death (in contrast to a lingering illness) is an event securely controlled by the medical professional” (11). Loved ones die with the healthcare team while their family waits in isolated rooms with the hope that resuscitation attempts will work to save lives, while the data suggest a very different outcome. These were some of the important findings from Timmermans’ research which was conducted during sudden death events in which there was no preparation for the trajectory or the timing of death. Timmermans (1999) discusses the limitations of his research and emphasizes the importance of further researching not only the staff perceptions but the perceptions of families as well, related to the sudden death event. A decade later, I set out to address this very important research gap identified by Timmermans, by interviewing both the staff and the family members and identify the rituals connecting the two and the meaning-making that occurs during a sudden death event in the ED.

## **Organizational Culture**

In order to complement these key ethnographies on death in hospital settings and their major themes of time, decision making, ritual and meaning making, I will also draw upon organizational theories that are relevant for this study. Much relevant research is related to organizational culture and power (e.g., Van Maanen, Dabbs and Faulkner 1982, Van Maanen 1988, Wolf 1999, Nader 1997, Pfeffer 1992, Jordan 1994, and Martin 2002). Van Maanen et al (1982) specifically speak to the vitality of ethnographic fieldwork in organizations. One of the strengths of ethnographic fieldwork is the increased need for the knowledge relating to the “unscientific aspects” and attributes of research work in organizations. Van Maanen et al (1982) speaks to research that is specifically about the qualitative nature of organizations that is “inherently a social and cultural process with deeply rooted moral, political and personal undertones” (14). He concludes that storytelling, myths and other methods of qualitative design are increasingly becoming of greater interest to persons involved in organizational research. These ideas are highly relevant for hospital ethnography in general and can also inform our understanding of death as a social act and a ritual process. I find it important to consider these ideas in the ED setting in particular as they have not been discussed relating to dying processes with this research methodology.

Ann Jordan (1994) states that in order for anthropology to understand organizational culture, one must realize that organizational culture is holistic and not an additive term. Organizational culture then becomes interplay of the interwoven and hierarchical groups. Building on Jordan’s central ideas for purposes of this study, the

hospital is the larger organizational culture, one subgroup is the ED department and within this subgroup are the nesting cultures of staff, patient and family. In other words, I will explore small cultures situated within a larger culture in this research project. These cultural forms will be explored in considering sudden death event data in the ED.

Additionally, practices (both formal and informal) need to be examined in order to understand how power is obtained and used to ultimately shape the making of sudden death events in the ED, and in conducting the ritual investigation of sudden death events in this hospital context. Ethnography as defined by Geertz (1988) is a “record of being there”, the making of a story. The anthropologist enters into a “field” and describes in detail what he sees and finds out there. Kaufman (2005) states that ethnographies are “partial truths” interpretations of what the researcher sees and finds they are always seen through their subjective lens of personal experience.

### **The Auto Ethnographic Method**

The specific method of ethnography in this research is auto ethnography. This researcher is a bereaved parent; her daughter died a sudden death in 2006. She is a nurse and hopes that this research will contribute to improve the quality of healthcare for families involved in a sudden death. Encompassed in how I define auto ethnography I have employed the more traditional ethnographic methods of participant observation and in-depth interviewing. This research was conducted in a large urban hospital ED. Through participant observation, I recorded staff and families experiences as they journey through sudden death events. The value of an auto ethnographic approach here is the

enriched understanding that comes from the dual lens of an anthropologist/nurse and the reflections of the lens back to the researcher who has had the lived experience. Through ethnography one can see the making of a story and the method used here more specifically will be an auto ethnographic approach to understand sudden death as a social act and a ritual process in an urban American ED. There has been some controversy concerning the methodology surrounding auto ethnography and I would like to address those issues here.

Reed-Danahay (1997) defines auto ethnography as “the intersection of three writing genres:

1. Native anthropology (authors write about their own group),
2. Ethnic autobiography (authors write about their own ethnic groups),
3. Autobiographical ethnography (authors place personal experience into their ethnographic writings)” (p.2)

She summarizes auto ethnography as a form of “self-narrative that places the self within a social context” (p.9).

Authors from other disciplines joined in this genre of writing and have written newer forms of ethnography, somewhat experimental moving away from the “realist” tradition of ethnography to different forms including those that deal more explicitly with positionality and reflexivity. Some of these authors for example (Richardson 2007, Ellis and Bochner 2000) also calling their work auto ethnography.

The definition from this genre Ellis and Bochner commonly cited throughout the literature. They define auto ethnography as:

“An autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural. Back and forth auto

ethnographers gaze, first through an ethnographic wide angle lens, focusing outward on social and cultural aspects of the personal experience; then they look inward, exposing a vulnerable self that is moved by and may move through, refract and resist cultural interpretations” (2000:739).

Auto ethnography is a genre that is “reflective” in nature (Ellis and Bochner 2000). Auto ethnography is done by a researcher who is a member of the group, an “insider”. There are three aspects to auto ethnographic work; research, culture and self. The boundaries are always blurred and very personal. According to Ellis and Bochner (2000), the researcher is looking outward through a lens to the other and then looks back inward towards oneself. The view is always two ways. The researcher is vulnerable. The researcher is recording not facts, but how the facts were perceived by her informant, which in this case is subject to her experience. The value of an auto ethnographic approach is that enriched understanding that comes from the dual lens of an anthropologist and the reflections of the lens back to the researcher who has had the lived experience.

Ellis and Bochner throughout their writings understand and engage in the conversation surrounding the controversy involving the personal nature of writing of auto ethnographies. They defend the scholarship aspect of this genre of writing as being the meaning making that occurs for the author and the reader of the auto ethnographic work. In this dissertation research that involved some healing for the researcher and for those persons both the staff and the family members who told their stories of their own experiences within the social act and ritualistic process that occurred for them during the sudden death event in the ED setting.



Wolcott (2004) also traces briefly the history of auto ethnographic work, and enters the debate. He writes specifically about David Hayano's (1979) work where the "method" of ethnography was emphasized and the importance of not only the "self", but the self in the social context, the importance of the setting, and the inclusion of the "group" in the auto ethnographic work. Wolcott speaks generally of the auto ethnographic work following Hayano's work and comments that these interdisciplinary narratives although they were very well written personal stories; he did not consider them to be ethnographies. Wolcott (2004) writes that some of the "auto ethnographies" emphasized more of the "self" than the ethnography. Ethnography according to Wolcott takes place in the context of a social setting where an ethnographer observes and records the actions and interactions of the people who live there as a social group. Wolcott (2004) asks for a specific approach to auto ethnography one that "bears the stamp of anthropological orientation" (p.99) and that discipline's methodological approach to ethnography.

Anderson (2006) articulates the value of differing genres of research, but understanding the confusion relating to the methodologies, proposed the use of two terms relating to auto ethnographic research. One term is "evocative auto ethnography" where the research is of a postmodern genre, auto biographical, self narrative and self reflective. The other term is "analytic auto ethnography" where more traditional methods of ethnography are used by the researcher. He listed five criteria necessary for research to be categorized as analytical auto ethnography. The researcher is "(1) complete member researcher status (2) analytic reflexivity, (3) narrative visibility of the researchers self, (4)

dialogue with informants beyond the self, and (5) commitment to theoretical analysis” (p.378).

Throughout his article Anderson (2006) uses Robert Murphy’s The Body Silent (1987) as one example of analytic auto ethnography. In his section on the advantages of using analytic auto ethnography as a research approach, Anderson writes about several issues that I found to be true in my research project. The researcher has special access not only to the certain field sites but certain kinds of data and certain kinds of meanings of data, because the researcher has had a lived experience and has different access to participants. All of the above creates access to insider meanings. I had multiple reasons to do the research and multiple incentives to do the research as I have listed above. I found all of these criteria present in my own auto ethnographic writing.

Chang (2008) appears open to discussion with both Ellis and Bochner (2002) and Wolcott (2004). She writes that while auto ethnography is a powerful way to communicate sensitive and intimate knowledge about self and society however, “mere self- exposure without profound cultural analysis and interpretation leaves this writing at the level of descriptive autobiography or memoir” (p.51). The auto ethnographer uses their own lived experience as data with which to start to begin their research and this data is integrated into new data that is collected during the research process. (Chang 2008).

Ngunjiri, Hernandez and Chang (2010) although sensitive to the criticism challenging the scientific rigor of auto ethnography for example ( Anderson 2006, Sparkes 2002) and acknowledging the presence of two very differing opinions of this genre of ethnographic writing, offer a suggestion of collaboration. In their article titled: *Living Auto*

*ethnography: Connecting Life and Research*, they include a table adapted from Ellis and Bochner (2000) where they include the following: on one end of the continuum would be those who write from the point they label autobiographic, others may call this category personal or emotional and the other end of the continuum are those researchers who write from the place of analysis or interpretation. One side of the continuum leans more towards the art (Behar 2007) versus the other researcher whose goals and social settings were very different and whose research would be more analytical (Anderson 2006) on the opposite extreme end of the continuum. At any time a researcher could move back and forth along the continuum. The three axis of auto ethnography are research (graphy), culture (ethno), and self (auto). Ngunjiri (et al) depict in their table that the researcher can emphasize art or analysis depending on the goal of the research and the researcher. As explained above, Anderson (2006) would use the terms evocative or analytical auto ethnographic research when describing the two ends of this continuum. These authors encourage a full collaborative model to encourage the use of auto ethnography as an approach and as a method. Ngunjiri (et al) encourages collaboration, not polarization in this genre of ethnography with all scholars. They end their article listing current innovative research being done in the area of auto ethnography.

Taking into consideration all of the above information, I designed my auto ethnography accordingly; I am a nurse with 30 years of experience that includes working with patients at the end of life. I am also a bereaved parent who has experienced sudden death. I believe that by utilizing this method there will be an enriched understanding of the data. I have no false sense of “true objectivity” as in realist style ethnographies of the

past (Van Maanen 1988). I do not purport to have “fresh eyes” on the topic of sudden death in the ED context nor do I believe that it is essential for this research. I realize that the ideas of “self” and “other” are already intermingled in my mind as I am a “native” to sudden death. However, I also know from my nursing experience, my own grief experience and previous research experience that death and dying are a social and community event. The events that I know surrounding sudden are personal. In this research project I wanted to learn more about how “others” experience sudden death. I wanted to anthropologically better understand sudden death as a social act and a ritual process in the ED setting.

I know that the controversy concerning auto ethnography is continuing. I am reading and paying close attention to the anthropologists who are writing and critiquing this genre. I was warned by my one professor whom I admire greatly who told me “be careful that you do not get to the end of your research and discover that you have only discovered yourself.”

The point of view that I bring forth at the moment is my own and I have a desire to continue to learn how others view their own experience of sudden death. I think that my experience provides me with the sensitivity to conduct my research and understand the context in multiple ways. I also am a “native” in the hospital and I also understand the language spoken there. These circumstances informed this research in a valuable way.

The hospital in the United States, where most deaths occur is a difficult setting for an anthropologist to do research. The ED where these deaths are sudden is a particularly difficult setting for a researcher to gain access. The idea of rituals and meaning in death

from the staff and family perspectives will be explored. Are there rituals that give meaning to this experience? The use of power and organizational culture will be observed. The implications for anthropology as a discipline as discussed earlier are important here, this research will contribute in an important way to the body of literature on this topic. Death is an event that each of us will encounter eventually either as the family member or a person dying. I possess a strong drive to do this study and for all of these the reasons, I feel a responsibility to do the research.

Having written and thought about all of these issues concerning auto ethnography I came upon Beatty (2010) in his article titled: *How does it Feel for You? Emotion, Narrative and the Limits of Ethnography*, writes, that we need to know when and how to capture the significance of emotion in narrative. He states clearly that the story belongs to the social group that you are studying. He gives an example: beginning by saying when you as the fieldworker “wait for the dying chief to expire, but your feelings are not those of his kinsmen; nor do you feel sad in the same way to recognize their sadness. Although your feelings provide some small insight, they are not your story. Only when fieldwork itself is the focus do the narrator’s emotions become of pressing relevance” (p.440). I kept all of these warnings and the warnings of my professors in the forefront as I continued with my research.

In this auto ethnography, the researcher will be commenting throughout on what it has been like to collect the data. The self within the context of the social setting of the ED and the interaction of the staff and the families involved in the sudden death events will be researched and documented. Ethnographic methodology will be maintained. The value

of an auto ethnographic approach as stated above is the enriched understanding that comes from the dual lens of an anthropologist and the reflections of the lens back to the researcher who has had the lived experience. This researcher had special access not only to the certain field sites but certain kinds of data and certain kinds of meanings of data, because the researcher has had a lived experience and has different access to participants. All of these aspects create access to insider meanings. The researcher has multiple reasons to do the research and multiple incentives to do the research.

The next chapters include, Chapter 2: Field site and Methods Chapter 3 Walking through the ED, Chapter 4: Gathering in the ED: Coming together for the death Ritual, Chapter 5: Transitional Social Process: Becoming Dead in the ED, Chapter 6: Reentering Society as a Mourner, Chapter 7: Final Rituals and Chapter 8: Concluding Thoughts.

## **Chapter 2**

### **The Field Site**

The urban emergency department (ED) field site where this research was conducted is located in a large northern industrial city of approximately 150 square miles. This city is shrinking; the population in 2009 was 100,000 fewer people than in 1990. The city was predominately African American, with Caucasian race being reported being second and other races less than 5%, according to the U.S. Census Bureau (2009). Like many other large U.S. industrial cities in the first decade of the 21<sup>st</sup> century, this city has lost manufacturing jobs. The manufacturing sector, once the city's major employer, is now ranked fourth in the city after educational services, health care, and social service agencies. According to the U.S. Census Bureau, the unemployment rate in the city from 2005-2009 from the ages of 16 and over was around 20 %.

Like some large industrial cities, this city is a city in crisis, with a high poverty rate, struggling schools, gang issues, high murder and other violent crime rates. Both national and local news media were reporting at the time of this study on the high degree of urban violence in this city. Each night on the news there was another story about scam artists targeting vulnerable people on the phone then later harming them. It was after these media reports that I began making cold calls to grieving people asking them to meet me in their homes to talk about perhaps the darkest, saddest day of their lives. I will say more about this aspect later in this chapter.

In this city a large medical center exists just outside of its downtown. This large medical system operates multiple hospitals and institutes and contains one of the city's Level I trauma centers.

The American College of Surgeons (2006) designates four levels of trauma care, with Level I being the highest. The criteria for each level of trauma care is very specific, related to availability of appropriate physicians, surgeons, critical care facilities, operating rooms, continuing education, clinical research and publishing opportunities. Level I Trauma care serves as the centers of large medical systems. Many ancillary services are also available. A Level I center must also maintain a surgically directed critical care service. They must participate in training of all surgical residents' education, scholarly research, and community activities. The trauma surgeon on duty must be dedicated to trauma activities.

A Level II trauma designation also provides comprehensive trauma care and supplements the medical center's Level I trauma center, (ACS 2006). In this case the Level II trauma center is the ED research field site for this study. The research field site is the one of the hospitals of the medical center and is within 20 miles from the main medical center. There is much cooperation and flow of clinical expertise between these two facilities.

This hospital is located in a residential neighborhood, taking up approximately one city block. The neighborhood is mostly two-story bricked house, all with neatly landscaped yards. All the streets have sidewalks. There are several bars and some small liquor stores near the hospital, as well as two large high schools and several churches of



different denominations. This facility sees victims of some of the worst violence in the city, especially gunshot wounds and injuries from gang violence. During my field work at this hospital, staff members told me that many of them live in the neighborhood around the hospital and were very proud to work at this facility. Quite often they knew patients who entered the ED by ambulance. Several stories were told to me about staff who had encountered close friends who had arrived in the ED seriously ill or injured. Many of the patients that came by ambulance lived in this community. Many of the stories were relating to violence in the neighborhood. They had life threatening events near their homes and were taken to this hospital. Other people had accidents in this neighborhood and were taken to this hospital, as was the case in my own ED story. The stories were told to me both in the “staff talk” during my participant observation and during the family and staff interviews.

Next I will explain why I chose this ED for my field site. This Level II trauma center is in a very busy ED. In 2009, there were approximately 85,000 ED encounters and 400 ED deaths. The role of the ED staff is to assess the injury of the patient, stabilize the patient, and then send them either to an operating room or to one of the intensive care units. Some patients arrive in the ED with little or no life saving options. This ED had 400 deaths a year. Given this high volume of patients, I assumed this field site employed a staff that had experience with sudden deaths and that there would be adequate numbers of families present there that might consent to be interviewed.

### **Gaining Access to the Field Site**

As I was developing my doctoral research program, I was invited to join an interdisciplinary group of researchers researching end-of-life issues. During this time, I approached one of the physicians Dr. A, whom I knew was very committed to end-of-life issues, and asked for the opportunity to explain my proposed dissertation research. The more I learned of the work he was doing at his hospital, the more I hoped I could gain access to the ED where he was already conducting research on other aspects of sudden death. After meeting in the group, I reached him by phone then met with him. I explained my idea for my research program and the reason for my passion. Dr A invited me to attend one of his established research committee meetings to meet others conducting research at this facility in end-of-life issues.

When I first attended the research committee meeting, I was warmly welcomed by this physician and the other interdisciplinary researchers in the group. There were several well established research programs currently occurring in the ED and several more in the brainstorming stages. It was very exciting to be involved in this group and asked if I could do some pre-research activities that included visiting the ED, getting to know the staff who worked there, before formally proposing any research there. I wanted to be sure that I could do the research, both from the practicality of studying the research problem and from the emotional viewpoint of this researcher. Could I do this research? I felt supported by this team of researchers and was confident that I could further explore research possibilities.

Soon after I started attending these meetings, Dr. A introduced me to the medical director of the ED. They asked me to send them a short email explaining my idea and what I would like to do there. The medical director sent it to the nursing director and they forwarded me an email giving me their support. Over the next few weeks, I casually spent time on the unit in this pre-research phase. I met some staff members, told them about the project that I was interested in doing there, and learned about the general workings of the department. Generally I thought about ideas for developing my research design and the feasibility of my research project. I collected no data during this time. I solidified what I thought my research project might look like and started writing my research proposal. I stayed in touch with the research team at the facility and continued to attend their monthly research meetings. I returned nine months later with an IRB approval and was ready to begin the study.

## **Methods**

### **Phase One: Participant Observation:**

I conducted extensive participant observation in this urban ED for three months. Participant observation is a research technique frequently used by anthropologists. Participant observation involves going into a field to do research and entering into the social world of the people there. Participant observation involves getting to know the people in their environments, getting close to them and making them feel comfortable enough with your presence that you can observe them, talk to them and take notes about their lives. Participant observation involves experiencing their lives in their world to the

extent that you can experience it. Participant observation also involves leaving that world, reflecting back on your time there and writing about it (Bernard 2002).

This hospital had an email system that could be used to introduce all staff members of the emergency department to persons who have permission to be on the unit and explain the specific reasons for the person to be on the unit. I did not have access to the computer system so I asked the nurse director to place an email in the system to inform the staff who I was and explain the goals of my research.

I also had a meeting with another nursing executive and the social work director to explain to them my research and they also received copies of my research proposal, a narrative of my research, my IRB and my resource approval. I would be working with professional representatives from social work and nursing in the ED. I had already spoken to the spiritual care team and the physicians in the research committee meetings. Everyone was on board. I was finally ready to begin my research in the ED and begin the participant observation phase.

My first day in the ED I spoke to the nursing staff before the day shift began and then later to the nursing staff coming on for the night shift. These meetings at shift change were called “nursing huddles.” The nursing director assured me that my research study had been discussed at a department meeting and she was the one who told me to go speak to the nursing staff at the nursing huddles on that first day. At shift change, the charge nurse from one shift gave out assignments and pertinent information to the nurses coming in for the next shift. That first day when I met the nursing staffs, I explained the conditions of their participation, that their participation in the research project would be

voluntary and confidential, and that their participation or their refusal to participate would not at any time affect their position or any benefits related to their position in the Emergency Department. If at any time staff members did not want their data included in the study, they should notify me and that specific portion of data and/or all data would be removed. If staff members did not wish to be observed, I would remove myself from their work situation on that shift. As it turned out, no staff member ever asked me to leave a room or a work situation. All names and information that could identify research participants were held in the strictest confidence. Their job roles would not be identified and no particular tragic event would be used if one person could be identified through the event itself. I reminded the employees that all data would be removed at their request and that they can remove themselves from the project at any time. Even this early in the research the staff was welcoming.

I visited the day and the night shift change room several other times to talk about my research. I also distributed my contact information at that time, inviting everyone to contact me to be interviewed. I also left my contact information for the staff on the tables in the shift change room.

Throughout the participant observation period I went to the shift change room, which also served as the staff's break room. When the nurses were on break or eating, I sometimes just visited them and talked to them about my study. I sometimes went to this area to eat, too. The TV was often on. Some of the staff watched TV or read. Some slept. In all of these informal conversations with the staff about life beyond the hospital,

the staff always finished conversations with question about my study and about my interest in sudden death.

Break times were very precious to me when I was a staff nurse, so I only answered questions if they asked me something. I would just go in and sit down. I was present if they felt like talking to me. Many times at least one of the nurses would engage me in a conversation about why I was interested in them and in their work... These conversations often led to scheduling an interview as these nurses were often intrigued by the study topic and wanted the opportunity to further discuss their own experiences with sudden death in the ED.

I spent time talking to many staff members during the participant observation period, and I asked everyone if they would like to participate in an interview. A number of staff members also approached me and asked to be interviewed. I continued to inform them that during the participant observation period and in the study interviews all names and information that could identify them would be held in the strictest confidence. They could at any time remove themselves or any data concerning them from the study. While I conducted participant observation in the ED I collected detailed field notes. I observed formal organizational policies and procedures and informal practices of the staff.

As the weeks went on, the staff became more and more supportive of my research. They greeted me by name when I came in the door and said things like, "You should have been here last night. We had a really interesting case." or "Did they tell you about last night? It would have been perfect for your research. The family was all here." They had come to associate me with sudden death and families. I did not expect the staff

to accept me or to talk so freely to me when I was in the ED. Their willingness to open up and talk about their work surprised me. The staff wanted to talk to me not only about staffing issues and recent sudden death events but also about their families. I only collected “staff talk” in those conversations. There was no direct connection between the families I saw in the ED and the families that I later interviewed.

I was extremely fortunate to spend time with the social workers in this field site. The social workers were highly regarded by the entire staff in the ED. I spent most of my time with two of these social workers, and I was very impressed with their interpersonal skills and how they cared for patients and their families involved in sudden death events. Whenever trauma patients or patients needing resuscitation entered the ED, the security, medical, nursing, social work, and spiritual care team would be notified. If families came to the ED, a patient representative escorted them to the family room and the social worker on duty was notified that the family was there. The social worker checked on the status of the patient and then went to the family room to meet the family and to introduce herself to the family members; I also introduced myself to the families at that point. I told the family members that I was a researcher from the local university accompanying the social worker. The family was usually waiting for information regarding their family member, and they never paid much attention to me. I stayed with the social workers and the rest of the professional team while they worked with the family during the sudden death event.

These field notes were analyzed using a thematic approach regarding organizational culture and ritual practices related to handling sudden death events in the

ED, (i.e. opportunities in the setting for ritual activity to be performed immediately preceding and following death).

### **Staff Interviews**

During Phase One, I conducted in-depth interviews with each staff member who agreed. I chose to use the in-depth interview technique because, as Kvale writes, “Interviews are conversation where the outcome is the coproduction of the interviewer and the subject” (1996, p.xvii). In-depth interviews could provide data looking at language, narrative and stories that create meaning for both the person being interviewed and the researcher. This interview method gives the researcher opportunities to ask sensitive questions relating to meaning in caring for the patients and their families at the end of life.

I elicited stories from the staff in these interviews with an open-ended question format. This interview format gave the researcher the opportunity to ask sensitive questions relating to the handling of sudden death events and their most memorable sudden death event. I also asked the staff how they would change current practice to improve the event for families and the staff. The staff members are living daily in the aftermath of the stress of sudden death events, and I set up these interviews to elicit meaning-making during an event that was particularly memorable for them.

I interviewed 20 staff members who were willing to participate concerning the stories of handling of sudden death events and related professional practice in the ED. I interviewed each staff member only once, and I scheduled each interview for one hour. I



conducted these interviews at times chosen by the staff members. Many staff members chose to be interviewed during a lunch hour, or immediately following their 12-hour shifts. Two interviews were conducted on the staff members' days off; one staff member came to my home for the interview, and I was invited to another staff member's home. The staff members were free to pick the place and time for the interviews.

The staff took the interviews very seriously. I conducted some interviews in private offices, in conference rooms, and in the Family Room when it was not in use. These conversations were very important to each one of them. I did not expect staff members to cry during these interview processes, but many of the staff did cry during the interviews. I would also tear up at times during the interviews, and many times I cried after the interviews. The staff members cried most frequently when asked about their most memorable sudden death event.

**Table One: Professional Staff Interviews**

Staff Category	Total #	Male	Female
Nurse	7	2	5
Resident	5	3	2
Spiritual Care	4	1	3
Physician (Attending)	2	2	0
Social Work	1	0	1
Security Police	1	1	0
Total	20	9	11

**Phase Two: Family Interviews**

I conducted in-depth interviews with the family members who agreed to participate. Initially the interview questions were developed from the literature. If, however, during the interview other constructs emerged, I encouraged the participants' stories with an open-ended question format. The interview format gives the researcher opportunities to ask sensitive questions relating to meaning of rituals in these sudden death events. The interviews were all conducted 3- 4 months or more following the sudden death event. The stories gathered from the families were of their actual lived experience of the sudden death event. A study done by Sedney, Baker, and Gross (1994) found that stories are constructed by families to make sense of the loss that has occurred in their life. Telling stories is a way to talk about emotional events. "Telling stories can (a) provide emotional relief, (b) help make the experience meaningful, and (c) bring people together." (p. 288)

In my field work, the families had had some time to reflect back on the experience and communicate any meaning-making that had occurred in the months since the events. The families were asked to tell the story of the death experience and then the probes were naturally occurring from the conversation. Three to four months is seen in the literature as a time period where families are willing to talk about their experience to others (Nadeau 1998). I realized that after approximately four months I was willing to return to the hospital where my daughter died to speak to them about their policies or lack of policies related to sudden death and how that had affected my family members and our grief journey.

During Phase One, when the researcher was in the ED setting accompanying the professional staff, the following process was used for recruitment of family members experiencing a sudden death event in the ED who would be interviewed in Phase Two: Either the PI or the professional healthcare staff, who work with families who are experiencing sudden death and have been directed on how to approach these families in a sensitive way for the purposes of this research, based on their professional judgment, gave the family members a "Permission for Telephone Contact" consent form. This form only asked if a researcher could follow up with them by phone in approximately 3-4 months. When I contacted the families by phone, I used another script to set up person-to-person interviews, at which time, if the families agreed, formal consents were obtained. It is also important to add that no pamphlets were given to families by this researcher during this time of shock in the ED. There was no connection of identifying information between the sudden deaths observed by the researcher in the ED and families interviewed three - four months later.

Another source of recruiting families was designed to occur when families attended the bereavement support groups offered by this hospital. These families in the bereavement support group would be asked by the PI for permission to set up an interview using the same script, as the script that was used by the PI to contact families by phone for permission to set up an interview; if willing, these family members would also be interviewed for their sudden death related stories. After attending two sessions of the support group, the PI did not find any families who fit the criteria for this study. None

of the participants coming to the support group during that time had experienced a sudden death in the ED at the field site.

During a sudden death event, I assumed that all involved would be in shock and disbelief. This event changes an individual's capacity to make decisions. In time, the shock and disbelief concerning the sudden death event may diminish. With this in mind, I made deliberate decisions in the recruitment procedures so that no participant would give permission for the study without a certain time period elapsing between the sudden death event (which was the request for a phone call only), the request for the interview (script), and the formal consent immediately before the person-to-person interviews.

The social work staff obtained the majority of the phone consents. All of the social workers but one obtained consents from families. All of the social workers were full-time employees and had the same access to sudden death events. One of the social workers who obtained several consents for the study was a part-time contingent employee. I spoke to all of the social workers in person and explained the study. I did not get any indication that that person who did not obtain consents was in any way uncomfortable or did not want to obtain consents for this research. I can only assume that it was an issue of personal work style or lack of interests either in research or end-of-life work. Perhaps this social worker was uncomfortable asking people to contribute to a research project at this time.

Three to four months later, the families who gave consent to be called were contacted by the researcher (by phone with a script) and asked for permission for an interview to be held at the place chosen by the family member. Formal consent for the

interview was obtained in person at that time by the researcher. Throughout the consent process, time was allowed for each participant to reflect carefully on their participation in this research study. It was interesting to the researcher that at the time of the phone call only some of the family members remembered signing the consent to allow the researcher to call their home. I started carrying the form with me to the interviews to show the family members the form they had signed. They would look at the form, verify that it was indeed their signature, but many of the family members said that they had no recollection of ever signing the form. This step verified for me that they were unable to give consent at the time of the sudden death event for the interview.

It took a tremendous amount of energy on my part to make the phone calls. I would have to psych myself up for them. I would make them around 7 in the evening. I would take the consents and my script and go into my living room and begin the calls that I could make based on the three-month time period. I usually would have two or three calls at a time that would qualify; sometimes I would have more. I would take a deep breath and dial the phone. Once I started, the calls became easier. The research process was formally scripted, but of course I never knew what the other person would say to me. One thing I did know, the person on the other end of the phone would still be in pain. I was never wrong about that assumption.

There were some interesting variations with the families that I noted when making the phone calls. Eight of the ten families that consented answered their phone and consented right away. Some numbers were disconnected. Some of the people did not answer their phone. I would leave a message for people who did not answer their phone,

which was my script and my return phone numbers, but only one family called me back from my message; that family did consent to the interview. Another time a family member that called me back initially answered the phone and told me that she wanted to think about it, and that she would call me back one way or another. She did call me back five months later, on the eighth month anniversary of her husband's death and asked me if it was too late; I included her in the study. Many family members told me that the topic of sudden death in the ED was too hard to talk about and they were not ready.

Only 25% of the families that consented in the ED at the time of the sudden death to be called by the researcher later consented to meet in person for the interview. I wondered if I could have interviewed several more families over the phone if my study design had allowed for that. Some families stated that they "did not have time to meet with me in person." I also wonder if that was a kind way of saying that they just did not want to say no to me. I never considered doing the interviews over the phone. I considered these interviews to be sensitive in nature and that they should be done in person. I thought meeting in person was a way to "honor" their story... I considered a face-to-face interview a way to create a "sacred space," something that I did not think I could accomplish in a phone interview.

All of the family members that met with me consented to the formal interview. The interviews all lasted from 45 minutes to an hour. The interview place was chosen by the family member. I conducted four of the interviews in family members' homes and I conducted the rest of the interviews elsewhere. I was surprised at the commitment of the families who consented. They seemed to "work" at meeting with me. It was very

important to them. Several of the families were late because of weather. They called me and told me that they were going to be late and asked if I would wait for them. Three of the families called me the day of their interviews to change the times or places and apologized to me for the inconvenience of the change. I could not have been more surprised by this. I continued to thank them for meeting with me.

Several widows that I spoke to initially consented but then said that they wanted to “ask their daughter what they thought” I would encourage them to do so. I would think that the next day when I called back they would say that they did not want to participate. That is what always happened. I would thank them, ask them to call me if they changed their mind, and tell them again how very sorry I was for their loss.

There were 39 family members who consented to be called. I called each of these family members personally and I obtained 10 interviews.

**Table Two: Family Interviews**

Family	Cause of Death	Age and Gender of Deceased	Ethnicity of Family Member Interviewed	Family Member(s) Interviewed/ Relationship to Deceased
#1	Gunshot Wound	19 Male	African-American	Grandmother
#2	Cardiac Arrest	61 Male	African-American	Daughter
#3	Cardiac Arrest	76 Male	African-American	Wife

#4	Cardiac Arrest/ Cancer	53 Female	African- American	Husband
#5	Cardiac Arrest	50 Male	Caucasian	Wife Daughter
#6	Cardiac Arrest	68 Male	African- American	Brother
#7	Electrocution	41 Male	Caucasian	Wife
#8	Motor Vehicle Accident	21 Male	African- American	Mother
#9	Gunshot Wound	48 Male	African- American	Girlfriend
#10	Seizure	49 Male	African- American	Sister

Ten families (11 family members) were interviewed for their sudden death-related stories.

All of the research participants were English-speaking adults; no minor children were interviewed. These families were contacted and interviewed only once. The interview was planned to last one hour. The families and their members were coded by number and names were not used. The interviews were audio-taped with permission and the tapes were transcribed and all data locked in a cabinet and on a password protected computer in the researcher's home.



## **Data Analysis**

Detailed field notes were taken during the participant observation period of the social interaction, informal conversation and observation of the researcher. The twenty in-depth staff interviews and the ten in-depth family interviews conducted based on structured questions were audio-taped and transcribed in a line by line format. All of these data was read and reread.

The interviews were also reviewed simultaneously later with a colleague who was a PhD-prepared psychologist and had conducted her dissertation research on grief. The interviews were read together and then discussed. We discussed and identified possible themes in relation to the research domains. I found this discussion process with my colleague most helpful. As Morse (1994) stressed, with qualitative research themes do not just appear from the data but that it is an active process of questioning, looking for answers and trying to separate the significant from the insignificant.

Once we identified the themes in the individual interviews, we compared them within their individual groups or sets of interviews (staff and then family) for patterns that might exist there. I did plan to utilize this time with my colleague as a way to form consensus. However, we did continue to talk over the transcript and the conversation at times did evolve into additional analysis and codes. We only compared the staff interviews to other staff interviews and the family interviews to the other family interviews.

The next chapter, Chapter 3, will walk the reader physically through the ED as the staff and families do during the sudden death event in this setting.

## Chapter 3

### **Walking through the ED: Seeing it as an Ordinary and Extraordinary Place<sup>1</sup>**

It was a beautiful spring day and I was very excited to be finally at my field site ready to begin my research. I had been there before and attended some research committee meetings and got to know some of the staff at the hospital. I am a seasoned healthcare provider, so entering a hospital is a very ordinary activity for me. I have entered many hospitals as a nurse and as a nurse educator. I have also entered emergency rooms as a mom. I have taken my children to the ED for minor injuries and not so minor injuries. However, the last time I was in an emergency room was as a mom, when my family received the devastating news that my daughter had been involved in a car accident and had sustained fatal injuries. Now this ordinary place in my work life has suddenly become an extraordinary place in my personal life. As a bereaved parent, I really came to understand that the emergency department (ED) is a place where in a moment lives are changed forever.

I walked into a hospital so many times before but this time I was entering in a very different role, as an anthropology doctoral student, a researcher. As I walked across the parking lot towards the urban ED where I was to conduct my research, I was surprised to notice the 3-4 ambulances parked in the lot immediately outside of the entrance to the ED. The EMS workers were drinking coffee and talking near the

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<sup>1</sup> The confidentiality of both the field site and the research participants is of the utmost importance to the researcher, therefore changes were made to the description of the facility to disguise the exact location. Any attempt to match this facility with the location of the emergency department is discouraged.

ambulances; they were acting ordinary. The line of ambulances reminded me of taxis waiting outside hotels. I walked past many ED entrances in my years of being a nurse and I do not remember ever seeing this scenario before, but I am certain that I have walked past very similar scenes in the past. My guess is I notice different things now and have been changed by my experiences and my perspectives as a nurse, social scientist, bereaved parent. As I spent more time at this facility, I found that these EMS workers standing around drinking coffee and talking was very common, and I began to notice it at other hospitals as well. It was also very common to get out of my car when I arrived at the hospital to hear ambulance approaching the hospital with sirens screaming and pulling up to the door just as I was getting there. I have been a nurse for 30 years, and every time I would approach the hospital my heart pounded with an all too familiar adrenaline rush; I was so excited to be part of it all.

I had been introduced to the ED team and possessed a security badge so I decided to enter the ED through the “trauma doors” where the ambulances pull up. These are double-wide automatic doors large enough to accommodate an EMS team pushing a patient on a stretcher through the door. As I approached the doors they flew open with a “woosh” and I felt the air in my hair. As I stepped in, my heart was racing.

I saw a security policeman just inside these doors, (who I would later learn is deputized and armed), standing at the door and making sure only people arriving by ambulance -- patients, their family members, EMS workers -- and authorized personnel enter through that door. I smiled and showed him my badge. He returned the smile and greeted me with a friendly hello. I continued walking past where the security policeman

was sitting and to the left was a pair of double doors to what appeared to be a closet. This room was the “viewing room” where families see their family members who die in the ED. I will speak about this viewing room in more detail later. I found it interesting that the viewing room is almost outside of the ED and away from where care is mainly provided.

Just further inside the ED I came to a small work station where a triage nurse sits at a computer. Next to this work station is a small room with several stools and a counter with space for several people to sit and write or talk, and there are also phones behind the work station on the wall and a switch that the staff calls “the tweeter.” This switch is the one that the nurse hits if she wants the resuscitation team to assemble in one of the ED’s two trauma rooms, or resuscitation rooms; the staff refers to them as the “resus rooms.” Again, I will write more about “the tweeter” later. The nurse looked up as I pass her. We exchange hellos.

I made a slight left into a hallway. At the end of the hallway are closed doors which lead into a large treatment area of the ED where there are approximately 20 beds for patients and a nurse’s station. The walls on both sides of this hallway are bare. Directly to my left are two closed doors that lead to the resus room, divided by a curtain into Trauma Room 1 and Trauma Room 2; pushing the door open and entering the Trauma Room 1 side – it has its own door -- I entered a very well lit, warm, cluttered room that at first glance appeared small and disorganized. Even when the trauma rooms were empty, they seemed chaotic. I noticed the difference in lighting and the difference in temperature immediately when I entered the room. There were large, bright lights above

each of the two beds in the room, and I was told by a staff member that the room was kept warmer than other patient care areas in the ED by protocol. I asked several staff while I was there about this protocol, but no one could tell me the exact temperature.

Everyone guessed it was in the range of 78-80 degrees. I was told it was controlled by a computer. No one was able to locate the exact policy for me. The walls opposite the partitioning curtain in these Trauma Rooms are covered with shelving units overflowing with supplies -- IV bags, gloves, trays gloves, linens, and other items. From floor to ceiling almost every space on these walls was taken up with equipment and supplies.

Portable equipment, including computers, was kept in the room for quick access. Behind the wall with the computers was another room where hospital staff develops x-rays and have more space to work if needed. A large control panel area was in the center of the room, several computers and related monitors, (e.g. monitors to read x-rays), and many shelves where supplies are held. Also on that wall are more monitor screens and clocks above each bed. There is a pair of analog clocks on the wall above each bed; one clock records time in hours and minutes and one in minutes and seconds. Medical staff uses the latter to record time more accurately during treatment. Two large garbage cans and two large laundry containers for biohazardous waste are in the room to dispose of soiled linens and other laundry is at the foot of the bed area also by the door; there are also two small wastebaskets for non-biohazardous waste.

There is space for the beds on each side of the room, and a small area for staff to work around each of these beds. The trauma room has two access doors. One access door

enters into each Trauma Room from the main hallway of the ED. These doors are used by staff to access each patient individually and to get additional equipment in such as x-ray machines in and out of the room quickly. The doors can also be closed for privacy and quiet. The two trauma rooms can be separated by pulling a curtain down the middle of the room. Curtains inside the room can be drawn to maintain the patients' privacies and can be pulled open to facilitate communication between the healthcare providers working on both patients. The healthcare team can also move easily between the patients and care for each of them when there are two patients in the trauma room. I also note two small work stations on each side of the room and space behind them where a pharmacist and a nurse usually stand.

I leave Trauma Room 1 and turn right, and I am back at the ED triage nurse's station again. To my left I press a button on the wall the door to go into another hallway within the ED but not part of the main treatment area. I press the button, the door opens, and I go through the door. On my left is a room labeled "Family Room Number One". I think about the families I will meet in this room and how their lives will change there. I take a deep breath and I walk across the threshold.

### **Family Waiting Room One**

Family Waiting Room One has a small table with a phone and a box of those horrible, hospital-issued, facial tissues. Beside the table are three institutional green vinyl chairs with arms, the chairs are connected to each other. Beside the last chair is a large wastebasket with a plastic liner. On the long wall in this room is another set of two chairs

all with arms again connected to each other. None of the chairs face each other. They are all against the wall, immovable. The floor is white linoleum tile, clean but worn to a grayish-white. One of the long walls is bluish green, and one of the short walls is a green-yellow color. A framed painting on the green wall is a depiction of a winged African-American female. The painting appears to have a spiritual tone. The female is dressed in regal robes and she is wearing cross earrings. There is a phone on a small table in the Family Room, and I would later learn from my participant observation that the families are permitted to use this phone to call family and friends. On a wall to the right of the door is a little white plastic box labeled "panic alarm." I was surprised to see a panic alarm. I wondered what families thought about the panic alarm, or if they even noticed it. I asked the social worker on duty about the panic alarm when I first saw it. Her response was, "What panic alarm?" I took her in to show it to her. "I never noticed it there," was her response. I did realize through my participant observation that her time in that room is very busy and very stressful when working with families. Perhaps that is why she never noticed the panic button. The Family Room also had a door that can be closed for privacy, but I found the door was usually left open.

### **Family Waiting Room Two**

Leaving Family Waiting Room One and turning left I entered into Family Waiting Room Two. This Family Room is very similar to Family Room Number One. It also has a small table with a phone and also a box of those horrible, hospital-issued, facial tissues on the long wall are six chairs with arms and they are also all connected. On the short

wall are two green vinyl-upholstered chairs with arms and the chairs are connected. Again none of the chairs face each other. The floor is linoleum tile, clean, a grayish white color and a random row of green linoleum. The walls are painted light green. There are two paintings in this room one on each wall. Again, one could perceive the art as having a spiritual tone. One painting consisted of a tree with a nature theme, and one painting of a heavenly, celestial theme. There is again a panic button clearly labeled and a door that can be closed for privacy. These features were the same or very similar to Family Waiting Room One.

I emailed the director of Spiritual Care to ask if she knew any history of the artwork in the family rooms. The director of Spiritual Care responded to my email that she was very pleased that the artwork was noticed. She stated in the email that one of her students in the Clinical Pastoral Education (CPE) program at this hospital had asked her son, to create or donate a piece of artwork to the ED. She went on to say that the spiritual care staff had had a ceremony with the artist, the CPE student's pastor and some other people when it was dedicated in the ED. She did not remember the date of the event or any other details.

Both of the family rooms seemed small and stifling to me. The rooms had no windows, and I knew if the doors were closed I would feel like I was suffocating in one of these tiny family rooms. After seeing the rooms and taking these descriptive notes, I lost my feeling of excitement that I had had in the parking lot. I am not sure exactly when or where that happened. I had no rush of adrenaline now; I felt very tired. I took a moment to collect my thoughts. When did that feeling of excitement leave me? Why was



I so unaware of the change? If I had been somewhere else I would have sat down, but I was not going to sit down in this Family Room, not today. I felt a slight heaviness in my chest. I took a deep breath. Time to get done, I told myself. I stepped out of the room into the hallway. I took another deep breath. I was starting to feel better.

I continued my walk-through. Once in the hallway outside Family Room Number Two, I was directly across from the social worker's office. The door was closed. To the left of the door to the social worker's office, another hallway intersects this one. This other hallway leads to the main waiting room of the ED. To the right side of the social worker's office were two bathrooms, one for men one for women. Both bathrooms are secured, employee bathrooms, and hospital employees have to press the correct combination on the keypads to gain entry into the bathrooms. The social worker that I met previously had given me all the codes in order to gain entry to all of the secured areas, including these bathrooms. If any of the family members needed to use a bathroom, they would have to go out to the main waiting area, down the hall and around the corner. These locked bathrooms reminded me of the night my daughter died, when I went into the bathroom right across the hall from that hospital's Family Room and vomited. I wondered if any of the families at this hospital ever needed a bathroom suddenly like that. I immediately felt sorry for the families that would eventually be at this hospital, families like my own whose lives could change in an instant. I tried to shake off the sadness that the Family Rooms brought to me.

### **Walking to the Viewing Room: The Path a Family Member Will Take**

I return, full circle, to the secured doorway where I first entered this hallway. I wanted to take the steps a family would take as they left the Family Room after receiving the news that their loved ones had died sudden deaths. Through this door, the family is led out of the ED. They are taken out of the area where care is delivered almost to the door leading out of the ED, the threshold to the outside world. A keypad is immediately to the right of the secured doorway. I know the security code, so I key in the combination and the door opens. I go through that door, and I am again at the triage desk facing the ambulance entrance of the ED. This space can be a very high traffic area. The families leaving the hallway with the Family Rooms would have to walk past any and all people who happened to be in this high traffic area to get to the Viewing Room.

Immediately I notice all the activity. I am facing the trauma door that I described earlier. To my immediate left is the triage nurse's station. A nurse sits there on the computer, talking on the telephone. The security police are talking to an EMS person at the doorway. Several other nurses are talking to each other to my right, outside Trauma Room One. At times there might only two or three people in this area or it could be very congested. One thing for sure, it never made sense that families are being led out where new patients are being brought in by EMS workers. I walked past the hospital workers standing around and up to the two closed doors that look like a maintenance closet, the doors to the above-mentioned Viewing Room. I asked, "Is there anyone in there?" "Not now," the triage nurse answered. "Go ahead in, if you want." In my mind I was thinking, *If I want? Of course I do not want to. I am doing research. This day has nothing to do*

*with what I want. I feel absolutely compelled to do this research.* That was what I would have liked to have said. But, Instead I said, “Thanks. I have to take a look for my research.” I opened the doors. This designated Viewing Room, which was not signed in any way, was where families would go to view the body of patients who die in the ED.

I need to stop here and speak to the language of the word “viewing.” My use of this term and the hospital’s use of this term, “viewing,” was pointed out to me by my advisor. Normally, when family members come to visit a patient in the hospital they come to the information desk and ask to *see* the person they want to *visit*. When a person dies in the ED the language changes immediately from “seeing” and “visiting” to “viewing.” It was so automatic, even to me, that I did not notice this use of *viewing*. Soon after patients die in the ED, there is a difference in the language staff uses with family, and I would later hear in my interviews with staff “We are not a funeral home” although they use the language that is used in a funeral home, where people coming in the door are asked “Who are you here to view?” I also heard that one of the Spiritual Care workers called this viewing the “first goodbye”. I loved that language, but I could never trace it back to the exact person who said it. Here is this ED there was a stark cultural distinction between the living and the dead.

### **The Viewing Room**

The doors open into the Viewing Room, and I walk inside. The room is the size of a walk-in closet. This “room” is currently empty, where staff takes families who experience a sudden death of a family member. Families come to this room, to where the

stretcher with the body of the deceased person has already been taken. The stretcher is pushed up against the back wall opposite the double doors. There is no space at the top or bottom of the stretcher, only on the one side of the stretcher facing the door through which families enter the room. There is not even room for a chair when the stretcher is in this room. The family member stands in the room crowded just inside the door and say their goodbyes. It would be similar to standing in a freight elevator, with no way to move or change direction. The space and configuration was certainly not conducive to staying there. Once the staff takes the family into the Viewing Room, they close the door for privacy.

The walls are all painted, very plain with no decoration, no artwork, spiritual or otherwise. The floor is linoleum. I was horrified when I first saw this setup for the families. I could see using this room if there was no other room available. I realized as I did my participant observation that this room was the only space not being used for treatment. As I noted above, this hospital has a very busy ED that almost always ran at full bed capacity, and this room was the only place where families could have any privacy in the unit.

This room also had a curtain to hide decontamination equipment; the curtain is drawn shut so that a family viewing a body would not see what was behind the curtain. This room is set up as a decontamination room in this ED. It seemed fitting to me, because in our culture people like to think that they can decontaminate themselves from death or anything that came too close to them that would contaminate them or cause them to die. Behind the plastic curtain was a shower and equipment that is used for patients

who require decontamination. I asked a nurse who had worked there for several years if she could remember the room being used to decontaminate a patient, and she said she had never seen that room used for decontamination.

I left the empty room and closed the doors. I am glad the ED's trauma area is quiet today. I say good bye and thank you to the security policeman and the triage nurse on my way out. I tell them I will be back soon. As I walk towards the door its opening "woosh" again blows my hair. I step outside towards the parked ambulances.

### **The Emergency Department Entrance**

Sometimes family members arrive with the patient by ambulance. I had to use my security badge to enter the ED as a patient and a family member. Having done this I now get my bearings for a new activity. Many times there is no family member present with the person who has the life threatening event that leads to the sudden death event. These patients' family members are called by family members who are already at the hospital or a hospital representative and are told they need to come to the hospital. Next I will walk you through how those family members enter this ED.

Going up to the emergency room, I knew that I was going into the main entrance that the families come into. I felt like a visitor. Nurses do not use this entrance; staff enters and exits the ED through staff-only entrances and exits. I am glad that I am not doing my field work at the hospital where my daughter died. I could not have done it.

The main entrance is clearly marked "EMERGENCY ROOM." There are signs leading to the ED from all of the roads surrounding the hospital facility. There is a red canopy of

light over the entrance where the letters spelling out Emergency Room reside. Families can drive up to the door and security will assist them out of their car. Families cannot leave their cars at the entrance, but valet service is available or families can park in the visitor parking lot located right across from this entrance. I pulled into the visitor parking and I walked across to the emergency room entrance.

I approached the automatic double doors as family members would that come to see the patient. A tall, uniformed security policeman immediately inside the door and another just inside the door at the metal detector greet me. The security policeman at the door sees my badge and smiles and says, "Hello. You're okay. Come in." But family members are stopped and told to empty their pockets into the box provided prior to stepping through the metal detector. After I successfully went through the metal detector, I was in front of the reception desk where I was greeted by a patient representative. It is a large desk where two people sit who greet and appropriately direct people who enter this area of the ED. There is a large waiting area to the left with chairs and vending machines and public restrooms. To the right were a portable computer, chair and another waiting area with chairs and a TV with CNN playing, blaring from it. There was a sign on the wall behind the desk welcoming people to the ED. Immediately to the right of the desk was a hallway. This hallway had a secured doorway. I inputted the combination and the doors opened. I walked a few steps and to my right was a large room where patients are admitted, and as I walked to my left I was again in the hallway where the social workers' office is, the employee-only restrooms and the two Family Waiting Rooms. This entrance is how the family members would enter into the ED if they did not accompany the

patient. Family members are met in the main ED waiting area by the social worker who escorts them back through the secured doorway down the short hallway into one of the Family Waiting Rooms where they wait for news of the patient's condition. This is the room referred to so often in my interview data into which no families wanted to enter and where the waiting was forever.

Once again I walked past Family Waiting Room Two, Family Waiting Room One; I inputted the combination and the security door opened into the trauma area of the ED. I walked past the triage nursing station, the doors to the viewing room, and the security policeman, and I stepped towards the double automatic doors and left. I had seen the ED as family members see the ED. I was reassured that I would be able to go forward and employ this to this multidisciplinary lens: of nurse anthropologist, bereaved mother and auto ethnographer.

## **Chapter 4**

### **The Ritual Process of Becoming Dead in the ED**

The following chapters will take an in-depth look at the ritual process of becoming dead in the ED in a sudden death event. This ritual process will be investigated medically, organizationally and socially. In detailing the stories of how each step of the ritual process is experienced, I will present three different voices: namely, the professional staff person, the “native” in the ED; the families in the ED, those who come into the ED as “guests”; and the researcher’s auto ethnographic thoughts along the way as they pertain to the stories being told. For me, looking through the lens as a mother, nurse anthropologist, educator, and the lens reflecting back on the ethnographer, the lens of the researcher became wider everyday as the lived experience became deeper with each sudden death event that I learned about during the fieldwork process.

Using the stories of both staff and families about the activities that occurred during the sudden death events, I analyzed my findings in terms of the properties of secular rituals Moore and Myerhoff (1977). These properties as introduced in Chapter One are: 1. Repetition, 2. Acting, 3. Special Behavior, 4. Order, 5. Evocative presentation style, staging and 6. Collective dimension (p.7). Each of the properties will be explained in detail as I explain the ritual process as the sudden death event progresses and a person becomes socially dead in the ED setting. These properties will be applied to analyze the ritual process in the following chapters. Chapter Four: Gathering in the ED: Coming Together for the Death Ritual, Chapter Five: Transitional Social Process: Becoming Dead



in the ED, Chapter Six: Leaving the ED: Re-Entering Society as a Mourner, Chapter Seven: Final Rituals.

### **Talking about Sudden Death in the ED: Search for Ritual Process**

One of the questions that I asked the professional staff members whom I interviewed was: *How are sudden deaths handled in the ED here?* I usually got other questions back from the people that I was interviewing, such as: What do you mean? Do you mean how do we handle the families? Do you mean emotionally? Or I received this statement, “This question is so broad.”

Then what I found most typical was that the staff person whom I was interviewing would begin explaining to me the role that they played either with the patient or with the family involved in the sudden death event. For example the physicians would speak about the “running of the code” or the “telling the bad news” to the family members in the family room. Some of the nurses spoke to their role in the sudden death event, which was to “get the body presentable” for the family to view. Several of the nurses referred to “handling” of the sudden death in the context of their own emotional state. Both the spiritual care and the social workers spoke of handling sudden death as bringing comfort and support to the families in the aftermath of the sudden death event. The security police felt that their role was keeping the environment calm and safe so that the staff could do their work to the best of their abilities. All of the professional staff members whom I spoke to also talked about other team members, their roles and their specific involvement with the patient and the patient’s family.

What I began to see was that there was a ritualized process that occurred in the ED related to sudden death events that occurred here. The organizational culture delineated the roles of each professional staff member and how those roles were to be executed in this highly protocol driven setting of the ED. What I found was that while staff clearly did recognize the steps of the ritual process, they were not trained to recognize that death was being handled as a social event and a ritual process here. They were quite conversant in the medical and to some extent the organizational aspects of handling sudden death here but not well versed in the “social making of death” in this setting.

*Do you have specific policies and procedure related to these sudden events?*

This was the second question that I asked the during the staff interviews. I asked about written policies and procedures related to sudden death events in the ED. Official written policies in this hospital were kept within the computer system. I did not have access to this system. A spiritual care professional gave me a policy titled “Patient Expiration Check List.” After I read the policy, I realized that it was a policy for when death occurred on a general hospital unit. Many of the professional staff I interviewed had experienced dealing with death on other units of the hospital. These staff members were not just assigned to the ED, specifically, the spiritual care staff and the security personnel. The residents, prior to coming to their rotation in the ED, were also in the ICU units and experienced handling death events there.

I was also given a sheet from one of the social workers that listed some duties specific to the social worker’s role titled “Death in the Emergency Department Social

Work Procedures.” This was an unofficial document and would not have been accessible to everyone throughout the computer system. Here is a portion of an email I received after requesting a policy from a professional staff member who had day-to-day experience in this ED working with family members:

There are no official policies governing death in the ED. Unit specific policies are not accessible through a regular policy search... As far as practices in the ED, I found the more I asked the more different answers I got and it just seemed to make things worse. Staying away from knowing whatever the rules were proved to be a better way to go in terms of taking care of families.

As mentioned earlier this ED had approximately 400 sudden deaths a year. This statistic is more than one death a day. I have already indicated that the ED is a highly protocol-driven department and the social and cultural expectation is that the staff will employ technology and save lives heroically, and it was understood that “no one should die here.” It is not surprising that I found no policy on death or how death should be “handled” even when there are hard numbers that people indeed died regularly in this department.

Even without a policy what I did find were staff members who could talk about specific team members who would be called during a sudden death event. These team members had specific duties and carried those duties out in a specific pattern with the family members of the deceased. This was a team effort where each member knew their role and their responsibility. This pattern was part of the organizational culture and communicated through oral tradition and role modeling. I was told that the knowledge of how to act in these situations was handed down initially through the orientation process. Related behavior was then role modeled to all members of the interdisciplinary

professional team regardless of that team member's professional role on the team. Interestingly, I found this process was communicated to team members more efficiently and effectively than the communication of any written policy or procedure that I have witnessed in the ED or elsewhere in my lengthy hospital experience. I saw this ritual process of socially making someone dead carried out repeatedly with competence and compassion in different sudden death events during my participant observation time on the unit. It was also interesting for me to discover that the staff also made exceptions in a patterned way especially relating to pediatric sudden deaths in the ED. I began learning about these pediatric exceptions on my first day on the unit and saw them throughout my fieldwork there. These exceptions will be covered in more detail later.

## **Gathering in the ED, Coming Together for the Death Ritual**

### **Arrival at the Trauma Door**

As indicated in the walk-through, when a person is brought to this (ED) by ambulance they enter through the "trauma door" or the ambulance doors at the side of the ED. The side of the ED is a large parking lot area with a driveway up to the ED doors which open automatically. The ambulance opens its doors and the EMS workers take the person on the stretcher in through the doors. Once the ambulance is empty it pulls away and the driveway leads into a small parking lot where the empty ambulance can park. The EMS workers push the stretcher with the person on it through the doors. Just inside the doors sits a security policeperson, and just past the security police is a small enclosed desk where a triage nurse sits at a computer. Behind the nurse is a switch that the staff

calls the “tweeter,” which is what this nurse hits if she wants the resuscitation team to assemble in one of the trauma or resuscitation (resus) rooms.

The EMS worker entering into the ED stops immediately inside the door where the triage nurse sits. The EMS workers have been communicating with the ED while transporting this patient to the ED. At this point, the EMS workers continue to communicate with the nurse as she does a quick assessment, a gathering of information, on the patient. At some point during this communication the team makes the decision to hit the tweeter and to assemble the resuscitation team.

### **Signaling the Event: Use of the Tweeter**

There are two tweeters in the ED one at the “trauma door” and one inside the main entrance at the front of the hospital that the staff refer to as “up front”. I spoke to a triage nurse who explained how the process for the tweeter works. She pointed to a switch labeled “staff call” that is on the wall right behind where she sits at the triage desk at the trauma door. The triage nurse told me she decides whether or not to hit the tweeter button. She bases this decision on her nursing judgment combined with the patient history.

Once the patient is in the trauma room the doctor makes a definitive decision on the tweeter. If the patient is a hospice patient or has decided on a DNR (Do Not Resuscitate) they do not activate the tweeter. If the ambulance calls ahead of time and the doctor is at the door, the doctor gathers that information on the patient and decides on the status of the tweeter. The triage nurse I was speaking to about the tweeter stood up to

demonstrate for me. She straightened her arms above her head and stated “any gunshot wound above the elbow and below the knees, a wound where no major arteries and no major organs are involved does not involve hitting the tweeter; otherwise, push the tweeter for all other gunshot wounds”. (Field note, Summer 2010)

There is also a tweeter “up front” at the main ED entrance. The triage nurse explained to me that a “penetrating trauma” can also be brought to the main entrance of the ED and be dropped off by car to security. They can come over to the main ED area in a wheelchair. Security or the triage nurse can hit the tweeter up front and then transfer patient to the trauma room in the ED, the team can be gathering, getting ready to administer the appropriate medical care. The tweeter switch at the main ED door is located under the counter where the nurse sits.

### **Gathering the Medical Team**

Pages for trauma can also be initiated at this point, social work, chaplain, pharmacy, trauma surgeon and their surgical team. They are paged to come to the trauma room immediately when a patient with a traumatic injury has arrived. There is a trauma surgeon in the hospital at all times. The trauma team needs to be paged. They are not necessarily present in the ED as the other staff members who are there and can hear the tweeter.

If the patient needs resuscitation (CPR), the nurse also hits the tweeter. This switch elicits a high-pitch tone, much like the beep when the food in the microwave is done, but shorter in duration. This scenario is different from the media portrays crisis in the ED on

television. There is no yelling, running or other drama, only a brief beep that the staff have trained themselves to hear and then respond. I missed hearing the tweeter the first day I was there. I was astounded to learn that I had missed part of resuscitation because I just did not know that it was happening. If a major trauma such as a stabbing or gunshot wound is coming in, a trauma team is assembled which includes not only a CPR team but a specialized surgical team. Those team members are also paged individually via their personal pagers to come and gather in the ED. These team members walk immediately to the trauma rooms located to the right of the triage nurse. After the nurse hits the tweeter button, she and the EMS worker escort the patient into the first empty trauma room. I have provided you with a description of how the medical team gathers.

## **Gathering the Family**

### **Arrival at the Trauma Door**

In the midst of the controlled chaos, if there is family with the person coming in by ambulance, the staff will interact with this family. The family is escorted past the triage nurse through the security door into the empty family waiting room to wait for information from the doctor concerning their family member. The people who were transported to the ED with the patient in the ambulance would have been present at the time of the event when the EMS was called. EMS workers usually ask family members to follow behind in a car. If a person is in the ambulance, EMS workers have made that decision at the scene and considered that person a family member until further information is gathered in the family room. A social worker having heard the tweeter

would know of the incoming patient. The social worker's job is to be with the family. The social workers introduce themselves to the family and offer them the additional service of spiritual care. The family is also contacted by a hospital representative for information (name, address, health insurance, allergies etc.) so that the patient can be properly admitted to the ED unit.

### **Arrival at Main Entrance**

If the family is not with the patient entering by ambulance they might be entering through the main ED entrance located in the front of the hospital. The family enters through the main doors and the security scanner manned by the security police. They then go to the main desk and ask to see their family member who has come in by ambulance. The hospital representative then calls the social worker and let them know that the family had arrived, and asks if the social worker is ready for the family, if permission is granted. (Usually this situation depends upon the social worker being able to spend time with the family, the family is escorted through the secured door to the family room to meet the social worker and await news from the resuscitation room). If the social worker is not ready, the family is asked to wait and the Spiritual Care representative is called. The family is not left alone at this time. The family is met in the ED waiting room and escorted to the family room by an appropriate professional staff member to await the news.

If there is no family with the patient, there are several methods used to contact family. The EMS workers sometimes say that the family had been at the scene and were "on the way", the charge nurse can retrieve emergency contact numbers off the patient's



cell phone and the social worker can begin calling those numbers and trying to contact family or friends. The family is told that there has been a serious accident or other situation and that they need to come. They are never told that there was a death over the phone, even if the sudden death had occurred. If the social worker is not available the charge nurse tries to make those phone calls to the family.

The description above is the beginning of the ritual process that was observed repeatedly during the researcher's fieldwork. The organizational, medical and social aspects of the ritual process were well integrated into the categories of repetition, and of acting for this particular part of the secular ritual.

### **Analysis of Gathering in the ED: Coming Together for the Death Ritual**

#### **Repetition: Staff Stories**

The first property of a secular ritual Moore and Myerhoff (1977) is *repetition*; this aspect is the process that gathers the medical staff and then they gather the family in the family room. This process was described in detail above and was repeated with each and every sudden death event. The only exception was made for pediatric deaths and will be explained later. The following is an excerpt from two of the staff interviews telling me of the repetitive activity of gathering staff and family when a sudden death occurs in the ED.

Here are those examples from two interviews from nurses:

**Mary:** Do you have specific policies and procedures related to sudden death?

**Nurse:** The procedures that we do, they're not written in policy but we, if we know a patient is coming in and they're in cardiac arrest or they have no vital signs at the scene, if it's a accident, we notify the social worker and our chaplain

so that they can come down and be available for the family and for the patient as well. If we have like an instance coming, that the staff doesn't think they are going to be able to handle it, then we just kind of like take care of one another and they're excused, and somebody else would take over for them.

**Mary:** Okay. That's just kind of word of mouth?

**Nurse:** I'm sorry?

**Mary:** That's just kind of word of mouth? You don't have that written down somewhere?

**Nurse:** Um, no, nothing – that's not a policy. That's just kind of procedure that we've just kind of followed.

**Mary:** So, when you get a call from EMS, that automatically the social worker is notified and pastoral care is called?

**Nurse:** Yes.

**Mary:** Before they even get here?

**Nurse:** Yeah.

**Mary:** And then does the family come in soon after that usually?

**Nurse:** It can vary. I it's a home accident and the family's there or if it's like a sudden, like cardiac arrest and the family was there and witnessed it, we've had them follow or come in the ambulance with them, and as soon as they arrive we direct them right into the family waiting room, and then that way they have somebody be in with them, like the chaplain or the social worker, and then we're prepared for the influx of family members that could, that can come in because we've had like crowds come in.

**Mary:** So who calls the family if there's no family? Let's say it's a car accident?

**Nurse:** Social worker. Our social workers are very, very supportive here. They do things for us that most hospitals probably don't do.

**Mary:** And they stay with the family?

**Nurse:** Yes, they'll stay with the family. They will assist them, taking to and from the viewing room and helping them, you know, fill out – because there's documentation that has to be completed for, like, the funeral home and the death certificate and they usually take care of that.

**Mary:** And who notifies the family of the death?

**Nurse:** If the family is not there, the social worker will try to contact them and he will tell them, you know, your family member has come here and here in the hospital, you should come in. They don't tell them the patient has expired, and then they wait when the patient – when we know that the family is en route, then we again do the same thing, we'll get the chaplain to come down and we'll just wait for them, and then the physician will go into the room and talk to them and explain to them that there's been an accident or there's been an illness that's resulted in a death, and then they'll explain that to them with the support there.

**Mary:** How do you feel about how sudden deaths are handled here?

**Nurse:** I think we do a pretty good job because we can have instances where there's more than one patient pass away, and we have, we have to separate them, and have areas in the hospital we can take them. So we're sensitive to the

family's needs. Like little babies or little children, we've taken them over to \_\_\_ area because we know they are going to have a lot of family so they can sit with them, give them that time that they need. (Staff 4)

And another example of the repetitive activity described by a nurse:

**Mary:** Do you have specific policies and procedures related to sudden death here in the ED?

**Nurse:** I'm sure we do, but, you know, we just try and – the big basic ones are just, you know, the doctor goes and talks to the family. We try and keep it to the, just the immediate family anyways because some people mourn a little wild. So we have security there just in case with the social worker and the chaplain always there with the family so they can help with the coping. I'm sure the policy's in there, but that's, you know, we follow those standards every time so we can, you know, ease the family's pain anyways.

**Mary:** Who calls the family?

**Nurse:** Well, a lot of the times the family shows up with the patients, I'd say 90 percent of the time. If they don't, we have our social worker – we have a social worker 24/7. They always call the family and tell them to come down, and then the doctors go on and talk to the family when they do get here.

**Mary:** And who on staff stays with the family?

**Nurse:** Usually the chaplain. Social worker is busy between, advocating between the doctors and, you know, the nursing staff and the chaplain and the family, so the chaplain is usually the one who stays with them the whole time.

**Mary:** Who notifies the family of the death?

**Nurse:** Usually the doctor. Basically, like I said, most of the time they're here so the doctor will go in, the third-year resident, senior resident or the attending. They go in and they have a procedure on how they speak to the family. You know, if they come by ambulance, they say, you know, this is how the patient presented with EMS, this is what EMS did, this is how they presented here, and, you know, give them a little history of what happened prior to arriving here before we tell them they're passed away.

**Mary:** What happens then?

**Nurse:** Well, in the trauma room, once the patient's dead, declared deceased or whatnot, we do our post-mortem care, don't intubate or anything or any IV lines we keep in the patient. We just prepare them for family. So we just, you know, put sheet underneath but we make sure they are nice and clean, as long as they are, you know, not trauma stuff that you have to leave exposed, but, you know, make it presentable for the family to see, and then we put them in our viewing room.

**Mary:** How do you feel how about how sudden deaths are handled here?

**Nurse:** I feel they are handled pretty good. We see a lot of them. Our social working team is magnificent. Our chaplains come down right away. And our doctors are well prepared for talking to the family, so there's always one or two

that get out of hand, but everything's always under control. We take the precautionary measures beforehand, especially any trauma event. If any young children that got shot and stuff, we always expect the worst reaction from the family, so we set in place all the proper barriers before, you know, anything gets out of hand, preventative.

**Mary:** What are those barriers?

**Nurse:** Well, security, that's the biggest one, you know. We have, we tell what's going on and we show a lot of force, you know. They are just there, just in case, and we just keep it to the immediate family in the viewing room so the doctors don't get, you know, assaulted, and stuff like that. And, you know, the chaplain and the social worker are there to see who can handle stress a bit. Some family members, they just don't need to feel – not immediate family – but, you know. When they show up with 30 family members they can see the patient at the funeral home. (Staff 1)

### **Repetition: Family Stories**

I will now further consider how the category of *repetition* Moore and Myerhoff (1977) occurs with the family from the viewpoint of the family stories and how the family gathers in the ED during a sudden death event. There are times when a family member will arrive at the ED in the ambulance with the patient. This decision is made by the EMS at the scene when the decision is made to transport the patient to the hospital. The family member calls other family members to also meet them at the ED. If the patient is alone when the life-threatening event occurs and comes to the ED alone in the ambulance, the family is located and called by the social worker to “come to the ritual event.” Everyone who is called comes to the ED. They are given very little information over the phone, but the information that they are given is enough to make them afraid, nervous, scared, hopeful. This is how they arrive in the ED.

Families arrive either at the ambulance door or at the main ED entrance and the ritual process described in the above paragraph begins. The ritual process under the social

control of the hospital staff members was repeated to me over and over again by the families, even though some of the details differed slightly. In general, the family stories began prior to the patient admission to the ED. The family member told the story of the events that precipitated them coming to the ED of how they came to arrive at the ED and what happened to them upon arrival at the hospital. The families spoke of being taken to the “room”. All of the families knew that going to the “room” was a very bad sign. Here is one story that describes a trip in the ambulance and the phone calls for the gathering of people for the social act and the ritual process of death. This couple had just finished breakfast at home in the morning just prior to the sudden death event. This story was told to me by the wife:

**Wife:** I’m turning from the window to look back at the TV which was on, and he’s here, and he says, cough, cough, cough, and he turned his head to the wall. So I glanced this way because I’m going to fuss at him about not taking the cough medicine that I bought for him, and he never turned his head back. So I jump up out of the chair and I look at him, and I said, cough, oh, my goodness, this man has had a stroke. This is what I said. So I come around the corner, and the phone is right there. And I tried to dial the EMS and I, I can’t, I can’t dial the telephone, so I race out the door and race across the street, and I bang on the door and everything, and the man, as it happens, these people were on their porch, these people were on their porch, and these people were on their porch. I don’t know why everybody was on their porch at that time of morning, but they were, so I bang on the door, and I told him, I says, something has happened to my husband, come and help me, come and help me.

So he comes back over here, and my husband is still sitting there with his head like this, as calm as a summer morning. He didn’t say anything. And so, so this man is standing behind him, and he said, he’s still got a heartbeat. By now, this lady has come from over here, and she has got EMS on the phone, and then she hands the phone to me, and this lady’s asking me these silly questions. And so she said, is he unconscious? I said, I don’t know whether he’s unconscious or not. I guess he is unconscious. So I think is what I said. I really don’t remember exactly, but anyway, somewhere in the conversation, she says; lay him down on the floor. So I said, lay him down on the floor. So by now there’s three or four big strong men over, and they just lifted him up out of the chair and laid him on

the floor, and it didn't seem like it was no time, and the EMS was here, and so they, I think they asked me some questions, and they said something. Don't remember what they said.

And then I remember, I said, are you going to take him to the hospital, and he said, one man say, yes, we going to take him to the hospital, and I remember they put this long thing in his mouth, this tube 'bout the size of my finger, it was clear-like. And then they, you know, pumped him on the chest, and then they took the paddles, and before they took the paddles to him, one of them said to the other one, get her out of here. So then they took me on the porch because, I don't know why they took me on the porch, but anyway, I went on the porch. And so I – maybe they tried to take me on the porch. Because I remember saying, are you going to take him to the hospital?

And they said yes, and so then the lady that dialed the phone to get EMS, said okay, get everything together, all his medicine together, this-that, this-that, this-that, this-that, so I'm running around trying to get all of that and everything, and they're still working on him and everything. (Sighs.) So they are talking we are going to take him to the hospital. So they get the thing in here, and they put him in the car, and I sit in the front, and we start. The man in the back says he's not responding or something, not responding to – and he used this word – and this and the man who was driving said, well, take it off. It did not register with me then. I thought about this way later.

So we go to the hospital, and they put me in this room, and I'm in this room, and I call my step-daughter, and she comes, and I guess it must have been, I don't know, five, six, ten, fifteen minutes. I don't know. (Family 3)

Here is another example of a wife that did not come in by ambulance, but received a phone call and entered the ED through the main ED entrance.

**Wife:** And I had went downstairs at work to get a snack and came up, and always check my phone, make sure, you know, one of my daughters called, and I looked, oh, probably five or six missed calls. I'm like, okay, that's not good. Looked at my work phone, and my message light was blinking, and by that, I looked at the time, and I went, okay, it's around the time the girls would be out of school, I thought something happened to the girls, because my mom picks them up from school when I work. And I was shaking trying to call back on my cell phone number, and when I was trying to dial, I got a call coming in, and it was an ---- manager that we knew that lives down here. He's not----'s immediate boss, but our daughters go to school together, so he felt he should be the one to make the call. So he, you know, said his name, and do you remember me, because I had only met him a few times, and I said, yeah, I remember. I said, what's going on. And I could hear the crackle in his voice, and he said I need you to meet me at---

hospital there's been a horrible accident. As soon as I heard the word horrible, I knew, I knew.

And he said I need you to come, and I said his name, and I said, what happened. And he said, I just need you to come, and he wouldn't tell me, and I refused to leave my office. I needed to know. And I needed to prepare myself from that there to the hospital, and I said, \_\_\_ I'm not leaving here until you tell me. And he said, we think he's passed away, and he had a quiver in his voice, and I said, okay. And he says, I'm here home with your mom, because he came here thinking I was home, and my mom was outside with kids. It was one of the first pretty days in April, 80 degrees. And he said, I've already called your brother. My brother lives out in \_\_\_ And he's on his way to come get you. I said, okay, and I hung up the phone. And I'm remembering things now, but it's, you know, I get little shocks of (quick breath), oh, that happened. So it seemed like eternity before my brother – I'll start crying. I'm sorry.

**Mary:** It's okay.

**Wife:** Came to the hospital or came to the office. But work was very, very supportive. I've had so many – I've been there 19 years, I've had so many people that knew me and hugged me and supported me. And I knew he was gone, even though I didn't get a definite, even though he said we think he's passed away, but I knew in my heart that he was gone, and they kept telling me, no \_\_\_, no, don't jump to conclusions until you get to the hospital. I said, I know he's gone.

They kept saying, no, no, no \_\_\_, don't think that way, and I got, my brother came and drove me there. I was in such a state of shock that I was very calm, which is really surprising, because I'm not that personality. I'm a basket case. I have fibromyalgia now from this whole thing. My muscles shake all the time, they twitch, they hurt, and I was very, very calm. My brother, my younger brother who grew up with \_\_\_ kept (inhaling) breathing like that the whole way there, (breathing) and driving to the hospital, you know, I'm thinking all the memories. My youngest daughter was born there almost ten years prior, and walked in, got there, walked in, and I remember seeing some \_\_\_ guys I've never seen before, with their little, very detail.

I remember now just looking at certain things, the badges, those holding clipboards and social worker, and they whisked me right to the room. I knew then. (Family 7)

In total, two of the family members I interviewed accompanied patients to the ED in the ambulance and the remaining nine received a phone call to come to the ED. The story of the sudden death event began in a different way for these families because of the

varying ways that the family members were notified of the event. However, the staff quickly oriented the family to the proper starting point of the ritual.

The beginning place of the ritual for the staff is the family room where the staff and the family gather. Each family member that I spoke to stated that they knew immediately that their family member was seriously injured because they were taken to the “room.” Several families had had prior experiences in a hospital and knew that when you were taken to this “room” that the news could be worse than serious. One of the reasons that the family members knew this aspect was stated in several of the interviews. This “being taken to the room” is part of the ritual and is repeated over and over. The family arriving is routinely separated from their family member. One of the physicians that I interviewed called this room the “penalty box” for families, referring to how it must feel for families to be separated from one another when they want so desperately to know what was happening to their family member. (Staff 9)

Through participant observation and interviews I noted that although the families were involved in highly repetitive behavior themselves at this point however; even the simplest tasks became extremely difficult for them to accomplish. One family member told me that she could not even remember her grandson’s birthday, or make a simple phone call. For the most part, this “gathering in the ED and coming together for the death ritual” was not something that they had done before or had prepared themselves to do. Unfortunately though, there were cases for family members where this was a familiar activity and they knew the death ritual in the ED.



### **Acting: Staff Stories**

The second property of a secular ritual according to Moore and Myerhoff (1977) is *acting*. This is when each person involved in the ritual knows their role in the performance. As I described before, the professional staff had well defined roles that they acted out. They had a specific way of knowing, thinking and then ultimately acting out a protocol or procedure in a planned, sequential order to move the sudden death as a community event forward. Each member of this interdisciplinary professional team – physician, nurse, social worker, spiritual care person, security police – they all know their roles and their lines. They never act out another person’s part. For example, the nurse never delivered the news that the person has died. One exception was that when a social worker was not available the nurse called the family to come the ED when they did not accompany the patient in the ambulance. Here is a story that gives an example of the acting role from an interview with a nurse in the ED:

**Nurse:** There was a young man who was probably in his mid-20s, recently married, who was a lineman working, and he was working on a Sunday, which they typically don’t do, and he fell. I’m not quite sure what the exact cause of death was, but his fall resulted in his, in the death. When he came in, they brought him into us, he, just like a normal person, working trying to make a living for his family, and you could see that in his, his work gear that he had on, that that could tell you, I mean, I don’t know, and I have friends who were linemen so I guess that might be that personal part that connects with you, and I could see that and we had to locate family. He had no co-workers that were with him. He was working alone. He did not have a harness on, like he should have. So we had to go off of what we had as far as identification and the police helping us. Social worker did locate family, and they were like an hour drive away, and his wife, I was in charge that day. His wife called and she says I understand my husband’s had an accident at work, and he got hurt, and that he’s there. She says – and I told her, yeah, he’s here. Says, if you want to just come on down, you know, I gave her directions, and I says, you know, we’re in the \_\_\_area, you probably don’t want to come alone. I didn’t want to tell her what the real outcome was, and I don’t know if she just had a bad premonition, but her, the rest of his family started

calling, asking for directions, how is he, is he okay, and again, we couldn't give them. . . Anyways, they finally made it here. It took them almost two hours. Typically we only keep bodies in the department for an hour, and we like to move them on, but I felt an obligation that I had to hold the body there for him and just for the family because what they were walking into was going to be really, really terrible. And you know what, I couldn't, I couldn't do it. Every time the wife would call me and ask me for directions, it's just you don't know how our life is going to change. (Crying) I'm sorry.

**Mary:** That's okay. How long ago was this?

**Nurse:** It's probably been five years or so.

**Mary:** You think he was about 20?

**Nurse:** He was in his, I would say his mid-twenties. Just a young person, you know. He had a young wife, and he had young kids. Anyways, I couldn't cope with it, so I gave it to one of my friends to handle. So that was sad, you know, and then you just go him and you know . . . and I pray. . . .

**Mary:** Did you see his young wife?

**Nurse:** Yeah, I did. I couldn't deal with it. I just had to leave. I mean it bothered me for a couple of days.

**Mary:** Yeah, it does. And then you go home, you go home.

**Nurse:** Yeah, you go home and it's like, oh my gosh, I'm so grateful for what I have. That I have my kids, and every time I see my kids and say goodbye to them, I always tell them I love the, because you just never know. Yeah, but I would have to say that probably one of my – I've seen a lot of heartache, but that's one of those that probably stands out.

**Mary:** So how do you deal with that?

**Nurse:** I have a lot of faith. (Staff 4)

This nurse cried during this interview even though this event occurred five years prior her telling of this story. I felt this story demonstrated how the staff implemented the rules to somehow maintain order and meaning in the chaos of the sudden death event. She would not give out any information to the callers on the phone no matter how painful it became for her. She had to maintain some order to act out her part in this drama, the sudden death event. Even when the circumstances became very difficult, she would not deviate from her role or the activity of the ritual.

Here is another excerpt from a staff interview with a nurse concerning the need to act out one's role and one's performance of that role:

**Nurse:** Our role has become a lot more broadened and autonomy and respectful what we have to do when it comes to patient care. So me as the person in charge I had to take his personal cell phone and call his, look through his phone and look for the ICE thing, In Case of Emergency, or since that wasn't there, he was pretty young guy, he was 19 years old, I looked for Mom and Dad. I found his dad. So I had to call his dad and tell his dad, I need you to get down here to the hospital immediately, ASAP. When he responded, he responded as if his son had called him, so he was totally unaware of anything else going on. So his immediate response to me was what's wrong with my son? And at that point, you know, we're not allowed to say anything. I just need you to get down here and it's regarding your son but I need you to get down here to the hospital. And his entire time, what's wrong. Well, we're not allowed. You know, once you know, you don't give that kind of information over the phone. (Staff 2)

Another example from a nurse:

**Nurse:** We have, whenever I'm getting a patient ready to be viewed or whenever somebody has died or whenever I'm dealing with the family, I always think like how – because that's going to be the last thing they remember, you know, no matter what happens, that's going to be the very last thing that they remember. And you know like when someone passes away, the last thing you remember is how they looked the last time you saw them. So I always try to think about that when you, you know, when I talk to people or when they see their family member or – if I can do anything, that's what I can do is make sure that nothing horrible happens. (Staff 3)

Although the staff members spoke most explicitly and clearly about acting out their given roles, I learned that the family members were also expected to “act” in a certain way. They were not to be too loud, too upset. There were definitely roles and rules that they were to abide by that were set by the social standards of the hospital culture and the security police. Anyone who was seen as too loud, too dramatic or viewed as causing a “scene” or to be potentially unstable or unsafe to the staff could be asked to leave the family room and go out to the main ED waiting room.

**Special Behavior or Stylization: Staff Stories**

The next category that Moore and Myerhoff (1977) write about is *Special Behavior or Stylization*: this category is particularly symbolic in a hospital because of the clothes that people wear and how these artifacts inform others about who they are and what their roles are as well. For example, the nurses and doctors are in scrubs, social workers and spiritual care people are in street clothes and all hospital personnel wear name badges identifying name and position in the hospital. The security police are armed and wear police uniforms and security name badges. Every person there behaves in a certain way because of their professional role that day, and what special behavior their role calls for, to be ordinary people expected to act in extraordinary ways.

Again this category pertains mainly to the professional staff member at the hospital and not to the family members. The staff is watching and spending time with the family, assessing who the family members are and their role in the family and their relationship to the family member being “worked on” in the resus room. This description is a foreshadowing of the role that the family members will take as time progresses in the family room. A high pitched noise much like a microwave tone gathers a team together; this tweeter separates the team from their normal duties and they enter into the work of the sudden death event. An ordinary room becomes a family room where bad news is delivered; refreshments are served to try to make a family more comfortable as they try to adjust to the jarring news that their family member has experienced a sudden death event.

Ordinary behaviors and places now take on extraordinary attributes because of the circumstances and become part of a ritual process for these family members.

Many of the professional staff interviewed also talked about their fear of possible violence erupting with the families in this stressful ED situation. Various staff members stated that they knew of stories of violence occurring when family members were told of the sudden death of their relatives. This staff had been exposed to the repeated violence in the neighborhood, as well as broader messages concerning violence in the metro area as well. The sudden death experience can be in itself a violent event, a volatile situation. It is not entirely surprising that in my fieldwork I heard the words “unruly” “drama” and “violent” all used in relation to managing the situation with numbers of family members allowed in the family room. I also observed that security police were called with each sudden death as a precautionary measure. They were part of the team in a sudden death event in this ED. I learned during my fieldwork that the security police teams here at this facility actually carried guns and were deputized city police. I have since then asked security at other major inner city hospitals where I have been and I have not found their security guards to be armed in this way. The following is an excerpt from a security police person demonstrating their role in this ED:

**Police person:** The system is designed very well to focus on the families’ needs, and they prepare themselves before they inform the family, but there is no such thing as preparing in that event. Eventually the doctor comes out of the treatment area and tells the family they’ve lost a loved one. I have found it to work very well here as long as you have the support staff near, social work, spiritual care and security kind of just being in the background and offering any type of assistance to the family they may need. Escort to their cars, anything they need, wheelchairs. In some cases we’ve even given refreshments... But I think the system works very well here, and I think that the bedrock of the system is you tell

your players first, your team, spiritual care, social work, security, instructs the doctors sometimes if this is her or his first time, so they just don't walk in... I send out in-service training bulletins repeatedly on how to deal with customer service issues...But they demand a general one-hundred percent patient approach. I for one practice it daily, and I don't say that without exaggeration. (Staff 15)

### **Order: Staff Stories**

Taking the family members to the family room demonstrates the fourth property of the secular ritual process of *order*, and gathering them in a certain space puts boundaries around the chaos. All rules concerning the family members in the family room are highly prescriptive. There were "rules" concerning who could be in the family room and how many people could be there at one time. The people in the family room had to be immediate family members and the staff could control how many family members they let into that area. Usually the rule meant two to three family members in the room at a time. They could ask other family members to wait in the outside ED main waiting room area.

I would like to use Victor Turner's (1967, 1969, 1982, 1987) description of the liminal period for the dying, the transition from life to death, a threshold where the dying person crosses over and cannot cross back to characterize this situation with the family in the family room. The dying person, their family and the staff are in a liminal space, a place that they have crossed into and they cannot cross back. They have no idea of the future or even of the very next moments. This limin is a time of anti-structure and creativity, where both sense of time and boundaries can become blurred. In this ED setting the time of transition or the liminal time will involve receiving devastating news

concerning the condition of the family member, learning that they have died and getting ready to view the body. This time could be extremely short. In the ED setting the boundary between life and death is largely organizationally constructed by the hospital teams and their policies. This is a time however, when there is a break in the normal rules, this is a time where the staff will bring people together. This will be a time of “communitas” where people will lean on each other, similar to when I leaned on my friends in the ICU when my daughter was dying. This is the ED setting, not an ICU, the time is shorter and the professional staff will step forward and develop a ritual even though they will not call it a ritual. The staff will gather together, encourage family members to gather together, have a break in the normal routine and all lean on each other. They will develop an intense experience of community in this ED during these sudden death events. This very intense meaningful experience takes place in the family room.

There are two family rooms. They are side by side. Here in these rooms is where the waiting is forever. This particular ED, as mentioned, before can accommodate two traumas or resuscitations at one time, so there can be two families present at the same time and there can be several families and many family members present at once. This can make it more chaotic, stressful time for all involved, staff and families.

This stress was confirmed in both the staff and family interviews. The social worker usually enters the resus room to see if she can gather some information regarding the patient that she can take back to the family. She will also tell the doctor running the code that there are family members present in the family room and who those members are. One example of a typical question I would hear the social workers ask the

physicians would be “\_\_\_ ‘s wife is in the family room and is anxious for some news. How long do you think it might be before you can send someone out to talk to her?” The physicians would usually give her some indication of when they would be available to talk to the family. I have seen the social worker stay in the room with the patient and I have also seen her go back to the room and tell the family some small bit of news, depending on the situation.

In terms of creating order, there is emotional gathering and guiding of the family here, for example: “They are working on your husband and the doctor will be out soon” or “Your sister is able to talk to the doctors, at the moment; they will be out soon to talk to you” or “They are doing everything they can, the accident was very serious” or “I know that waiting is very hard. Can I get you anything?” Family members are also reminded that there is a phone there in the room and it is available to them if they would like to make calls to other family members. I found during my participant observation time, the family interviews, and my personal experience that the families made many phone calls to friends and other family members during the time prior to and following receiving the news of the death of their family member. These phone calls verified for me the social aspect of death and the need for social support during this time and the families’ own need to create order in this way. Many family members came to the hospital during this time to support the families and this support was viewed as somewhat threatening and stressful to the staff. The rooms are small, and if people began to overflow into the hallways this became a stressful event for the staff. The event then became more chaotic, and noisy, less orderly.



Auto ethnographically going back to my own experience I have no memory of the hospital security, but I do remember the police women who were very angry with us in the waiting area. The hospital, of course, had many rules that they were trying to enforce to maintain order that they thought were “for the best” for all involved.

### **Evocative Presentation Style, Staging: Staff Stories**

As time goes on order is much harder to maintain here. This leads into the fifth property of secular ritual Moore and Myerhoff (1977), *evocative presentation style, staging*, where the ritual involves a set of rule bound activities that take deep concentration on the part of the staff and the family members. Tasks during these times can be very challenging and demanding so that the team must be creative in their approach to the family. The social worker would go back and forth between the family room and the resus room quietly gathering information both for herself and the spiritual care person. She is also reminding the doctors, (who are trying to save this life and may also be getting messages about other patients in the ED) of the family presence in the family room. The spiritual care person usually stays with the family. The ED team would work together knowing that their work would lead to the final stage of this ritual at this moment in time, the gathering stage for the family and staff. There is definitely staging happening here getting the family ready for whatever the news will be when the medical team comes out into the family room. Everyone is tense and anxiously waiting for some news.

**Evocative Presentation Style, Staging: Family Stories**

Through participant observation, I noted that many people are tense: as they anticipate what the outcome will be for their family member who is in the other room. Auto ethnographically, I believe, having been on all sides of this experience, that each moment seems like a very long time for all involved. Everyone, staff and family members, is watching the security door hoping the next person coming through the door will have some good news to tell. Staff and family members are pacing in and out of the family room into the hallway and back into the family room.

**Collective Dimension: Staff Stories**

The sixth property of the secular ritual Moore and Myerhoff (1977), the *collective dimension*, is clearly demonstrated by the very existence of the family room, and the entire staff and team involvement in the process. Throughout the interviews this researcher found that there was clearly a deep social meaning attached to each of the events discussed in the above paragraphs. This social meaning was clear in both the staff and family interview data. As detailed earlier an entire medical team was assembled. Everyone took their own role seriously, everyone knew the role of the other professional staff members, and each member of the team clearly respected the role of the other team members. The process was carried out with precision and in a patterned way leading to the next step in the ritual process.

### **Collective Dimension: Family Stories**

The family members also felt a need for a social collectiveness; this need was demonstrated by the large number of people called to gather in the ED. This event had social meaning for all involved and those who were not present who were important to the family were called to come to the ED. Each family that I interviewed told me of the many family members and friends that they called either on the way to the hospital, while waiting for the news in the family room or immediately after receiving the news of their family member's death. I recalled having done the same thing on the way to the hospital after getting the call from my husband that our daughter had been in an accident. Although the time period can be very short, the families make many phone calls, and regardless of the time of day large numbers of friends and family members arrive at the hospital. As I have mentioned earlier, this large-scale gathering of family and friends causes much stress for the staff. The rooms are small and the family members spill into the hallway and interfere with the orderliness of the ritualized activity: however, the collective consciousness of acknowledging death as a community event must be recognized. This need was seen so clearly by this researcher. The families kept calling friends and other family members; they had no idea how many people they have called.

Here is an example of that phenomenon from a girlfriend of a sudden death victim:

**Mary:** So you were in the family room?

**Girlfriend:** Yes. And the priest, he was there, and they were just, you know, giving us comfort, but, so I don't know how long we waited before we was able to go into that room. I guess they were waiting on his mother to come or somebody, next of kin, to sign the paper. I don't know.

**Girlfriend:** My oldest daughter had come. His sister was there, his oldest sister was there. His mother came. His youngest daughter, mother, I had called her, and she came. And his son had come when the ambulance came, him and my

nephew. They had come when the ambulance came, because one of them called me while I was still at the house to tell me he had passed. They had left the hospital when we got there. And then his mother came and his other step-sister and his brother were there. That was pretty much it. And then some friends. (Family 9)

The more time I spent in the ED the more I saw that gathering for these sudden death events had social meaning to all involved, staff and family members. Coming together in this ritualized way was essential for the activities I will describe in the chapter explaining the transition of becoming dead in the ED.

## **Chapter 5**

### **The Transitional Social Process: Becoming Dead in the ED**

#### **Working on the person and then ...“calling it”: Staff Stories**

At this point a high-pitched tone, the tweeter, has socially cued the entire team to “gather together and pay attention” to a situation that is serious, potentially life-threatening. The patient and the family will not realize the tweeter has been activated, but the staff certainly knows. Up to this point, the first part of the ritual has been carried out rather routinely. There is the protocol of the EMS radio call and entering the ED by ambulance. There is specific acting by the EMS workers and the triage nurse, not just thinking in specific ways but following through with certain rehearsed actions. When a sick or injured person enters the resus room, the ED staff quickly assembles, assesses the situation, and delivers the heroic measures they determine are necessary to save that person’s life.

The next actions could include many different interventions, such as repeated CPR, repeated drugs, as well as a myriad of emergency trauma interventions. Many persons who come to the ED in these circumstances are next transferred to the OR or the ICU. This research only followed the person and their family who experienced a death in the ED. Now, I will turn my attention to describing and then analyzing the transitional process of becoming dead in the ED.

The following is an excerpt from a physician of one example of how a person becomes dead in the ED.

**Mary:** So tell me how sudden deaths are handled in the ED at \_\_\_\_\_

**Physician:** What portion of it? I mean, the actual resuscitation or the, or the, what follows after?

**Mary:** Either or both. Anything that's routinely done.

**Physician:** Well, what's routinely done is I mean, people come into the emergency department typically from EMS. We'll get a radio call ahead of time letting us know that someone is, you know, dead or they're doing CPR or something like that, and then we go on to resuscitation. We resuscitate the patient or attempt to, and then if we're not successful, we go down and talk to the family afterwards. Social work usually gets the family, puts them in a quiet room. And depending on the nature of the death, we'll have security nearby, because if it's traumatic, a gunshot wound or a stabbing and it's somebody young or something of that nature and we have a lot of family there, then we will ask security to be nearby, you know. They kind of gauge that on the patient.

**Mary:** Now, I have noticed that there's something that's done when somebody comes in dead on arrival. There seems to be a routine that's done, where there's an ultrasound done. Is there some kind of like three things done on everybody that comes in with no heartbeat?

**Physician:** Yes. I mean, you know, they should have asystole confirmed in all three leads, all three limb leads, they should have asystole. Breathing should be absent. So somebody should listen to the lungs, somebody should listen to the heart so that heart sounds are absent. You can check pupils to see if they're dilated and fixed, and then some people like to add the ultrasound of the heart to take a look (Staff 11).

In this teaching hospital, I learned that usually the resident physician who is being supervised by an attending physician and has run the resuscitation or the "code blue" is responsible for pronouncing the death of the patient and for giving the bad news to the family when their family member dies.

### **Preparing to Tell the Bad News: Staff Stories**

As part of their education a resident learns about the procedure of how to tell the family the news from the attending physician. The resident also confers with the social worker about the number of people in the family room and how they are related to the deceased. The resident gathers as much information from the social worker as they can

about the family and the context of the family room. The physician then walks to the family room. I gathered some data from several residents about those first experiences of talking to families in the family room and how they continued to feel delivering news to family members. They never felt that they were “good” at doing it, but they did feel that they were much experienced at delivering bad news to families because there were so many sudden deaths that occurred in this ED. The following are five residents who commented on various aspects of delivering bad news, and saying if they felt they were “good” at death notification or if anyone had told them that they had done a good job notifying a family of a sudden death.

A resident commenting on training to deliver bad news:

**Mary:** Do you get any training in the ED?

**Resident:** Not really. It’s more so you watch, observe, figure out what you like, don’t like from what you see, but no real training.

**Mary:** I have data from families that they are satisfied with their experiences here.

**Resident:** We don’t get much positive feedback in this program, so it’s nice to hear. I remember the first time I went in, I had the clipboard in my hand, because I was shaking, and it steadied me. (Staff 18)

Another resident commenting on the importance of delivering bad news:

**Resident:** Learning how to give bad news. It is something that we, I mean, we do read about it and we try to do it well, but it’s not something that we try to perfection, like management of like emergencies. (Staff 16)

Another resident on whether he is “good” at death notification:

**Resident:** This is a hard residency, and the amount of positive feedback we get is kind of minimal (Staff 17).

This next resident echoed how hard death notification is to do. Yet she thought because the residents had so much “practice” at death notification and this ED had such a good team that they are “good” at delivering bad news.

**Resident:** Because the ED is so busy and then they feel stressed, the attending wants to hear, you know, it’s hard sometimes, but for me it’s also hard sometimes in our ER, you can’t stay human. Its part of the reason I’m not so sure I’m going to stay in this ER, you know.

It does make it a little easier that you know, at least, since you couldn’t save that life, at least you made it somewhat easier for that family because I can’t even imagine. I really can’t. I mean I will start crying if I think about it, because that’s how much, when I get to that position, I’m like, I can’t imagine walking in there and having that be me, you know. I mean, people, it’s easier when you can relate it directly to you, right, where it’s not like grandma, but it’s like somebody lost their husband, someone lost their kid, someone lost, shwhew, forget about it, I can’t even imagine.

I really do think – I mean, it’s funny you come to me at this point, because I’m deciding that I don’t really think that I can stay here forever in my career because it’s too much for me. Not so much because of this particular issue, just the day-in, day-out reality of it is hard. But I do think we have a really good team down there, and I think it’s a lot of experience. I really think that’s what it is. I don’t think it’s anything special about any of us, other than we’ve done it so many times, that we’re good at it. (Staff 19)

This next resident would like more time delivering bad news and being with family members in one sense and yet in another sense would not change what is currently happening in this ED:

**Resident:** Well, in theory, you run codes, but of course, there’s always somebody there mopping up your mistakes, you know, the attending physician, but it is your responsibility as the “code runner” to talk to the family. About informing – well, what I’d like is more time to do it. I think that that would make it much smoother. Not that there’s really much more, I mean you can’t make it too much smoother, but I think it can be a little bit nice, more considerate of the families, actually appear more relaxed while you’re in there knowing that you’ve got a block of



time set aside rather than just run in, give the news, hope there aren't any questions, and then move on and put on a happy face for it. But that's just not in the cards, so for what we've got, the limitations, I wouldn't change it. (Staff 20)

This ambivalence was common in the interview data from the physicians. The residents on one hand wanted more training and yet no one wanted to have more deaths in order to get the training. The residents thought that they had enough "practice at death notification" and that they did not get enough positive feedback for doing this very difficult task. Many of the residents spoke to the difficulty of delivering bad news, and many of them spoke to the need to get back to the other patients in the ED. Some of the residents saw saving the patients who could be saved as their main job; after all they were trained to "cure" people. Physicians also expressed that they would have liked to have had the luxury to spend time "caring for" the needs of the bereaved family members. However, they felt that the patient who was dead no longer needed medical care and their family members were not their patients. They as physicians could however, make a difference to the patients who were alive and in the ED. The family members of the person who had died in the sudden death event could be taken care of by the other members of the professional team such as the social workers, the spiritual care team members and even the nurses. There were professional staff members available for the family members. The family was not being neglected. However, ambivalence in the interview data regarding this issue for the physicians was present and merits further exploration in future research.

**Telling Bad News: Staff Stories**

The social worker usually accompanied the physician to the family room. At times two doctors, one resident and one attending, went into the family waiting room together to deliver the news; sometimes one physician went alone. I assumed that this decision seemed to be depend on how comfortable the less experienced doctor was in giving bad news. The doctor would enter the room and would sit down with the family; the spiritual care person would be in the room. The social worker would stand by the door. The security police person would be somewhere in the hallway outside the room.

The beginning of the conversation differed slightly from physician to physician, but the physician would eventually say, "I am sorry, but your family member died." They could wait several minutes for the reaction of the family, and then they would say that they were available for questions if the family had some later, and then the doctors would leave the room. I will cover these reactions from the viewpoint of the family members in further detail shortly.

Regardless of the news, it was the protocol here that only the physicians would deliver any definitive medical news to the family that had gathered in the family room. No matter how long it would took, the entire medical team, the social worker, the spiritual care person and the security police-person would wait for the doctor to deliver the news.

The professional staff would attempt to place some order or boundaries around a chaotic event for a family that was in shock and disbelief. Here are additional data related to me concerning death notification by physicians to family members in the family room.

A spiritual care person commenting on being with families in the family room when they are hearing news said the following:

**Spiritual Care Person:** Well, okay, there are two different classes, at least two different classes of sudden death. One is where family has come in with the patient and so they will be sitting in the family room on the other side of the door outside of the trauma area, maybe 15 feet away from where the action is, and the other is person can come in unidentified, either a crime victim, an accident victim without identification or they may have identification and the social worker spends a lot of time trying to flag family down. So, of course, the first thing that the social arm does after the medical thing has been done is contact family and request they come in. If the family is already present, the family will be assembled in family waiting room just outside the trauma area, and the head of the trauma team will send one of the young doctors out to tell family what has transpired. So it's always a doctor who speaks to the family. I as a chaplain may not tell the family that the person has died. If they ask me a direct question, I have to evade, and I have been known to basically avoid them because I can't lie directly. I'm not about to lie to a family and go back and say, well, gee, I had to do that. But if they're asking me direct questions, I'm going right back to the trauma room saying, they know, will somebody please go talk to them. So, first thing is notification. Notification, I have some problems with that. Yes, the doctors do need to get some clinical information but to me it seems wrong, wrong, wrong for the doctor who's come to tell them their child has died, their son or daughter or spouse, by saying, who is his family doctor, and had he been ill, and demographic information, and then they say, well, we were unable to get a heartbeat, or but after they collect their clinical data, why can't they just say, Mr. and Mrs. So and So, I have bad news. I'm terribly sorry, your son didn't make it, and then give them a few minutes, and if you want the demographic information, go back after, but to lead up with that, it's already, it has fooled people into thinking their person is still alive, and the doctor is just asking for medical information. And then their hopes are starting to rise, and then oh, by the way, your son didn't make it. I can always go cringe, couldn't we do this differently, please, but. . .

**Mary:** Do you think that's a policy for them?

**Spiritual Care Person:** I don't know. I really don't know. I don't like it. And I, you know, I'm not in the business of telling doctors their business, but I don't like it for its effect on the families. It's hard to be the bearer of bad news, and it's hard to know what to say to people. I believe in the truth compassionately told. I'm terribly sorry to have to tell you this, or I have bad news. When, for instance, I know that person is going to die, I'll make little visits, like I do rounds, I put my head in, and I go, they're working on him, its touch and go, they're doing everything possible. And that way the family isn't holding their breath thinking it's a television style rescue. I kind of prepare them a little. And I learned that

from an old chaplain who was one of my proctors, said, even if you know that body is stone cold dead, you don't start by saying the body is dead. You say they're working their best. I don't know what's going to be possible, whatever, and do kind of do a little softening, (Staff 13)

I saw many of the spiritual care people and also the social workers use this technique described above of evading the question. I also observed during participant observation the "making little visits" she described, above. Usually two physicians came into the family room to talk to the family members in the room. One would have "run the code" and the attending physician who would have provided supervision for running the code. The physicians were usually very serious as they entered the room to deliver the news that someone had died. They would sit down or at least get to eye level with whomever was indicated by the social worker as the family member to whom they should speak. The physician would introduce themselves and begin a type of script with the families to tell them that their family member had died. Each resident had their personal way to deliver the same script, but each resident did get a little history of the day's events and then they would say the words that the family member had died. It appeared to me that the resident was trying to establish some relationship with the family before saying the words that they did not want to say.

Another case about death notification from a physician:

**Physician:** Oh, I definitely think its person dependent. However, in general because we see it really often, what happens is somebody comes in, and it's a major trauma. We most of the time have family in a separate room. They aren't with us. And then if we cannot revive the patient, then we go with a team, we go with a social worker, depending on the volatility of the family, security, and whomever wants to come along, I usually bring an intern... Not for me, so that everyone can learn, and then a chaplain. We go in, sit down with the family. I think you really have to read the family, because some families they want to hear

the whole story, and they want the play-by-play, and some families just need you to tell them pretty quickly.

So...if I feel like the family is really agitated, and they are pretty sure the patient has passed away or is dead, I give a brief version, but I still give a version, even though I think they might hear a lot of what I say because they know where I'm going. So I'll explain what happened from the way that I understood it... I'll ask, were you there, you know, can you tell me what happened? And then I'll start from EMS, from what EMS told me, and then I tell what we did, and then I just say I'm so sorry, but your loved one, their name, has died.

And I'll stay as long as they want me to stay, and sometimes, you know, I always ask for questions, does anybody have any questions, and if you have any questions at all, at any point, they all know who I am, they know that I'm the doctor who took care of whomever, and I'd be happy to come back. And social work, I think, does a relatively good job of, you know, tracking us down and hounding, making sure that gets done. I've never had to use security. I've never been, felt like it's been necessary, but sometimes they'll stand just outside the door, if social work feels that the family might be volatile.

And then a chaplain is just there to sort of help, too, but you know, I tend to be physical, you know, like if someone needs a hug, I'll put my arm around somebody. I do that, and then I wait for a period of time while they sort of start their grieving process, which down here culturally is very loud. And then I just kind of wait.

I've had to go back. You know, people come in – I always tell social work, I don't care how many family members come in. If you need me to tell the story again, I'm going to come back and tell you the story, that's my priority, so come find me. Because I don't really want to put that burden upon the person who happened to get the story first. I don't think that's fair. And if that person that got that story first, a lot of times, they're the person that was there when that person went down or they saw what happened, and I always reinforce what a good job they did, that they did everything right, that they called EMS, that they started CPR, in front of everyone, so that they don't end up being, well, if you had just done this or, you know, or wondering themselves or pressure from somebody else. Which is another reason why I think it's important that I come in and tell the story and don't have them relay everything, you know, because people will find someone to blame or way – if they are going to blame anybody, I want them to blame me. I don't want them to blame a family member.

I don't really say anything else after that, either, the first time. That's why I try and feel them out if I think I can get a little story first; they absorb more before, for sure, than after...

And one of the things I try to impress on the residents is they are your priority the whole night. I know that they aren't your sickest patient, because they have already passed away, but that family, this is what they have the rest of their lives to remember the night their loved one dies. So I had to get after somebody the other day, who was putting it off, and I went and pulled her off from the attending and walked her down there, you do this now, this is hard. (Staff 19)

This particular resident had been in the ED for multiple years and had responsibility for training other residents. She had a higher social status because of her years of experience and training here. She took the less experienced residents with her when she was delivering bad news and helped them to learn, she would also follow up as you see in the above excerpt that they would deliver the bad news in a timely fashion. She also had an interest and additional training in end of life care and talked to me about her own personal experience with grief in her family. She was known in the department for taking a lot of time with the families and answering all their questions thoroughly and clearly. The residents knew that once they told the family members that their loved one had died the grief reaction would begin. The family members heard very little if anything at all after the word "dead". The physicians would begin their "script" with the story of the care that they had provided to the patient, hoping that the family members would hear that first. Then they would deliver the bad news.

This physician was firm in wanting the family to know that the hospital had done all that they could for the family members in her care and that she wanted no family members to feel any blame for any of the sudden death situations. She also felt that the circumstances of sudden death were so random that the family members needed to have all of the pieces to the story to put together later if they so desired. In the end the family needed to know that everything that was medically possible was done to help their family

member to live. No medical technique was left out or undone. All was done to help their family; there was nothing else that could have been done. The staff was so sorry that their patient had died.

This staff member also mentioned that the beginning of the grieving process was at times “culturally loud” here in this ED. This aspect of grieving was talked about by several of the staff members and I also observed this during my fieldwork. The immediate reaction to the bad news many times was screaming and falling to the floor. This was very different culturally for most of the staff members and I saw them getting very uncomfortable with the reaction. The pastoral staff and the social workers were more comfortable with the grief reactions than the physicians. Although the resident in the above interview was very comfortable with the reaction stating “I just wait”.

Many of the staff interviewed were very uncomfortable with the grief reaction and would leave the family room as soon as they could leave.

### **Hearing Bad News: Family Stories**

Just as the staff delineated how they consistently used a particular process for delivering bad news the families also spoke in a patterned way of being taken to the “room”. If the family came in with the ambulance they were immediately escorted to the “room” by a staff member and asked to wait there for news from the physician. If they were called to come to the hospital because their family member was seriously ill, as soon as they arrived they were escorted into the “room” by a staff member and told to

remain there and wait for news from the physician. All of the families knew that going to the “room” was a very bad sign.

The following account is from a woman who had come in with her husband in the ambulance and received the devastating news in the “room”

**Wife:** And this man, this doctor, he’s a white man, but it’s been about five, four, five, six, I can barely see him, and he said, Mrs. \_\_\_\_\_ we weren’t able to save him, and I lost it. So I’m hysterical now. I call my sisters... So I called them and they quieted me down and everything. Then this lady came in. She about so high... a hospital person. And I think she asked me, did I want to go to the chapel. I think she did. I don’t know. I don’t remember...I’m going to call my pastor...and somehow or another, I got the right number, and I called him, and he was there like in about 15 minutes (Family 3)

Another example follows of a young woman who received news about her husband in the family room.

**Wife:** My brother died of a heart attack, oh, gosh, seven years prior, and, you know, they whisk you to a room. I know this. My husband’s best friend died at 27 of a heart ailment, and I remember his wife saying they whisked me to the room. And I knew. They sat me down, and I waited for a few moments, and the ER doctor, really nice gal. I can’t even remember her name. Young, I remember, and told me that he had gotten hit with an electrical line while he was working on the phone lines, and he died instantly. She told me his, I asked her how did he look, because I wanted to go see him, and I wanted to be prepared, and she says his face is blue. And I go blue-blue? Why that mattered, and she said yeah (Family7).

Below is another example of news that another wife received about her husband in the family room:

**Wife:** Now I was shuffled off into, you know the family room and sat there until finally the emergency room doctor could come out, you know. It was, felt like an eternity. I don’t know how long it was...it felt like an eternity sitting there waiting for the emergency room doctor.

**Mary:** What did he say to you when he came out, do you remember?

**Wife:** He was personable. I was sitting in the chair, pretty upset, so he like squatted down to my level and just said that they worked him about 10 more



minutes after he got there, and they could never pull him out of asystole. That was about it. Asked me what, because he had been complaining of shoulder pain, and I was like kind of describing the pain he was having, and he said he probably, that's probably what happened is a heart attack or by the time he was there in the emergency, they could never, they weren't able to pull him out of asystole, so that was about it. I remember the lady that I signed all this paperwork. I remember her more. (Family 5)

Only one of these families spoke of the script with which the residents begin their death notification. This does not mean that the script did not occur with the other family members.

The timing is very important to note here; there is a two-to-three hour time frame within which this process takes place. This time frame was talked about in all of the staff interviews. It was not written anywhere, but it was an accepted time frame with the staff and it seemed to be acceptable to the families in the family interviews. The staff saw it as the time needed to complete the "ritual" although they did not use that language. This time frame was attended to by both the pastoral staff and the social workers and perhaps monitored most closely by the nurses. As I experienced and observed, the families are in shock and most of the families that I interviewed spoke of some numbness or disorientation during that time of chaos. This confusion is evident in the language above and here are some more examples of that disorientation and shock.

The following is a grandmother speaking about her grandson who had just been shot and pronounced dead in the ED. I asked her if she remembered signing the paper with the social worker saying that I could call her to ask if she would be interested in talking to me about that time in the ED:

**Grandmother:** That's what I'm saying. When she asked me, did I remember signing the paper? I don't remember none of that.

**Mary:** You don't remember all that.

**Grandmother:** I couldn't remember his birth date, couldn't remember the year. I knew he was born in September. I say he was born September the 8th or 9th or something I say, you know, you can't think. Your mind don't work on dates and times and none of that. (Family 1)

Another example of a wife telling what it was like to be in the ED following the electrocution of her husband:

**Wife:** "How unreal. I felt like I was in a glass box looking out." (Family7)

Another excerpt follows from an interview of a wife and a daughter talking about the loss of certain memories relating to the time that they spent in the ED during the sudden cardiac death event of their husband and father:

**Wife:** Like if she didn't approach me, I don't think I would have remembered what her face visually (speaking about seeing the social worker again at the hospital several days later.)

**Daughter:** I don't really even remember it. Like something that, it's like, I don't know if I block it out, could be, but I don't like remember hardly any of it. I remember going in the room. I don't remember it, like what anyone said to me, even. (Family 5)

This disorientation and numbness, was a common theme in the interview data. The family members that I interviewed talked about this state of mind throughout the interviews. They would recall some events in minute detail and then have no memory of other moments. This element is especially important data when training residents on delivering bad news. The family members can only remember certain things that they are being told, and the families need time to process information given to them and to have time to ask questions. The earlier interview with the resident, where she talks about offering to go back to the family room to speak to the family a second time to answer questions and to talk to them about concerns that they may have, is indeed a very

important aspect of this time when the bad news is delivered to the family members. The story may have to be repeated a second or even a third time to the family members who are present.

I found during my fieldwork that the residents did not want to go back a second time. But before I conducted this research I did not have a good understanding why this was the case. I went back in to the main part of the ED to get a resident once because another family member had arrived and was questions and requested to see the resident again. I had heard the resident say that she would return if the family had additional questions. The resident was immediately anxious wondering what the “new” family member wanted to ask her. I assured her that from what I had heard the questions were the “usual” things. “Did the ambulance get to him in time”? “How long did they work on her father”? “What exactly did they do”? The physician had already answered all of the questions once. The family just needed to hear the answers again. Perhaps they were too numb to hear them the first time. The residents learned about this need the more they went back to see the families a second and a third time.

### **Viewing the Body: Staff Stories**

In beginning to think about viewing the body, it is important to keep in mind that, becoming dead in the ED is at times a violent sudden event. It is always a sudden event. This death is an immediate transition for both the staff and the family. The social worker and the spiritual care team begin by telling the family that the nurses are getting the body ready for viewing. At times, I observed a conversation would take place with the family

about whether or not they would view the body. The social worker would encourage them to spend a few minutes thinking and talking about this decision. The social worker would then check with nursing to see if the body was ready for viewing. Sometimes the spiritual care person would offer to say a prayer. In my observations no family ever refused a prayer.

The walk from the family room through the main area past the triage nurse to the viewing room was a short distance but appeared to be a long walk for the family members. Many times the family would physically lean on each other and the hospital staff as they walked to the viewing room. When the family stated that they wished to view the body they were escorted through the security door by the social worker and the spiritual care representative. Once through the door, they were at the triage desk at the main entrance of the ED. This part of the ED could be a very high-traffic area. Family members would have to walk past any and all people who happened to be standing there. Many times there were other patients entering the ED. The staff would notice the family members coming through the security door with either the spiritual care person or the social worker. The staff would stop talking and step back to accommodate the family as they were escorted through this main area.

The families were treated with great respect, as every staff member knew where they were going. The members of the families of the deceased were escorted past that area into another small area where the security policeman sat. Directly behind that area are two double doors. The hospital representative (either the social worker or the spiritual

care person) opened the doors and entered with the family into the viewing room then closed the doors behind them.

I observed several families in the viewing room. The reactions of the family members to the body were varied. Most of the people touched their loved one, some cried, some kissed their family member and many talked to their loved one.

Some family members would stop in the doorway before completely entering the room. The door would still be open, and some cried loudly and many screamed out. I saw several family members faint at the doorway. When they did, either security or the triage nurse would help put the person in a wheel chair until they recovered. Sometimes the families left the room, went back to the family room and cried there; at times they would ask to see their family member again. These events could all be happening as new patients and their family members were entering through the doors of the ED by ambulance for care.

Many of the family members moved in and out of the viewing room several times with different family members as new ones arrived at the ED and requested to go to the viewing room. They did not seem to notice the staff and the other patients moving around them in the ED entrance and hall as they maneuvered through the space back and forth through the secured doorway from the family room to the viewing room and back to the family room. The spiritual care or social worker would escort them through with the security code on the other side of the door back to the viewing room to view the body with other family members and then the nurse in the triage area would patiently show them how to touch the security button that opened the door that allowed them back into

the family waiting area. This activity theoretically would continue in the best of circumstances for as long as the family needed to do it, or perhaps for as long as the family had the energy to do it.

Some social workers and spiritual care personnel were more patient with the family; there was, however, a two-hour time limit that was understood, but was never clear to this researcher if that two-hour time limit was from the time the patient was admitted or the two hours from time of death. I would hear the two-hour time limit whispered between staff and then at times hear it told to the family. I saw this rule used to set limits on grieving time in the viewing room. Of course, all activity with the family and staff was dependent on how busy the unit was with incoming admissions. The viewing room was small and, depending on the number of family members, only a small number could go back to view at a time. There were no chairs in the viewing room. The staff preferred to take two to three people at a time, and the spiritual care person and the social worker would work as a team during this time.

### **Viewing Room: Family Stories**

A family would be told that their family member had died and that they were being offered an opportunity to “view the body.” Many times the family would be screaming and crying totally uncontrollably, falling to the floor and just lying there. Many of these families had been in the hospital a very short time, some of them perhaps one hour. Some of them may have seen their family member collapse at home and had some minimal warning, but many others may have been called to the hospital after

leaving their family member earlier that day often healthy and happy. To some family members this was a rapid change of circumstances. I remember one woman telling me “*I just ate cereal with him one hour ago and we kissed each other goodbye and I left for work. How can this happen*”? I heard many statements so similar to hers. I remember thinking, I know how you feel. But I never said it.

After viewing the body, I heard statements made by family members similar to these: “*I was just with her. She seemed fine.*”; “*I just left her how could this have happened?*”; “*I just do not understand how did this happen*”? Families going over their day and the last time they spent with their loved one. Many times the family members would be falling on the floor and screaming. They would be crying, and most times appeared to be in shock. The staff sitting with the family would be respectfully silent during this time. The staff showed the family great respect. The staff came to realize that there is so much unpredictability in the sudden death event. Each day this staff in this ED sees someone’s day shattered in this way. The staff here has done the best they can to create this ritual to try to bring meaning to the raw suffering both for themselves and for the families that they encounter every day in their work. There is the social affirmation that the staff respects the family for what they are going through, what they are all going through, the staff included. All of this matters; it has great social meaning.

As in the case above, the bad news is given simply to the family members that their loved one has died, and everything and everyone in the room changes in an instant. The family has lost the ability to see their loved one. The patient has transitioned from

being a person to a body, and the family can no longer “see” the person but is given the opportunity to “view” the body after “the nurses have the chance to get the body ready”. I also was stunned with the instantaneous change in language. Each family was given the option at this facility to “view their loved one” after the physician delivered the news of their loved one dying. The question was no longer “Would you like to see your husband,” but “Would like to view the body”?

After that the professional staff “places” the body in the social context of their own family. The following are excerpts from interviews where the family members explained to me what it was like to be in the viewing room with their family members.

A wife closing her eyes, telling me her story:

**Wife:** But in, in those 15 minutes, they let me go in to him. And he was so peaceful, like nothing was wrong with him. They had that thing in his mouth, though. (Sighs.) So I just looked at him and I held his hand, and I rubbed his face, and I caressed it as much as I could. He was still warm, very warm. I kept waiting on him to tell me to leave him alone, because that’s what he would do when I would get lovey-dovey. And I said to this lady, she stayed with me a lot, I say, he’s so warm. She said, yes. And his hands were – I never saw that doctor again. I don’t know, if my life depended, I couldn’t tell you what he looked like or, except that he was a white man and he was not real, real tall and he was not young. (Sighs) So they let me stay with him as long as, as long as I, as they dared. This lady, she stayed with me.

She finally, she said, Mrs.\_\_\_\_, we’re going to have to, we’re going to have to take him to wherever they got to take him to do whatever it is that they have to do. (Sighs.) I didn’t get to say whatever it is that people say, if they say anything. I didn’t get to do that. I didn’t get to kiss him. I didn’t get to – I wasn’t expecting it. And that’s a darn thing to say, I know, but he was on, he was on dialysis, and he never really accepted that condition... (Sighs.) And there you are, and there’s the story. I miss him (Family 3)

Another wife telling me her story:

**Wife:** So it took me a while to want to go in the room, because I didn’t want to see him in that condition. So she left, and chaplains came and social workers



came and discussed – I wanted to do organ donation, so they saw his license already had the sticker, so they were in the process of getting that arranged, and a chaplain came, and there was a shift change, so I started with one, and then I ended up with a different one. Both of them were really nice. The first one I didn't really get a chance to talk to, but the second one I did, and I can't remember her name.

**Mary:** Do you remember what she looked like?

**Wife:** She was an older lady. I think white hair, grayish-white hair?

**Mary:** White person?

**Wife:** Yes, yes, yes. Really nice.

**Mary:** Really soft spoken chaplain?

**Wife:** Yes, yes. She sat with me for a long time and explained to me what I was going through. She said you're in shock, and you know, I was worried about calling this person and calling that person, because on the way I remember I called his cousin \_\_\_ who's very close to him, like a sister, and I called her on the way to the hospital and said I'm on the way, there's been an accident, and I said that, and she said call me when you get there. So bunch of my family was arriving, \_\_\_ guys were arriving, and it was a while, it was about 30 minutes and they asked me, you know, if I wanted to go in the room alone, and I said no, I want my family with me. So the chaplain said, do you want me to go see, because I kept asking about the condition of his body, and she said, do you want me to go in there first, and I'll come back and tell you. And I said, okay. So she came back and she said, well, he looks like himself, and I'm thinking to myself, how you know what he looked like.

**Mary:** Yeah, yeah.

**Wife:** So I said, okay. So, my family and I went my two brothers and my niece's boyfriend,

**Wife:** So I passed some \_\_\_ guys when I walked down the hallway when they were escorting me to the room, and two managers, I didn't know one, the one that called me, and I said, you guys can come in the room if you like, and they said, no, no, no, no, no, that's okay, you go in there, and I said okay. So I went in, and you know, you see a person laying there and you can't believe. He looked like he was sleeping. They explained to me that he had a tube in his mouth, and he had the hospital gown on... But looked so peaceful and ...but he just looked like was sleeping. He snored with his mouth open, so minus the plastic thing, he just looked like\_\_\_,

**Mary:** So the pastoral minister was right, he did look like himself.

**Wife:** Yeah, he did, he did, and he did look like himself. Um, I didn't like the room they put him in. I had to walk down to the ER past the security guard, double doors, and it was a very small room, and I thought he was worth more than that room that they put him in. I thought it was too sterile, too – he deserved more. I just remember that room, it's horrid. And I'm like, oh, my gosh, couldn't they put him in something else, you know, a little more decorative, or, you know, I've seen hospital rooms before, you know. Not asking for a big Taj Mahal, but I

was just, so we all squeezed in there, and you know – the first thing I said to him was what they did to you. And I thanked him for our girls and for being who he was. He was a fantastic guy. (Crying.) I knew this was going to happen. ...

**Mary:** Did you feel real nervous then?

**Wife:** I was shaking after I saw him. I'm a high-anxiety person. ... and I just feared how my daughters were going to react. But I'm kind of glad I did it on my own so I felt the emotion.

**Mary:** Did you touch him or kiss him or anything?

**Wife:** Uh-hum. Oh, yeah, I laid my head on his chest. At one point I thought I heard it breathe through the hose, the plastic thing, and I thought\_\_ because I didn't want to believe he was gone, and I thought he's going to hear my voice and wake up.

**Mary:** Uh-huh.

**Wife:** Because he was my soul mate, he's going to wake up. I remember jumping when I heard it. I go; I think I heard him breathe. They said no, you didn't hear him breathe, you know. But I kept my head on his chest for a long time, it seemed like, and talked to him, and I wanted him to wake up, but he didn't. That was hard. That was really hard. But, yeah, I kissed him, and I – we had –...I was running my fingers through his hair and kissing him and thanked him for our beautiful daughters, and yeah, I touched him a lot (Family 7).

A husband relaying his story to me about what it was like to say good bye to his wife in the viewing room:

**Husband:** About fifteen minutes after we got here, they came out and told me that she was gone. And they took us all to the little waiting room there, and they asked us, did we want to see her. They was going to take a couple minutes to clean her up a little bit, you know. They were very nice about it.

They got everybody together, gave us all Kleenex and everything, and wanted to know how we were feeling, and you know, they asked if we wanted to talk to the psychologist or anybody like that. And to be truthful, I was, I had been preparing myself for this for a while, because you know, over the last year, \_\_\_had lost an incredible amount of weight.

We got in the hospital, like I said; it wasn't fifteen minutes after we go there that the nurse came out and said she passed away.

**Mary:** Was it a nurse or a doctor?

**Husband:** I think it was – I'm not sure, I'm not quite sure. But I think it was – who was the head person that was down there that day, the day they came. Then the psychologist, sign that paper when she came in and talked to us, you know, about it.

**Mary:** And you said you prayed over her?

**Husband:** Yeah, we did.

**Mary:** Good. And were you able to touch her, if you wanted to?

**Husband:** Oh, yeah, I was ready to touch her, kiss her, hug her, you know.

**Mary:** And you did all that? That was important?

**Husband:** I did all that.

**Mary:** And what about her children?

**Husband:** Her children, you know, they all got a chance to touch her, they all got a chance to give her a kiss, you know.

**Mary:** Oh, good.

**Husband:** Got a chance to, you know, a place to handle her one more time, you know. They were – it was kind of hard for them.

**Mary:** Yeah, it's very hard.

**Husband:** It's hard when you lose someone like that. (Family 4)

A grandmother telling me her story about viewing her grandson after he had been fatally shot:

**Grandmother:** There was a rag, towel on his head. I thought that he was shot in the heart. I made them come back and tell me. He was shot in the leg, the heart, and the head. They let me see him. They tried to be decent. They were real nice. The chaplain stood with me. They did good, real good. He died on the street. They were nice and considerate. They treated me good. They done good at the hospital. (Family 1)

A wife sharing with me what it was like for her to be with her husband in the viewing room:

**Mary:** So did you feel like you had a chance to say good bye?

**Wife:** Yeah, I said good bye to him. Yeah, I did do that.

**Mary:** And did you feel like you had time with him?

**Wife:** I probably could have stayed in there a little longer, but I didn't.

**Mary:** Did you have time by yourself?

**Wife:** No.

**Mary:** Would you have wanted that?

**Wife:** I don't know. (Family 5)

A sister talks to me during the interview about being in the viewing room with her brother:

**Mary:** So what was that like to view his body?

**Sister:** It was scary, especially for my daughters.

**Mary:** They all went, everybody went?

**Sister:** It was a sudden death. You know, like my ma was sick. Sometime you can expect death to come, but with him, we never, ever, ever seen him sick before, never ever. And for a healthy man to die in front of your face like that, I mean, just have a seizure, come out of it and get well, and then die, they still haven't gave us no answers yet about that.

**Mary:** When you went into the room, did you touch him or talk to him?

**Sister:** Oh, yeah. Sure did.

**Mary:** What was that like? Do you feel like you could tell me about it?

**Sister:** Yeah. I was first in shock to see him in that position because I've never seen him sick let alone just have a seizure and just die. Once I got past the shock, it was just, I just couldn't stop crying. It was just hurting. I just touched him like, what happened.

**Mary:** So it was you and your daughters that went in. Who else went in? Your niece?

**Sister:** Later, the family came.

**Mary:** Okay. Did you go back in again?

**Sister:** A couple of times, yes.

**Mary:** How many times did you go back?

**Sister:** Maybe twice.

**Mary:** Is this upsetting you for me to ask you? I'm just wondering what's important to families so I can tell nurses what's important. Is it important that you see him?

**Sister:** It's very important that you see him because you could feel like you could say your good-byes even though you didn't make it before they passed. It's like, I didn't want my daughters in there. I just wanted to just have a moment with just him, just to say my little words.

**Mary:** So you were there alone with him?

**Sister:** Yeah. Then the second time I wanted to go in there with my daughters because I didn't know how they were going to react. And then a third time I went in with my family.

**Mary:** Did your daughters touch him?

**Sister:** I don't think so. I don't think so. They was in shock, too. They couldn't stop crying. It was a shock.

**Mary:** So you think sudden death is different, that was different than your mother?

**Sister:** Yeah, because sudden death is not expected and it's like a shock. we wasn't expecting her to pass that quick, but we knew she was getting worse, but with\_\_\_\_, you ain't never seen a sick person, to see him die like that, it's different. (Family 10)

The way that these family members relayed these intimate moments during the interview process was a profound experience for me as a researcher and as a mother who had experienced a sudden death event. Each family member entered the viewing room for the first time, not knowing what to expect and entered immediately into the relationship with the person in the viewing room; there was a repetition to the way that the family members entered the room and how they responded to the person who had died. I began to wonder if their response mimicked how they would normally respond to this person.

The process for the family was repeated by the staff with each sudden death event. There was also a pattern to the way that the families responded to the viewing room. Many of the family members thought that the family room was not big enough or nice enough for their family member who had died. They often commented that their family member who had died and their other family members who were viewing the body deserved “more,” a better environment to begin their grieving process. The staff agreed with the family members. They knew that the viewing room on this ED unit was not adequate. Everyone agreed that the environment here was severely lacking the respect that the family and the deceased deserved.

### **Repetition: Staff Stories**

The secular ritual category Moore and Myerhoff (1977) of *repetition* is seen in the staff and family data above. This process of becoming socially dead in the ED, of preparing the family and telling the family member the bad news, and of physically walking the family members who were ready to view the body to the viewing room, and

of taking turns sitting with the remaining family members was repeated over and over again. The staff members were the leaders in the process, and the family members were the participants.

The reactions of the family were also somewhat predictable and repetitive in nature. Some of the families were in shock and were very quiet. Many of the family members would express their shock and disbelief by screaming and falling to the floor. Some of the family members would respond in rage and would scream loudly and pound on the wall or the floor for several minutes or longer. Some of the family members would cry quietly, some more loudly. The suffering and raw grief at times was overwhelming. It was always most profound. My heart ached for all of them as they were thrust into this space of liminality.

I noted that the families were given very few choices; I did not know if the reason was because the ritual was so well established by the staff or because the families were numb from shock and could make very few decisions. Auto ethnographically, I remember that I wanted more choices for my family and I asked for them. I was not in the ED with my daughter, but if I had been I would have asked for the same rituals, such as bathing and gathering around her body to pray, that I later asked for in the ICU. I had offered these options to other families in my nursing practice and I was aware of them. I was also in shock, but I had enough knowledge to know what was possible, and I asked for at least some of those possibilities as options for my family members.

I also knew that since this was an ED, since space was at a premium here, other rituals were almost impossibility. There was no space to put a bed in the viewing room,

so there was no possibility of anyone getting into bed with their deceased family member. There was no possibility to bathe them or to spend quality time with them during the limited time period that was allowed in this ED. There was not room to gather around the stretcher to pray as a large family group. The limited number that was permitted, both with the “rules” and the space in the viewing room, limited the social event and the rituals that could occur with the deceased in the viewing room. However, what was possible was done here.

### **Acting: Staff Stories**

The second category Moore and Myerhoff (1977) of *acting* is also seen. In this category of secular ritual, the activity of the staff is not spontaneous instead it is more like acting a part in a play. The staff members each had their own role. Only the physician could deliver the “bad news.” The nurses would make the “body” presentable for the family to “view.” The social worker and the spiritual care person would work together. One would view with the family and one would stay in the family room with the other members of the family. If the sudden death involved the police or potential criminal activity, the family was not permitted to be left alone with the body and was “somewhat” restricted on touching or manipulating the body in any way, although those restrictions were never clear to me, and not clear to anyone that I asked. These rules were passed down to each other verbally, and several staff members mentioned these regulations in their interviews.

The professional staff member who was assigned to stay with the grieving family in the family room would be quietly sitting with those family members in that room. Family members might be crying and passing tissues down the row of chairs. Depending on the circumstance of the sudden death event the social worker would also be doing some paper work at this time in the family room. She would be explaining the possibility of the medical examiner being involved if the sudden death case met the state requirements for an autopsy. The social worker would be explaining Gift of Life and tissue donation, if applicable, to family members. She would be giving them information concerning funeral homes, if the family desired it, and filling out other necessary paperwork for the death certificate. Staff usually came in during this time with personal items of the deceased to give to the family. Some of the staff reported during their interviews that the nurses prefer this time to take no more than two hours. When I asked the families how long they thought they were in the family room, most of them reported the time to be about two-three hours.

When it seemed as if all the family had viewed the body, the social worker would ask if there was anything else the hospital staff could do for the family. The social worker would answer all questions at this point. The staff would then say again how very sorry everyone there was for their loss. The social worker would suggest that the family go home and be together and rest. The social workers whom I observed would give the family their business cards and offer to be available by phone for questions if the family had questions later in the day. They would then escort the family members to the waiting area and say good-bye.



These professionals worked together handling sudden death events almost daily for extended periods of time, in many cases they had worked together for years. They each knew the role of each other, but like in a play they never took on the role of another person. They would patiently wait until the right person was available to act out their assigned role. The only exception I ever saw to this might be the social worker and the spiritual care person might exchange with each other that was walking with the bereaved to the viewing room. During my fieldwork, when I would ask a question about a role concerning the professional staff during a sudden death event and I was told in great detail about the role, the professional person in the role, and when that role was called to the event. But never would the role be taken over by another person, but it was not due to the fact that the role was not known to all of the actors.

### **Acting: Family Stories**

The data presented in the *repetition* section also relates to this section. The family members whom I interviewed did not actually tell me that they felt that they were in a dream or a play but they indicated to me that things seemed not real to them. They did say they felt “numb” and “blank” and that they were looking through glass. The auto ethnographic lens tells me that at least some of the family members felt like they were in an imaginary surreal place going through motions as if in a play. I did not ask them if they thought they “needed” to act in a certain way, as I knew I did in my own situation as a family member. I knew from my clinical nursing experience that if I acted “unruly” or

in any way socially unacceptable in this environment, I could be asked to leave or my family members could be restricted in some way.

### **Special Behavior or Stylization: Staff Stories**

An example of the next property Moore and Myerhoff (1977) of the ritual “*special*” *behavior or stylization*” was demonstrated several times in the family interviews. This category demonstrates something ordinary carrying special meaning, or someone being set apart. The staff data that follow indicates the fear of violence that was present when delivering bad news to family members. I think that some of this fear came from the feeling of inadequacy on the part of the physician when telling the family member that their family member had died in the ED. Dying in American hospitals is often seen as a system failure and personal failure. So telling a family member this news is in many ways “*special behavior*” for a physician. The family room is indeed utilized in such a way as classified as “special.” In each family interview the room that they were taken to hear the “news” was significant, and they all knew that they were going to get bad news in the family room where they were taken. The staff expected the family to react with very raw emotion to the terrible news. They were ready for any and all reactions that occurred. They were hopeful however, that the “ritual” that they had in place would be enough to help the family and staff get through this sudden event.

This hospital sits in a neighborhood known in the city for violence and gang related crime. The staff in this ED sees and treats victims of violent crime. All of the staff function with an acute awareness of safety in the workplace.

The following is an excerpt from a nurse:

**Nurse:** And our doctors are well prepared for talking to the family, so there's always one or two that get out of hand, but everything's always under control. We take the precautionary measures beforehand, especially any trauma event. If any young children that got shot and stuff, we always expect the worst reaction from the family, so we set in place all the proper barriers before, you know, anything gets out of hand, preventative.

**Mary:** What are those barriers?

**Nurse:** Well, security, that's the biggest one, you know. We have, we tell what's going on and we show a lot of force, you know. They are just there, just in case, and we just keep it to the immediate family in the viewing room so the doctors don't get, you know, assaulted, and stuff like that. (Staff 1)

Another nurse also commented during the interview about security issues:

**Nurse:** You know, we set up, we try to keep the groups small because we know larger groups can cause more conflict and a little bit more chaotic. It's hard to control. (Staff 2)

A spiritual care person speaks to the way that families react to bad news here in the ED:

**Spiritual care person:** There is a policy. The policy is that the families can only be here two – one hour, two hours max, and we are supposed to somehow ask them to leave after, after duration of two hours. If the families are unruly, very unruly, we are to call security, but I, I have been able, thanks be to God that I have been able to manage families that are unruly and that it doesn't get to the point where I need to call security.

Then what happens, after the doctor – well, there's a team of us that come to the family, the social worker, the chaplain, and the doctor, and the doctor comes and tells the family about the sudden death. We are there for support, and then it's primarily where my role takes over. I take over comforting and allowing them to grieve in the ways that they want to grieve. If they want to wail, if they want to scream, if they want to shout, it's okay. It's okay with me, and for the most part, I have been able to handle whatever kind of behavior they have decided to do. If they want to sit on the floor and roll on the floor, it's okay, I'll let them roll, and then when they come to themselves, they're able to get up, I never tried to stop them from, from rolling or from crying, because I think that's how they are reacting to that sudden death, so I'll give them that freedom.

If the families are calm and cooperative and not giving us a problem, we just let them come on in, and you know, we just sort of take a risk and do what we feel is best for the family. This is really why we're here, we are here for the families, absolutely, so we do everything we can. We do hospitality with families. We,

you know, we give them what we have to offer them. I wish we could do more things to offer them. (Staff 7)

Another nurse speaks to who is with the family in the family room and the viewing room:

**Mary:** So viewing the body could be social work or security?

**Nurse:** Usually the social worker is there. Oh, sometimes the chaplain will come, too, if the chaplain's around, will go in there, as long as somebody's in there with the family, but if it's a case where there's a trauma and the family is really dramatic, security will go in. (Staff 6)

A physician talks about his role with the death notification process:

**Physician:** What happens? Usually after giving the bad news, I will ask the family if I can do anything else for them, and then step out and let the social worker and the chaplain handle it from there or security. If things get violent, security.

**Mary:** Does that happen very often?

**Physician:** No, not even here. I've heard cases. I've never been involved in a, in a bad notification where their family gets anxious or violent (Staff 16).

The last excerpt is from a security police person who relates the conditions of the neighborhood and the city where the hospital resides to the conditions in the hospital ED:

**Police person:** Employment, unemployment is high, the world's getting so competitive, and people are feeling less control of their own lives and so forth, so you have the opportunity and the mix for violence and anti-social behavior, I mean, or whatever. So hospitals, because of all the people arriving, those with criminal backgrounds and those that just have unfortunately experienced the tragic death in their family, been told that they got four weeks to live, you know, critical condition, all these emotions are arriving, and it takes a skilled police authority officer to neutralize those and to balance it out and to deliver, so your health care people can deliver. But our nurses and our medical staff have enough to worry about that they cannot feel threatened in the environment, you know. (Staff 15)

It is important to note here that I did not have a question related to how family members react to bad news or if staff member were concerned about violence in this ED.

This data came up spontaneously in many of the staff interviews.

**Special Behavior or Stylization: Family Stories**

This category of *Special behavior or stylization* Moore and Myerhoff (1977) also had special meaning for the family members. The family members in their data did not seem to notice the different roles of the professional staff members, for example they did not know the role of the person that gave them the bad news. One family thought it had been the nurse. However one family member did notice a staff member holding a clipboard. I am not sure who that person was; I never noticed anyone ever holding a clipboard the entire time that I was there doing fieldwork.

Here is one specific example of the special meaning that the badges and people carrying clipboards carried for this family member a wife whose husband died suddenly in an accident:

**Wife:** I remember now just looking at certain things, the badges, those holding clipboards and social worker, and they whisked me right to the room. I knew then. (Family 7)

Interestingly, many of the family members talked about the physical characteristics of the physician who gave them the bad news that their family member had died. Many family members mentioned that the physician was white and young, one mentioned height. I remember nothing about the physician in the ED the night that my daughter died, except that he was tall, white and very young. I also remember the physician from the ICU that told us that my daughter would not survive. I remember he was in scrubs, and he was middle-aged and handsome. He leaned back against the table and told me that he could not do anything to save my Jessica. He was so sorry that he

could not help us. There was no surgery, no miracle, and no hope. She would not survive. I remember after those words only seeing his lips moving, deafening silence.

I was also amazed when I was looking over my family interviews that only one family mentioned seeing the security police and I would assume as was their “policy” that they had been called at least initially to the hallway area outside the family room for each of these sudden death events. The one family member that did comment on the security police casually mentioned passing him on the way to the viewing room. That was a “normal” station for a security policeman. The security police are there to maintain order and maintain a sense of safe environment.

Another place that was used as *Special behavior or stylization* is the viewing room. This is a closet that is set aside to be used in this department as the viewing room where family members can view the victim of a sudden death event. Separating this closet from the decontamination room as described earlier is a plastic curtain. This decontamination room has become a very significant room to these family members in this ritual. This is the place where they will first see their family member after they have become dead. In the interview data this place was very significant to each and every family member and many of the staff members especially the nurses spoke to the care they took to preparing the body and the importance of the body looking “presentable” to the family as they will always remember how they body looked to them at that moment. Many of the families spoke to the way that the room was not suitable for their loved one. This room was an ordinary room and is was set up to do an extraordinary role and the

families involved spoke many times to the way that the room and its environmental shortcomings.

### **Order: Staff Stories**

The fourth property of secular ritual Moore and Myerhoff (1977) is *order*. This category is staged, repetitive and very precise. As indicated before the staff all know what their specific role is and they do it in an exaggerated way. The following are some examples from two spiritual care persons that demonstrate these ideas:

**Spiritual care person:** I usually tell the families, now, I'll tell you what to expect. He's going to have a tube, and by law we have to leave that in. It won't be, you know, when you see him in the funeral home, it won't be there, but we have to leave that in, so it's going to look kind of clinical, and kind of prepare people. So I will say something, well, when he was struck, he was injured, and his body shows evidence of some of that injury. Now, at the funeral home, that will be invisible, but right now, he looks like a person who's been really injured, if the face is. If it's the body but not the face, I will say, he looks very peaceful, like he's sleeping, looks very calm, looks like a nice guy. Something to normalize... So the nurses are very sensitive to how the family sees the body. They'll wash it, they'll make sure that sheet perfect and the folds are just right. And it's not a mortuary, it's not a funeral home, and we don't encourage people to do their first mourning there. In fact, we tell them, we need to take this person's body to the cooler, they've been out a long time, you know. You need to go home and be with your family, but all the personnel are very respectful. You know, you'll see them move out of the way, because they will recognize this is the family walking around dazed between the family room and the little viewing room. Because we have that traffic problem. (Staff 13)

The next scenario is from a spiritual care provider who details the category of order from the beginning of the death notification to the end of the time when the family has finished the viewing process:

**Spiritual care person:** When they arrive, typically they are ushered back into the consult room. When they arrive there, if the chaplain's not there already, they'll be there shortly, and the social worker and the chaplain work together to get information from the doctors and nurses, to be present with the family after, well, when we find out something to tell the family. Until then, on occasion the chaplain has the ability or option to stop in and introduce themselves to the family first, let them know that they're here, but typically the families want to know what's going on, and they're not as open and ready to talk to a chaplain with everyday conversation. So the typical way that it's dealt with is the chaplain meets with the social worker and they'll go see what's going on with the doctor. And when the doctor's ready to give the official report, they'll come with him in there to the room where the family's waiting.

After the doctor's finished sharing of the death, typically what happens is the doctor will leave the room. I, as chaplain, will stay behind and make sure that the family heard properly what the doctor had to say. The social worker typically also stays behind because the next thing the family's going to want to do is see the body. Most of the time and it's the chaplain who assists the patient's family members in to see the body of the patient when the staff has prepared the body in the viewing room, so I remain and wait with the family, try to be a presence with them. Sometimes they will allow you to, you know, provide services for them through prayer, or just a hand to hold or a shoulder to cry on. But just to be present with them until there's opportunity to go back and view the body.

During the viewing, we take back two at a time of the family members and allow them to, I'll walk them back to the room, open the door for them, allow them to go in and see their loved one, stand with them in the room, and they typically have some words to share with their loved one or some emotions to express. They spend some time there with their loved one, and then I'll escort them back to the family room, for the family to go view, I'll assist them then to do the same thing. That's the hospital standard policy, yeah. If there needs to be an exception, we can do that, but typically it's a very small room. You can't have a lot of people in there at the same time, and the more people, the more dramatic the reactions could be. Humans tend to feed off one another sometimes or off the reactions of one another, so those two things combined, it's typically better to have two at a time. And sometimes it's just the strong one in the family who can take one at a time to go back with them, each one, same person taking them back to help them be able to deal with the crisis. When the family's all had opportunity to view their loved one, I'll sit with them in the family room for a little while; allow them to do any of the processing that they would like to do.

A lot of times they have questions, what do we do now? What's the process from here? Is there any paperwork we got to fill out? The chaplain and the social worker are both present there, and the social worker deals with death certificate – or not death certificate – funeral home release form with the family so that they



can name a funeral home to have come and receive their loved one's body to prepare for burial or cremation or whatever the family chooses, so and any of the paperwork questions that the social worker needs to ask. Here at this hospital social work does that. Spiritual care is there, available to give support, perhaps to answer any pastoral questions. I've had them ask question about, you know how do we, who could be our officiate at a ceremony. Where should the ceremony take place, what should that look like, and sometimes they want to talk through those things. I encourage them to allow the funeral home to walk through the details with them because that's what they do.

They're very, very professional at it, and could give them the best information possible for their area. So typically social work and chaplain are hanging around to give support to family afterwards, for whatever needs they might have. When we feel their questions are answered and they've said so, we will escort them back to the main waiting lobby, and most of the time, they're ready to leave. (Staff 10)

The two scenarios above are typical of what I observed during my participant observation. If the family is crying and emotional, the process will be slower but will proceed throughout the steps that have been established. The staff has spent some time in the family room prior to the death notification talking to the family and establishing some relationship with the members of the family. The staff has identified who of the family members is calm enough and can help with the ritual process of the paperwork; they also have some idea who will be the family leader in the situation. If they are suspicious that there may be too many people in the family room and the family may be too "dramatic" when they get bad news they will have security very close by. The idea of the body being in the ED only a certain number of hours and that they do not encourage people to do their "first mourning here" is all part of the process in this ED. The routine activities that would occur in the ED and the special ritual activities that were developed by the staff to make the sudden death event more meaningful for the family were often intertwined during my fieldwork. The staff needed to function within certain legal protocol but

interestingly along the way I also found oral tradition filled in where the protocol was missing or forgotten.

### **Order: Family Stories**

My experience with the families at this time is that they listen carefully to the instructions, and they ask questions, as noted in the previous interview data about what to expect in the viewing room. What will he look like? What paperwork do I need to fill out? What do we do now? They are given very few, if any, choices. They are given a choice to take personal possessions if the sudden death is not a criminal case. They are also given a choice on whether or not to view the body. They are given choices on who sees the body first and who accompanies who to view the body. They make some choices during the viewing as you can see from the data previously presented.

Some social workers and spiritual care personnel were more patient with the family. However, there was a two hour time limit that was understood, but was it never clear to this researcher if that two hour time limit was from the time the patient was admitted or two hours from time of death. I would hear the two hour time whispered between staff and then at times told to the family. I saw it used to set limits on grieving time in the viewing room. Of course all activity with the family and staff was dependent on how busy the unit was with incoming admissions. The viewing room was small and depending on the number of family members only a small number could go back to view at a time. There were no chairs in the viewing room. The staff preferred to take two-three people at a time and the spiritual care person and the social worker would work as a team

during this time. Order was maintained at all times by the staff enforcing the rules and family members learning what the rules were as things progressed.

### **Evocative Presentation Style, Staging: Staff Stories**

The fifth category of secular ritual Moore and Myerhoff (1977) *evocative presentation style* describes the next step of the ritual process for the family living through the trauma of the sudden death event in the ED. Moore and Myerhoff would describe this is a challenging category and perhaps even physically demanding time for the staff and the families, where the ritual involves a set of rule bound activities that take deep concentration. This category is the beginning of the fifth property of secular ritual: *evocative presentation style, staging*: Some of the process is completed, the process of telling of the bad news, the staging of the security police, the setting up of the presentation of the body for family viewing. All of those events are over for the hospital purposes and now the family needs to complete the final forms. The staff needs to keep the family member's attention to do the last highly structured tasks before sending them home.

The staff would offer ice water to the family members during this time in the family room. I was told during staff talk that on other units a hospitality cart with coffee and a cookie tray would be offered to families, but that was never offered in the ED. I was told that there was no budget for a hospitality cart in the ED. After hearing this explanation, I wondered whether another unstated reason was that more hospitality might

increase the time that families would stay in the ED. It would not fit into the two-three hour time limit in the ED.

I also heard an intriguing statement, “This is not a funeral home,” many times during my observation time and staff talk on the unit. I also literally heard this statement in two or three staff interviews and actually from one family member. I am assuming that the family member might have heard it from a staff member while on the unit. I heard this statement from the staff member during an interview in two specific instances. One instance occurred when a family member was calling other family members to come to the hospital to view the body of the deceased and the family asked for the hospital staff to hold the body in the viewing room until the family arrived. The nurses did not like to have the deceased person on the unit longer than two hours after the death occurred, so any activities that prolonged this time could stimulate the comment about not being a funeral home. I also heard the comment this is not a funeral home when there was a large number of family members there at one time. The following is an excerpt from a social worker concerning this situation:

**Social Worker:** I’ve heard so many times, well, we’re not a funeral home, but, you know, we’re not; we’re something more than just where a person dies. You know, we could, we could be doing, and we could be doing a lot more than we are. It doesn’t have to be the struggle that it is. I don’t know, you know. I think it’s okay. I feel like if I’m there, I haven’t been a part of too many where – I don’t know. I feel like if I’m there and I trust my colleagues, if we’re there, we’re going to make sure it’s as okay as it can be.... We’re not a funeral home, but, you know, we serve the community, and, you know, trying to, you know, sometimes some of the things I find myself having to say, I mean I guess there are some understood policies. You know, we don’t take people to the morgue, well, we do but we really don’t want to. And I understand why it’s difficult, but some of the things that I have to say or I think about having to say, I think if the president of the hospital heard me say that, you know, what would he think. I mean I can’t

believe, you know, we say we want to be excellent in customer service and take care of people; yet there's this disconnect, I mean, there's these things going on, and I think they don't go on because I think, you know, most of the time we manage. We manage with what we have, and we do okay, but wouldn't it be nice to, to be more pro-active and try to address the need, you know, not just good enough but, you know, it's a critical time in people's lives to try, try to purposefully meet the need. (Staff 12)

And yet another opinion from a nurse:

**Nurse:** Some family members, they just don't need to feel, not immediate family – but, you know, they show up with 30 family members they can see the patient at the funeral home. (Staff 1)

The staff repeated to me many times that the ED is not a “funeral home” and that viewing should be limited to immediate family. I did, however, see this rule broken most times to let others view the body. The staff seemed to understand that the ritual gave meaning to the family and perhaps even helped with the so called “unruly” behavior. When the ritual was being enacted, the fear of violence was not as active for staff. Perhaps, I thought the routine could be violated and in its place could be put the ritual order.

### **Evocative Presentation Style, Staging: Family Stories**

For the families this category of secular ritual Moore and Myerhoff (1977): *evocative presentation style staging* was very important. Many of the family members commented how important the viewing was, not only for the immediate family but for others they had called who had come and gathered in the ED to support the family. Everyone who is important to this family has the opportunity to be involved in this sacred

activity. Interestingly, the families told me that the deceased looked more like themselves, much more natural during the viewing in the ED.

Here is what one mother told me about seeing her son in the viewing room in the ED:

**Mary:** Were you glad you went to see him?

**Mother:** I can't say that. Yeah, I guess I can say so, because that's most of himself that he ever looked to me. After that, he never looked like himself again.

**Mary:** So you think that's important?

**Mother:** Yes.

**Mary:** To view the body there?

**Mother:** Yes, especially just because you always want to know what they looked like at the time. They had him in a gown. (Family 8)

A husband's comments about being with his wife in the viewing room:

**Husband:** And you know, they let us go in to see her, you know, and all the kids came in, all the grandchildren came in; her brother and sisters came down. She don't have any sisters, but her brothers came down, and some friends of hers, they call came down. You know, we all went in and, you know, we paid our last respects right therefore \_\_\_\_, you know. The staff here, they treated us really well, I mean, you know. They kept saying, well, you know... We gotta put the body away, because it starts to deteriorate. But other than that, they let everybody come in, everybody see what was going on, you know, they let us all, we all had a private moments with \_\_\_\_. They let me go in by myself to have private time. You know, pray over her, you know. (Family 4)

Another comment by a wife about the importance of viewing in the ED:

**Wife:** I touched him a lot. Even at the funeral home I did. And my girls did, too. I kissed him a lot on his lips when he was in the coffin, which surprised me. She was very, very strong, and now she's the one who's having the harder time, but ...would just kind of go like this and felt how hard he was. She was younger, too, but yeah, I did, I did kiss him and put my head on his chest and play with his hair, and so when they took me back to the room, I wanted his, I wanted a lock of his hair, and I can't remember who it was, a social worker or something said, why don't you let the funeral home do that, they'll wash his hair and all that, and I said, uh-uh, because I didn't have anything, because everything they had went to the police department. I didn't have, he didn't wear his wedding band because he

grew out of it. That's how big his hands were, so nothing. I didn't have anything at all. It all got bagged up and went to the police department. So I said, I want some hair. I said I'm not leaving here until I get something from him. So the chaplain said, I'll be right back, and she, she had something in her pocket and she went in there, and he still had his ponytail in, and she gave me the whole ponytail. (Family 7)

A girlfriend stated how important the viewing in the ED was:

**Girlfriend:** Then they finally let us in the room to see him. As the family members came, everybody took a turn to go in there and see him.

**Mary:** Do you think it's important to view the body?

**Girlfriend:** Yes.

**Mary:** In the emergency room?

**Girlfriend:** Yes, I do, I do, because you know, his body is still really his body. You can still feel, you know, the softness in the skin, you know, because after they get to the funeral home, you know, the body is so stiff and hard, you know. You know, if the body is visible at the time at the emergency room, it's best to see it then, because like I say, a lot of people like to touch the body. You know, you still want to feel the tenderness of his skin. (Family 9)

These tender statements about the importance of seeing the body in the viewing room are very important to caring for family members and healthcare practice in the ED. Many family members are initially afraid to "view" the body. They are not sure exactly what their family member will look like. It can be very frightening to a loved one. Healthcare providers may feel that they are protecting the family members from a traumatic event by not encouraging them to view the body, especially if there is a sudden death event.

Auto ethnographically, the nurses did not want me to "force" my sons to see Jessica; however, I felt that it was important for them to say good-bye to her in the hospital. I have asked them since that night and they have both told me that they are grateful to have had that experience of seeing her immediately after she died, before she

was taken to the funeral home. Giving family members choices is very important as was seen in the above data from the family interviews.

### **Collective Dimension: Staff Stories**

The last category that Moore and Myerhoff (1977) list describes the secular ritual process is the *collective dimension*. This category speaks to the larger social meaning of the ritual. This category of *collective dimension* from Moore and Myerhoff relates the key theoretical idea that Hertz (1960) puts forward that death is a social act. The existence of this whole secular ritual process in the ED has social meaning including this transitional social process where staff and family participate together. The walk to the viewing room that brings the mourners ever closer to the door that exits the ED is symbolic of the new walk that the mourners will take in the days ahead.

In some cases there were members of the broader community who came to say good-bye to this person who had experienced a sudden death. The staff certainly was also participating in the goodbye. But the friends and family of the deceased who came to the ED were there to support the family and the family also helped to support the other friends who came to the ED. In my situation the coworkers of my daughter asked for permission to say goodbye to her body in the hospital. I also found this situation occurred with the coworkers of one of the deceased in the ED.

A young widow told me this story:

**Wife:** And I remember being there for about ten minutes, 15 minutes, and I heard a knock on the door, and it was the chaplain, and she said the guys want to come and see him, which I thought was great, because the reason that I stopped to ask them to go in there, I wanted them to see how dangerous was the job potentially is. I never knew it until I was there. And I wanted them to see what could



happen. So they all went in... my family and I went out, and then the three of them stayed in and said their goodbyes to him, and then – sorry – that was it. (Family 7)

This situation of the co-workers being there with the family also demonstrates Hertz's theory that the deceased has a place in society, a role. Society has made an investment in this person. In this example the co-workers are standing with this woman beginning this social process, this transition of transforming this man from a member of society to the deceased into an ancestor. Van Gennep (1960) calls this a rite of passage for all involved; the deceased is moving through the transition of liminal time as described and this wife is moving from being his wife to being a widow. The ritualistic activity that the staff has created is very helpful in bringing meaning to all as they transition out of this liminal period. I can however, hear the staff saying "This is not a funeral home." All of their mourning cannot be done here in this time frame. As a bereaved parent and a social scientist, I know that the mourning starts here. The families become mourners here in this place, in this ED.

### **Ritual Exceptions**

Before leaving our discussion of this transitional stage of becoming dead in the ED, it is necessary to consider some ritualized exceptions that occur in this phase in a patterned way. As indicated before, the lack of a formal policy related to death in the ED was an interesting indication of the organizational culture of this ED. This professional staff designed a secular ritual process that, like all rituals, brought meaning to a situation that otherwise appeared meaningless to them. They also developed an informal system of

rules that went along with the ritual process. Some examples of these rules: immediate family only in the family room; no one under 12 years of age; two people at a time in the viewing room; no one is left alone in the viewing room; the entire ritual should last no longer than two-three hours. The informal gatekeepers of the power and the rules seemed to be the nurses. At least that was the answer I received several times when I asked, “Who will be upset if you break the rules?” “We will hear about it later from the nurses.” (Field note, Summer 2010)

There were certain exceptions made to these rules. I would see particular professional staff, regardless of job category, make exceptions. These staff members were those that were experienced and had been in the department for several years; they were members of the team who also looked for other team members to be present before the rule was broken. Thinking all the way back to my early nursing experience and the couple story presented in the prologue, I came to realize that there was safety with certain other group members who had the same philosophical feeling about death and dying rituals and patient satisfaction. Of course, how busy the ED was that day always still had an impact on how much time could be spent with the family of a deceased patient.

All of the above rules, however, had a clearly recognized exception. That exception was if the deceased patient was an infant or a child under 12 accompanied by the parent. Everyone was on board with the exception, even and perhaps especially the nurses. The parents of the infants went into the trauma rooms; there was no two-three hour time limit, no limit on the number of family members, and there was a special family room used. This room, which was a multipurpose room at other times, was larger

and could accommodate more people more comfortably. This room was only used for infant or pediatric sudden death events. Staff often connected on a different level with families who lost a child. Many of these sudden death events had a profound impact on the staff, which was evident in their staff interviews.

One of the questions that I asked was *Tell me the story of your “most memorable” sudden death?* Many of the staff told me several stories. All of the staff in response to this question told me a story about a memorable pediatric death. These stories combined with my observation also gave me data that indicated that during a sudden death event that involved a pediatric patient there was a clear exception to the established ritual. The social message was clear that the only time there was a ritualized exception process was when the patient in the sudden death event in the ED was a child. It appeared to this researcher when the patient was a child (approximately 12 years of age or younger) and the family accompanied the child to the ED, there were many exceptions made for the families of these children. I observed one such event, and I was told of many such events in the staff interviews.

The collective social meaning of an infant’s or child’s death demanded a different social and ritualistic activity for both the staff and families of those children. The parents were not escorted into the family room but were brought into the trauma room and given a chair to watch the resuscitation on their child.

The following is a field note, an example of how this family of an infant was treated:

I walked into a very crowded room where I saw the CPR team working feverishly on a very small baby, the team was frantically working on this little baby laying on the bed and the mom was sitting on a stool in the corner of the room at the

bottom of the bed and beside her was the nurse standing holding her hand and the mom was crying, the nurse was also crying.

The nurse was standing straight, staring at the baby tears rolling down her face. I was thinking that she was standing like a sentinel, guarding the mom, tears rolling down her face staring at the baby. The mom was staring straight ahead at the baby. I was looking at both of them. There was a knock on the trauma room door and someone poked her head in and identified herself as spiritual care as she entered the room. I stepped back away from the mother. She stepped towards the mother, identified herself as spiritual care placed her arm around the mother and stood there. All of us at attention waiting and watching anxiously to see if the baby was going to respond to the CPR and the cure that this team was attempting to give that baby. The stress on these staff members was obvious, many of them crying as they worked giving instructions to each other.

At some point the physicians pronounced the baby dead. They walked over to the mother and they explained to her that they felt the baby had aspirated, but that they were not exactly sure what had happened with the baby. But that she had come in not breathing and with no heart activity and they had done everything they could. They explained briefly to her what they had done. Despite all of that, they were so sorry to tell her that her baby girl was dead. She continued to sob. They told her that they were very sorry. They asked the social worker to take the mom out so that they could prepare her baby for the family viewing. (Field note, Summer 2010)

This family was taken only temporarily to the regular family waiting room and then was also taken to another room to view their baby, not to the normal viewing room where other families of sudden death events were taken to view their family member. This other room was outside of the ED treatment area and down another hallway that was used for viewing of babies. This room was used because it was larger and would accommodate more family members. There were chairs provided there and the family was encouraged to stay there for a longer period of time. This multipurpose room was empty most of the time. There were empty beds in it some of the time, and at other times I saw meetings going on in there. This room was large enough for two patient beds to be there and several chairs. There was also a nursing station area. I asked once why this

room was only used for viewing of the babies and small children. I was never given a clear answer. It was just the way that they did things. It was their patterned ritualistic exception.

The families who experienced a sudden death event with an infant would be allowed to have as many family members as they would like in that room with their baby. Every rule that was in place with the ritual for sudden death with the other age groups was able to be ignored with babies. This practice was socially acceptable with all members of the group. A death of a child or an infant was very stressful for the staff. I was told during my staff interviews that if a staff member stated that they could not do resuscitation on babies, someone would “cover” for them, meaning that they would be relieved of that duty by another staff member. There was a special consideration of each other in this category of sudden death.

This special ritual activity also appeared to bring much meaning to staff’s work with these families. It helped them to place some order around the chaos that occurred in the lives of the staff members when these sudden death events with infants and small children occurred. All of this was well known and socially acceptable within this ED community. The staff members often went to each other and talked to each other for several days following the event. For example, I found the more experienced nurses attempting to help the younger nurses’ deal with the stress of the infant’s death. I also saw social work and spiritual care personnel attempting to debrief with all of the staff.

I heard one staff nurse talk to another nurse whose wife was pregnant:

Now, do not go home and talk to your wife about this. She doesn't need to hear about this. Talk to us all you want. Do not talk about it to her. Leave this here at work with us (Field note, Summer 2010)

These exceptions were similar to although somewhat different from some of the exceptions made for my family the night that my daughter Jessica died. Although Jessica died in the ICU the rules were quite clear considering numbers of visitors, and I realize now that we had many more visitors than were normally allowed in the ICU waiting room. I am also sure that bathing a loved one was not normal protocol for an ICU unit. I look back now and realize that the rules that night were organizationally and socially bent to accommodate my family. I also know that we were on that unit for more than two hours.

Looking back we must have broken many rules and there must have been many exceptions made for my family that I was unaware of at the time. Now having been on the "inside" during my field work in the ED, I know that I must have appeared very demanding and unappreciative. Now I also know after being on the inside that if the rules had been different, if staff had understood the importance of social and ritualistic processes, I would not have had to be demanding, I could have just been accepting care.

The physical arrangement of the viewing room, as explained before, was very close to the door, the family would view the deceased, and the staff would finish up the paperwork and answer questions, close the ritual activity at times with prayer, and then gently suggest to the family that the ritual, although no one labeled the patterned behavior, was finished. The families went back to the family room, the transition was completed with the completion of the paperwork, and the personal items of the deceased

were given to the family. The staff expressed their sympathy to the family and the ritual process was ended.

The family was then walked to the ED security door that led to the ED main entrance. They could be told good luck with all that they must do and what was ahead of them, and then told good-bye. In response, it was common for the family members to say “Thank for all that you did for us” as they are leaving the ED. The staff would open the secured door for the family and the family would leave the ED treatment area. The family then crossed a threshold they could not cross back; they left the body of their family member in the ED and leaving with only personal items of their family member.

## Chapter 6

### Reentering Society as a Mourner: Collective Consciousness:

#### Staff Meaning-Making

What was the experience like once the staff had said good-bye to the family at the door and returned to the ED to continue working?

The social and ritual process was obviously very important to all the staff and family members who were interviewed. The interviews gave me tremendous insight on how those days might proceed from the good-bye at the ED door.

Here are data from one of those interviews with a nurse:

**Nurse:** Sometimes it's really sad with the staff, because we do cry with babies. We cry. I've cried with moms with their babies, just younger people. I've cried several times in my years. I mean my most memorable one I think was when firemen walked in with two babies. They were pretty burnt up, and it was hard. Oh, no, no, if they need me to come in there, I'll be in there in a minute and cry with the parents, I have. I mean it's hard, because I've seen parents sit in that trauma room while we resuscitate their baby, and they're crying and everybody's crying, you know. It's, one of the saddest things. (Staff 14)

The staff also were asked what they thought the best practice would be during a sudden death event and what would be important for me to know about their practice. The staff communicated to me clearly that they cared deeply for their patients and that the care that they delivered to the families of the patients mattered to them. They knew that this was a life changing event for the family. It was many times a life changing event for the staff as well. The staff designed and operationalized this ritual here in this ED. It is not a product of official policy or procedure, but resulted from awareness and open discussion and caring for the families who come here. There were many emotions



attached to the ritual that they engaged in to help the family members and at the same time they often knew they were also helping themselves to be better practitioners. The rituals helped all involved to make meaning from what seemed at the time to be a meaningless event. Staff frequently spoke to the limitations of the physical space. Many spoke specifically about the viewing room stating that it was terribly inadequate. I thought it was interesting when asked, several of the residents had never seen the viewing room. They had no idea where the body went after it left the trauma room or where they were told that their family member had died. They knew that the family left the family room and viewed the body, but they had no idea where that viewing took place. These residents went back to their other patients, and to their own thoughts about the sudden death events. They had no closure with any particular family. Several of the physicians felt this situation needed to be improved. They wanted more time with families and more of a connection when they delivered news that someone had died.

Here is some supporting data from a physician (resident):

**Physician:** The only disadvantage, I guess with a lot of things, is this ER is very busy, and maybe a lot of other people don't feel this way, but when it comes to emergency medicine, at least for me, one of the things that's lacking, one of the things I have difficulty with is lack of time you get to spend with patients. A lot of people would consider that a plus, but for me, I wish I had a little bit more time. You're sitting there, you're telling them everything, and then you're leaving, and you're off to the next patient. So I wish I could spend the last – especially where there are some family members that just completely touch you, and you just feel that personal connection to them in those two minutes that you told them, so I wish I could sit down more and ask and talk to them and find out more about this patient who passed away, but unfortunately there's just no time. And especially in a place like this, where the population is so indigent that they don't have the normal relationship with primary care providers.

The ER doctors are it, you know. I'll say like, who's your doctor and they go, aren't you my doctor and I'm like, oh.

This is a hard residency, and the amount of positive feedback we get is kind of minimal.

Some say, ER doctors “don’t care about the patients. They just simply treat and street.” but I think the biggest thing is that we certainly do care, and when it comes to death notifications, **many of us have a vested interest in saving that person**, and we don’t care if they’re nineteen, we don’t care if they’re ninety, we don’t care if they’re a drug dealer, we don’t care if they’re a businessman. All we see is a life in front of us. We don’t care what insurance they have. **We come to work in a place like this because we have all the resources to bring somebody back to life.** Now, we also know that there’s more to life than just a heartbeat, as Dr. \_\_\_\_\_ tells us, but at the same time, there’s nothing more that we would like than to bring a person back, and if we can’t bring them back to spend a lot of time to get to know that life in front of us, but it’s just because of our job and the fact that seeing more and more patients, that’s why it may seem like all we’re doing treating and streeting. (Staff 17)

“Many of us have a vested interest in saving that person” again here is the ambivalence with the ED setting being a place to “save and “cure” people not a place where the emphasis is placed on delivering bad news. When questioned who was empowered to change the situation, the professional staff listed the administration by name as having the power to do so. I observed that in this ED the relationships with administration were generally very good. Each staff member seemed willing to ask for changes to occur. The physicians surprisingly appeared to be the most powerless in the situation. They felt a tremendous responsibility to go back to the patients who were in the ED waiting for them. They expressed a sentiment of needing to be everything to everyone. Here is data to support this from a physician:

**Physician:** Yeah, I think it’s important for you to understand the sense of urgency of residents to get back to the emergency department, to work. It’s really an unfortunate thing, but I think that’s important for you to know. (Staff 20)

There were approximately 85,000 encounters in this ED in 2009 the year before this research was concluded and approximately 400 sudden deaths. The staff obviously

had to say goodbye to many families and then return to work. What I learned was that typically they had very little time to immediately reflect upon their important work with families during a sudden death event. This situation created a tremendous amount of stress for those staff members.

Here are data from a nurse to support my observation:

**Nurse:** We have policies that talk about how to process the body, how to.... who we need to contact, who needs to be notified, things like that. We don't have policies as far as something routine or specific that states that okay, if you experience this adverse event or sudden death, then you need to go and talk to someone, get some sort of counseling. We don't have any polices that talk about that. (Staff 2)

Another nurse spoke of the stress that she takes home with her, and how it affects her if not consciously, on an unconscious level:

**Nurse:** I think that, I mean from my own experience, I think that, I think that just being a nurse for a long time, like it really doesn't, doesn't affect me like on a conscious level. But like I'll notice like either like after I've gotten home or like if I've walked in the door of my house or something isn't done that's supposed to be done, it's like I lose it. It's like why, why am I doing this. It's not a big deal. It's like I notice it coming out sideways, like instead of just directly like oh, I'm really sad about that patient dying. (Staff 3)

Another nurse talks about not only does the sudden death event affect her but that she remembers it, and thinks about the family for a long time following the sudden death event. Then she suggests how she thinks it would be helpful if they could know how the family was "reacting" to the sudden death. If the family was "ok":

**Nurse:** That even though we might not show it, it affects us every single day, and just because we might not talk about it every day, we still remember things. It could be years ago that it happened, and we'll still think about it and not having that, you know, follow up and know exactly how the family reacted or know exactly what happened, you think about it for a very long time.

**Mary:** What do you think would help you?

**Nurse:** If we were able to get follow up easy, you know. I don't know. Like family, if we could – it depends on how involved in the case, how emotionally attached we get to that, if we could see how the family's reacting. If they're okay, I think that helps us let go a little bit more too.

**Nurse:** I still think those few minutes that we have with them is very, very I think tragic how it happens to them and then there's nothing we can do. I mean there's no care we're really giving, so the families think that we don't care, and that's not how it is, because it really does affect at least me. (Staff 5)

Another nurse talks about how she thinks it is easier to detach when she is only with the patient and not with both the patient and the family of the patient:

**Nurse:** I would prefer that the social worker be with the family, because it gets too emotional. I can't detach. There's so much stuff that goes on here, I wouldn't be able to detach. I can detach now. I can just go on, move on to the next patient. If I had to spend time with all these dead people's families, I couldn't do it.

**Mary:** You couldn't do it.

**Nurse:** Uh-uh. It's not my role, I can't... I've seen a lot of death. If I would have had to spend time with all those families, I would be an emotional wreck. Now I am just stand-offish and I just let it go, because you got to let it go.

**Mary:** How do you deal with that?

**Nurse:** I just let it go. I just move on to the next patient. If I cry, I cry. I go into the bathroom and wipe my eyes and just move on, because that's what you have to do.

**Mary:** And how long have you been doing this?

**Nurse:** A very long time (changed for confidentiality, MM)

**Mary:** Has it gotten easier?

**Nurse:** Yeah, but now that I'm in my late forties, it's getting hard again, because my emotional self is back into play. So, yeah, it is getting a little bit difficult. (Staff 14)

One of the staff members who was a nurse also suggested doing follow-up phone calls to patients' families after a sudden death event. She stated that not always but often, she wondered how the families were doing. Another staff member suggested an outreach program in an attempt to give the families closure. This idea of a phone call seemed to me as if the staff needed to connect to the families in some way after they left the ED,

even if it was just to see if the families were doing okay or to make sure that they were doing okay:

**Nurse:** We deal with the families every day with the patients that we see so what makes it any different from when somebody dies. Why can't we have any family contact then? Maybe it helps us more to see the family's response and see how they're handling it so we can handle it better as well. (Staff 5)

After escorting the family to the ED door, the staff reentered the ED and continued their day as staff members until the next time the tweeter went off and the ritual process began again. It was noteworthy that every staff member interviewed routinely included the entire ritual process in the story when asked how sudden death was handled in the ED there and family members also included the entire ritual process when asked the story of the time of their sudden death event in the ED. The next stories I will present are from the families after they walked out of the ED into the parking lot area.

### **Reentering Society as a Mourner: Collective Consciousness:**

#### **Family Meaning- Making**

Let me begin this section with a memory from my own experience of this critical time. I remember vividly walking out to the parking lot of the ED and asking my husband out loud, slight dazed "What do we do drive home now"? Home to what? Our friend John was carrying the bag of Jessica's clothes that the staff had cut off of her in an attempt to save her life, and I clutched in my hand the urine cup that held her rings and watch that the nurse had handed me in the ICU. I remember telling the staff that I wanted all of her personal items; I wanted nothing discarded at the hospital. One of our friends Sharon walked over and told me that she and Father Jim were coming to our house to

spend the night with us. I was very relieved. I was in a cloud of shock and disbelief that I know now was a gift.

I watched that scene over and over again in my fieldwork, the staff respectfully walking the family to the threshold of the door of the ED, telling them good luck with what is ahead and good-bye. The family thanking the staff, turning and walking across the threshold into another liminal space, many of them carrying hospital bags and clutching Ziploc baggies filled with personal items. These families came into the ED as my family did, hopeful, and entered into a liminal space. Several hours later, they would leave the ED, as mourners, and leave to plan a burial for their family member and to transition into a place more structured and less anti-structured (Turner 1969). They left as mourners and entered back into a culture that does not prepare its members well for any death. This culture certainly did not prepare its members for a sudden death event.

As part of this study protocol I called these families three months later. They told me their stories, their memories of the liminal time in the ED and how they had fared since walking out of the ED doors.

The secular ritual described in detail above was repeated over again in the family interviews as in the staff interviews. The families enter through the two separate entrances of the ED hoping to see their family member who had been involved in the sudden death event. All of the families made calls to the important people in their lives to come and gather in the ED for the social event. The staff then gathered and guided the family into the family room, trying to maintain some order in this chaotic sudden death event. The two professional staff members mentioned consistently by the family

members that were particularly helpful were the social workers and the spiritual care workers. One family member mentioned calling the spiritual care person several times in the weeks following the sudden death of her family member.

The ritual continued with the physicians telling the family that their family member had died in the family room and then the viewing of the body and the rituals that occurred in the viewing room. The staff and family say good-bye to each other. The staff, then guided the family to the door of the ED and the family crossed the threshold of the ED, reentering the community as mourners.

Many of the families were very unhappy with the physical arrangement of the viewing room; they spoke of the public area that they walked through and the small area of the viewing space itself. One of the family members realized that it was a decontamination area. They felt that their family member deserved more than that area.

Seven of the families, when asked, stated that retelling their story did help them. Although many of them said that the telling of the story was not easy, it was “good”. Here are some examples of those data:

**Wife:** It has helped me to talk, though, for your information. It has helped me. It has helped me. (Family 3)

And another family’s reaction to the interview:

**Wife:** I felt a connection with you when you called, because you have been through - you know what, if you had called me, and I think that you didn’t go through what you did, I don’t think I would have been able to do it. I think that it helped me connect with you because you’ve been through, you’ve been through it, plus I needed for someone to know how I felt and understand and have been through what I’ve been through.

**Mary:** Now, my research says that when people get a chance to tell their story, it helps them feel better. Do you think this helped you?

**Wife:** Yes. It hurt like hell again to go back to all those feelings, and I'm actually having chest pains.

**Mary:** Oh, do you think you're okay?

**Wife:** Yeah, I'm fine. It's just me.

**Mary:** Has that happened to you before?

**Wife:** Uh-huh, uh-huh, yeah, yeah. Um, it feels better to get it out, though, and I think I didn't realize it at the time, but yesterday I had such a bad day at work. I just cried a lot, cried a lot. (Family 7)

And another family's response to the question:

**Mary:** Why did you agree to this interview?

**Girlfriend:** Well, I don't mind doing it. I used to be an interviewer, so I'm kind of partial to interviews.

**Mary:** Did you think it was important to tell his story?

**Girlfriend:** Yes.

**Mary:** Now, there's research that says it helps some people to tell the story. Do you think it helped you?

**Girlfriend:** It eased something.

**Mary:** Did it?

**Girlfriend:** Uh-huh. Yeah. Going over it and still feeling the emotion, but not, but going over it like in a formal way, you know what I'm saying, to be able to speak it out, you know, say it out loud. (Family 9)

These data affirms that research done by Sedney, Baker and Gross (1994) that indicates that retelling a death story provided emotional relief and helped connect people.

I heard this theme often in the interviews.

I found that the families that I called, even the families that did not agree to a face to face interview, appreciated the follow-up phone call. The families I spoke to all thanked me for the call. They seemed pleased that someone was doing a follow-up call.

I did ask the families about taking personal items of the deceased from the hospital. The following is some data from those interviews from each of the ten families:

From a grandmother whose grandson died in the ED:

**Grandmother:** They didn't give us anything. I have nothing of his. His girlfriend is pregnant. That is the good that came from this. I came home and



called his cell phone. It was already turned off. I just wanted to hear his voice.  
(Family 1)

From a daughter who was interviewed:

**Mary:** When he collapsed. Did you take his personal items home with you?

**Daughter:** I still got them.

**Mary:** Where are they?

**Daughter:** When I came in, I set them by the kitchen table the dining room table. They are still there.

**Mary:** Did you move them at all, or touch them, or look at them or just left them there?

**Daughter:** I look at them.

**Mary:** You look at them.

**Daughter:** Yeah, then I put them back in the bag, and I just left them. My mother said I should get rid of them.

**Mary:** What's in that bag?

**Daughter:** Just the clothes he had on. I still got the bag with the money in it. That's still in my purse. His ID is still in my purse. He has a bag that had his medicine and everything from home. I put that; I put his partials in that bag.  
(Family 2)

The following is an excerpt from a wife who did not take home personal clothing of her husband's from the ED, but had other personal item at home that she related to him in a personal way:

**Mary:** Now, did you not bring home his personal things from the emergency room?

**Wife:** No, uh-uh. He had just gotten up and he had on a robe, and they put everything in a, in a plastic bag, and when they, when I got in the car with my niece, I told her to discard them. I don't feel sorry about that.

**Mary:** You don't?

**Wife:** No, uh-uh, no, I didn't want to see them.

**Mary:** Because some people, you know, feel that they should have brought stuff home. But you don't think that.

**Wife:** No. I keep his chair.

**Mary:** That's his chair?

**Wife:** That's his chair. That's green leather.

**Mary:** Green?

**Wife:** I think it's green. Green leather chair.

**Mary:** Did you ever curl up in that?

**Wife:** Uh-huh, yeah. (Family 3)

The following is interview data from a husband who did take personal items home from the ED that did belong to his wife:

**Husband:** Oh, they gave me all her earrings. All she had on was her earrings, that's about it, and some clothing that she had on, they gave me all that.

**Mary:** And what did you do with those things?

**Husband:** I still have them. Well, the earrings, I had two sets of earrings. The other set; I gave those to my daughters. And everything else, you know, the clothes, I just gave the earrings to my daughters, one has one set and one has the other set.

**Husband:** It's still some there, you know. I still kept some, and I kept some things, you know, that remind me of her, you know.

They bring you joy, because, like, you know, I mean, she got sick on particular bed we slept on. I just, I went back home that night and thought about it and just went right back to bed in the same bed. That don't bother me. You know, that's just, you know, some people think people come back. She wouldn't do that. I still got a picture of her on my TV set.

**Mary:** Yeah, yeah.

**Husband:** She had a bunch of teddy bears, you know. I still, I still haven't – I gave some to my little granddaughters. My little granddaughter, she has some things, you know. I gave some of them to her, you know. That was her favorite grandchild, her little granddaughter. I gave her some things to remember. She had, she had a watch. I gave that to my wife – I mean I gave it to my granddaughter. You know, so she always remembers grandma, she always has something of hers. I gave each of her sons some earrings and some other watches that my wife had, you know.

**Mary:** Yeah, I think that's important, and I bet they wanted them.

**Husband:** Oh, yeah, they did.

**Mary:** They did, yeah.

**Husband:** They asked me, did she have any other jewelry, anything like that. I said you can have anything in here, you know.

**Mary:** Right, I think it's really important.

**Husband:** I still keep her gloves, I got her gloves over on her side of the car, you know. So she still rides with me everywhere I go. I got, I got her driver's license in my wallet. So I got that picture, you know. She goes, so wherever I go, she goes. So if I ever get down, I pull her driver's license out. (Family 4)

More examples from a wife concerning their husband's personal things after he had died in the ED:

**Mary:** Did you take any personal items home with you.

**Wife:** Yeah, the clothes they cut off and then tennis shoes and I had to go up to, I don't know, second or third floor to get his wallet and keys and stuff like that. It was in security.

**Mary:** What did you do with those things?

**Wife:** They're in his top dresser drawer. Except for his keys, I use them.

**Mary:** What did you do with his clothes?

**Wife:** Actually, I just threw them out. They sat in the Hospital labeled bag, not too long ago, I just threw them out because, you know, they were all cut up, I mean. (Family 5)

Another example from a brother of the personal items of his brother that he took home from the ED:

**Mary:** Did you take any of his personal items home with you?

**Brother:** I took his sunglasses.

**Mary:** Yeah, what did you do with them?

**Brother:** I set them on my shelf up under my TV.

**Mary:** They still there?

**Brother:** Yeah.

**Mary:** Did you take his clothes or anything? Did they take his clothes?

**Brother:** We decided to donate his clothes to charity. What people didn't want - well, we let his kids, well, he had twelve kids, whatever they wanted, and they could take it. And the rest of the stuff, the clothes and stuff, we just, my sister took them down to Salvation Army, donate it to them. (Family 6)

Interview data from a young wife whose husband died suddenly in the ED:

**Wife:** I didn't have anything that was on him.

**Mary:** How do you feel about that?

**Wife:** I feel cheated. I wanted it. I wanted something. I got the watch back. I wanted something that was on him the day, you know, the day he went. I got his watch, so I felt better.

**Mary:** What did you do with his watch?

**Wife:** I had it on the counter here for the longest – I put it on initially. I wore it. It was way too big, but I had it sitting here on the counter for the longest time, but I just, I bought a really pretty keepsake box at Michael's and I've got things that I find, mementos, I've been putting them in there. My older daughter doesn't like that I do that. She doesn't like to see his stuff in a box, and I said, well, the only reason I'm doing that, honey, is because I don't want it to get, you know, misplaced, lost, thrown away. I want to keep it. And I'll go get it and show it to you, the stuff I have in there. ...

**Wife:** His wallet, cell phone, it was company issued, but they, you know, they shut the service off. And I remember calling his phone number a lot because his voice was on it, and probably a week, maybe two weeks, I had called it one day, and it was disconnected, and thank God the girls weren't here, because I was so angry. I called; I think I was on the phone downstairs. It was one like that, and I hung up and I dialed again, thinking I misdialed, and it I did it again, and I kept slamming and slamming it down, thinking why did you do that to me, why did you have to take his voice away. (Family 7)

Another example from a mother whose son died in a fatal car accident:

**Mary:** So did you bring his personal things home from the ER?

**Mother:** Yeah, I did, and I got rid of everything as quick as possible.

**Mary:** Did you? What did you bring home from there, his clothes?

**Mother:** Well, they didn't have his shirt on because he was bleeding profusely from his upper body, so he didn't have any of those on then.

**Mary:** How did you get rid of them? What did you do with them?

**Mother:** I took all his clothes from out his room, I took everything and put it in the plastic bag.

I just take everything and got rid of it. I kept a couple of shirts. I kept, you know, a couple of shirts, a clean and a dirty. Not mottely dirty, but just something he had worn, and I keep it.

**Mary:** Now, the stuff he had on in the accident, what did you do with it?

**Mother:** Got rid of it. Everything. I put it in a bag and gave it to Salvation Army.

**Mary:** The stuff you brought home from the emergency room, did you wash it and then get rid of it?

**Mother:** I didn't. I just, straight from, everything, I just put everything in one bag and just gave it to them.

**Mary:** Just got rid of it. What about like his wallet?

**Mother:** I still got it.

**Mary:** Yes.

**Mother:** I got his ID right now.

**Mary:** You carry it around?

**Mother:** Yep.

**Mary:** What else did you keep of his? I'm interested in what people keep.

**Mother:** Well, I just, like I told you, the two shirts. The last gift he gave me.

**Mary:** What was that?

**Mother:** A teddy bear. Of course the shirt and the teddy bear is together in a box in the corner of the room.

**Mary:** In a box?

**Mother:** Uh-huh.

**Mary:** What's the box look like?

**Mother:** It's just a brown box where I keep some things, you know.

**Mary:** Things that mean a lot to you?

**Mother:** Well, just some things, you know. Just, you know, not a special box, just a box –

**Mary:** A box.

**Mother:** That I keep some of my things in. Yeah, and I cleaned his room out. I got pictures of him. I keep a picture in my phone of him. I just deleted his name two weeks ago off his phone. His phone, I just deleted it two weeks ago. (Family 8)

A girlfriend stated the following in when questioned in the interview:

**Mary:** Did you take any of his personal items home?

**Girlfriend:** No, I did not. I don't know exactly who they even gave those to. (Family 9)

A sister whose brother died suddenly in the ED when interviewed gave this information:

**Mary:** Did you take any of \_\_\_\_personal items home with you?

**Sister:** No, uh-uh. We got it later.

**Mary:** What happened to his personal things?

**Sister:** My niece came and got it.

**Mary:** Yeah, and it's hard. Now, do you have anything of \_\_\_\_in your house? Any personal things?

**Sister:** Yeah, my kids have some shirts of his. (Family 10)

Each family answered this question. The idea of personal belongings was very important to the families. There was a pattern that several of the family members went home from the ED following the sudden death event and called the cell phone of the deceased. The driver's license was also carried in the purse of many of the family members, or some other personal item. Hair from the deceased was carried in the purse of one of the family members. I did all of the above. I called Jessica's cell phone for months and I was heartbroken when my husband suggested turning it off. I not only carried many of her things in my purse. I carried my things in one of her purses for the first several months. I kept her most personal items as did one of the family members that I spoke to. I

kept Jessica's hairbrush, full of curly blond hair, her razor and her tooth brush. I wore her gloves and her scarves anything that would make me feel close to her.

Two of the family members spoke about having a box where they placed valuable items that belonged to their loved ones so that they would not be lost. I understood that so well. I had several boxes because one could never hold the items that I found valuable and that reminded me of my daughter Jessica. Somehow the box helped me to contain the memories and perhaps the pain I felt when I took the time to look at those things that reminded me not only of Jessica but how very alive she was each and every moment of her life.

## Chapter 7

### Final Rituals

I found that the family involved in a sudden death event crossed one threshold as mourners but they left other mourners, the staff involved in the sudden death event on the other side of the threshold. Both sets of mourners spent important time in a place that they cannot turn back from; they must move forward. The staff, of course, is not seen formally as mourners; yet, I heard much grief in the stories that the staff told me. The professional staff also grieved the sudden and random loss of life. They also grieved the broken promises, the failures of technology and western medicine.

Here are data to support this statement from a nurse:

I mean, we do everything, we do everything – everything that we do is for a reason. I mean people might see us as kind of cold and just doing boom, boom... but it's done for a reason, and it's done according to the way it should be for traumas and what is best for the patient. I mean, we just move from head to toe, whatever, and everybody's doing something different, but it's really an organized chaos, is what it is. And we do make sense.

We do care. We really do care. Otherwise, we wouldn't be doing this, because if I didn't care, there's no way in hell I'd be doing this kind of shit every single day, put myself through this torture of twelve hours of dealing with the abuse and everything that goes on here. But I never see myself working in a suburban hospital. I don't think I could do it. (Staff 14)

And from a security person:

**Security person:** I think every ED needs to have a core set of nurses like a SWAT team or something that can do everything you and I am talking about right here. Don't – some people grow that hard shell because it's a defensive mechanism. They see so much pain that they become hard themselves or they appear hard, and all it is that they don't want to see it anymore. (Staff 15)

Here is an observation from a spiritual care person that I would like to identify as the final ritual in the process of becoming dead in the ED:

**Spiritual care person:** This woman, she's an old gray-haired lady, and she gets to mop the blood up off the floor. And when you see a woman with a mop, mopping up human blood and she's so calm, and she's so low-key, and she doesn't care if this person was rich or poor. She's just so dignified, and she's just so quiet and kind, and she's doing an awful job, but it hasn't made her into a hard-hearted person. She doesn't act tough. (Staff 13)

The woman mopping the floor quietly and with dignity transitions the entire staff out of the sudden death event. The sudden death event has come to an end, the blood has been mopped up off the floor, the room had been decontaminated, the social order has been restored in this setting, and the flow of the day is back to normal for this ED.



## **Chapter 8**

### **Conclusions**

#### **Auto Ethnographic Thoughts**

This is the story of how I learned about death as a social act and a ritual process. This auto ethnography has provided me a time of tremendous self-reflection and enormous growth. I was completely satisfied with the excellent care that my daughter Jessica received when she was in the ED, although unlike the patients in my study she was transferred to the ICU and died there. At that time, I was disappointed with the care that my family and her friends received during and after her death. I had to lead my family through the rituals that I felt were necessary in the aftermath of the sudden death event. I felt that the professional staff was not as effective with my family members as I would have liked at that time.

I wondered if other families felt the same way. I know now, that compared to what happened in this ED where I conducted my fieldwork, the social and ritualistic activity that my family was able to participate in the night that Jessica died was very rich and the physical environment was much better. I now have something to compare my personal and professional experience to and most of the families that I interviewed did not have that comparison experience. I also wonder now if I would have been more satisfied with the care that she received if I had not also been a nurse anthropologist. Because of my background, I had a different expectation of not only what was possible that night in the hospital, but what was necessary and needed to occur for my family and

Jessica's friends during that very personal sudden death event. I had higher expectations of my peers who work in healthcare and of the healthcare system.

As I reflect back now, I wonder if my desires are almost impossible in the climate of today's healthcare organizational culture. However, I remain hopeful. I do know from my own experience as a nurse clinician, a nurse educator, and now from research data that the professional staff want to do the best for the family members involved in the sudden death events. They do not know exactly what is best for each individual family. The staff in this ED setting was willing to participate in the research process to help contribute to that evidence and improve the care that families receive in a sudden death event. The staff told me repeatedly that they were interested in hearing the outcomes of both the staff interview and family interview data.

The last year of research in particular has been filled with suffering, profound learning and wondrous surprises. I entered into this experience hoping that I would interview staff and families and discover data that would change and improve healthcare practice. I was particularly interested in the stories that the family members would tell me about the sudden death events in the ED. How did those experiences stay with them? How did they make meaning out of those events? Did they have suggestions that could make sudden death experiences easier and more meaningful for the next family? What I found surprised me. The family members that I interviewed did have some suggestions, mostly related to the physical environment of the ED. But overall, they were satisfied with the care that they received at the hospital at the time around the sudden death event in the ED and felt that the staff there did what they could for them. One family seemed to

make excuses for the staff commenting that the staff was very busy the night their family member died but that they received good care in spite of all of that. Even the families that gave consent to be called by the researcher but did not agree to the face to face interview told me that overall they were satisfied with the care that they received at that time at the hospital.

The staff however, had many ideas about how they could improve their practice. The interviews that I elicited from the staff were genuine and sincere. These data were not what I was anticipating. I thought that the staff might give me excuses about time, energy, stress, lack of resources etc. I thought my access might be somewhat limited as they would protect their “turf.” As mentioned earlier the staff was open, and access to them and their work environment was almost, if not completely, unlimited. They were open to and answered all of my questions. I was most surprised to discover that they were also in the category of “mourners.” Most of the professional staff were grieving over their deceased patient and the family members that they had met many years after the sudden death event had occurred, recalling each and every detail as if the event had happened only the day before.

I wondered if the auto ethnographic approach would be a limitation to this study. For example, the psychologist and I reviewing the transcript did notice some differences in the transcript with the mother who had lost a child in a car accident. I realized that when I read the transcript, I talked much more and I disclosed more in that interview. I was more nervous during and following that interview. However, I also connected very much with another family member in a different interview. From these experiences, I

realized that it was not the relationship of the person that we lost but how we made meaning from that loss that was so similar. I connected in a deep way to a widow for instance, whose memory making was similar to mine.

In each family interaction I disclosed at some point in the consent process that I was a bereaved mother, and that my own family had experience a sudden death event. This sharing occurred at a different point in each case. In some cases during the phone call the person would ask me during the call why I was doing this research, or what made me interested in this research idea. I would then disclose the reason. Other times it was during the face to face interview that the question would surface. It gave me a different access to the families. Many times the families told me that they did the interview because they knew that I understood their situation or that they wanted to help me because they thought that what I was doing was very important.

I return to Chapter 1 to my explanations of types of auto ethnography to better define this auto ethnography as most in the genre of “analytic auto ethnography” Anderson (2006) where the researcher has a (1) complete member researcher status (2) analytic reflexivity, (3) narrative visibility of the researchers self, (4) dialogue with informants beyond the self, and (5) commitment to theoretical analysis (p.378); however, I do feel that I move back and forth on the continuum that Ngunjiri, Hernandez and Chang (2010) write about towards the art that Ruth Behar thinks is important in the social sciences, and that Ellis and Bochner define and articulate so clearly. Having written and thought about all of these issues concerning auto ethnography, I again return to Beatty (2010) in his article titled: *How does it Feel for You? Emotion, Narrative and the Limits*

*of Ethnography*, as he describes the fieldworker waiting “for the dying chief to expire, but your feelings are not those of his kinsmen; nor do you feel sad in the same way to recognize their sadness. Although your feelings provide some small insight, they are not your story. Only when fieldwork itself is the focus do the narrator’s emotions become of pressing relevance” (p.440).

I find myself in agreement with the above statement from Beatty, as with each interview I found that their story was never my story and my story was never their story. I did not rediscover myself or my loss with their story of loss, but each interview, each new story of loss, added a layer of richness to my own experience that made me more. I did discover something about myself: I have entered into this world of suffering and loss that even as a nurse I never saw or experienced in quite this way before this research. I have written many pages, but this life altering process I cannot fully explain, but I am more now, so much more.

### **Contributions to Anthropological Literature on Death and Dying**

As previously mentioned, there is a plethora of anthropological research related to death and dying and many interdisciplinary studies done in hospital and hospice settings in the United States. None of those studies have been conducted in the ED setting in the US, to my knowledge, with both the family and the health care providers related to sudden death events. The ethnographies that were done previously in the hospital settings were foundational to this study. The data analyzed in chapters 5 and 6 will contribute to the anthropological literature in a meaningful way. Death anywhere in the hospital in the

US is considered a failure of the medical system, and the aversion to death is especially strong in the heroic setting of the ED. The stories related to the social act and the ritualistic processes of death from the viewpoint of the staff and the family members up to this point have been virtually invisible.

There is also a difference found in this research between sudden deaths and deaths where families are more prepared. When death is more anticipated, perhaps more planning can be done by the family and less by the institution where the death occurs. All of the intimate personal parts of the death story, the good-bye, the clothing that the person was wearing when they died, all of this memory work can be done more thoughtfully when there is time. In sudden deaths in the ED, the families and staff have no prior relationship with each other and have no time to create a relationship. As I have shown, the family is typically in shock and disbelief; they are separated from the dying family member abruptly and are not present at the moment of death. Isolation of the families from the dying person and the isolation of the staff both from their own feelings and from the feelings of the family create great stress for all involved.

I discovered during my research process that the normal survey process is done nationally for patient satisfaction when a patient is discharged from the hospital. However, when a patient dies there is not discharge, so a survey is not sent out. There is no data collected on patient satisfaction when a patient dies in the hospital. The family data are never collected, and unless the hospital is very diligent about collecting addresses from a family member, these data will never be collected. Some follow-up calls

may be done by the spiritual care department in some facilities, but I was collecting data that to my knowledge was never before collected in the ED setting.

Hertz (1960) concluded that in the social practice of death rituals, mourners recognize that the deceased had a role in society and that role cannot be ended in one moment. Society made an “investment” in this person and that the “collective consciousness” of acknowledging death as a community event must be recognized. The funeral practices and burial rituals were used to mourn the deceased and to transform the deceased into an ancestor. This ritual process allowed mourners to say good-bye to the soul whose journey was to another place and to end the formal mourning time for the living.

These death rituals are social processes that involved a transition for all involved. I saw this social and ritual process beginning in the ED setting in the gathering of staff and family members as they were being called to the ritual process of the sudden death event. I saw this ritual advancing through the transition of becoming socially dead with the telling of the news and the viewing of the body in the viewing room. Both the staff and the family members then crossed over the threshold into a space that they could not return from, into the land of the mourning.

Related to these ideas of Hertz, van Gennep (1960) refers to three stages that make up the “rite of passage,” namely separation, transition and incorporation (reintegration). Progressing through these times in one’s life creates a change in the status of the person. Each stage has its specific ritual activity. In death events, the person is separated from the community through death and transitions from that community.

During this transition time, or liminal time, normal rules of the social order do not apply. This is true for a sudden death event in the ED where the person transitions into becoming socially dead in the ED and during the reintegration time, all mourners' family members and staff members must enter into their new social statuses. The family must cross the threshold of the ED and re-enter into society as a mourner and the staff reintegrates back into the "normal" work day in the ED.

Victor Turner (1969) influenced by the writings of van Gennep describes the liminal period for the dying as the transition from life to death, as a threshold where the dying person and their family have crossed over and they cannot cross back. They are changed forever. This research showed that the liminal time is a time of anti-structure and creativity for all involved, professional staff, family members and the deceased where both the sense of time and boundaries are so blurred. All involved in the sudden death event are thrust into the liminal event. In the ED setting, this time of transition began with the sound of the "tweeter" for the staff and continued in this way: all who were involved families and staff gathered together in the ED for the death ritual, the transition, the person becoming socially dead in the ED, the staff delivering the bad news, the family receiving devastating news concerning the sudden death of their family member, all involved viewing the body, and family members and staff each crossing their respective thresholds to the land of mourning. This time is very short, as I saw, two-three hours. This was a time of "communitas," a time very different from the time of order in the ritual category of Moore and Myerhoff (1977). A time in the ED when normal rules of social order did not apply, when normal routines did not apply, when people came



together, leaned on each other. No one seemed to have a different or higher status from anyone else.

All people understand great loss through a culturally constructed framework. The professional staff in the ED understood the randomness of sudden death and the unpredictability, the “anti-structure” of sudden death. Turner (1969) spoke to the spontaneity of this time of *communitas* for him was charged with affects, mainly “pleasurable ones” (139) of course in this situation sudden death is not charged with pleasurable affects, but the situation is similar in its sudden happening and unpredictability. In my research context, sudden death is also a very short phase and then the family members may move to the more structured funeral rituals when they leave the hospital. However, at the moment, the family room was a sanctuary and the ritual process that went on there was an organized social process for all involved; no one was exempt from the potential, unpredictable, spontaneous happenings of sudden death.

Death in the ED can also be seen largely as a secular ritual. Secular ritual can be used according to Moore and Myerhoff (1977) to analyze organizations and events and ceremonies that take place within an organizational culture. The secular ritual process is a collective ceremony that has social meaning. This is the first study that this researcher is aware of that analyzes the secular ritual processes of both the staff and the family members involved in the sudden death event in an urban ED in the United States. To my knowledge, this is also the first auto ethnographic research done in this setting.

I was continually surprised by the organizational culture that I observed in the ED. There was no policy governing sudden death in the ED, but a secular ritual that

involved six categories that involved both the staff and family members in a rich way. The first category of *repetition* was seen in both the staff and family stories. The pattern was repeated over and over again. There was an exception made for pediatric deaths and that exception was repeated in a patterned way.

The second category of *acting* was also present in this ritual process. When I was beginning my fieldwork; I expected to see a power struggle related to social authority between the different professional groups who needed to work together, yet, what I found was a sound understanding of the roles and responsibilities of each of the professional staff members in terms of understanding their role and functioning within that role. The new role that the family members had to accept during this sudden death process appeared to be understood and accepted as much as possible.

The third category of "*Special*" *behavior or stylization* was perhaps one of the best understood and articulated by the staff, and not as clearly articulated by the family members. The staff members were identified clearly by clothing, name badges, and even guns. Yet the family members did not know who delivered the bad news to them, who prayed with them. They did remember physical attributes of the staff members, such as gender, ethnicity, age, and height. Both the family room and the viewing rooms were also marked as places where special behavior patterns took place. No one walking past those rooms when they were empty would have had any idea of the amount of pain and suffering that occurred daily in those spaces. No one would know or understand the ritual process that occurred there in those rooms or know of the people involved in the process

who tried to help all those families involved in sudden death events find meaning in that pain and suffering.

The fourth category is *order*, and this category was very important to the staff members. The staff had rules pertaining to the family and the viewing room that were in place to keep chaos to a minimum. The idea of violence was a fear in this ED and the idea of keeping order was used in an attempt to minimize fear in this setting. I observed however, that the rules were also kept in place for the order of the staff members themselves: more order, less chaos, an attempt at less stress for the staff. The more predictable the situation was, the more in control the staff felt of the situation.

The fifth category is *evocative presentation style: staging* pertained mostly to the delivery of bad news and the family member viewing the deceased person. This activity was highly controlled for many reasons. This was highly emotional activity for all concerned, staff and family members. Those data showed that viewing of the body in the ED was very important not only to the immediate family but to the friends that the family called and perhaps even to co-workers of the deceased who gathered in the ED. The family needs to be given choices and perhaps even suggestions on what is possible within the context of the viewing of the deceased member of the family. This category would also be the place where choosing how the personal items of the deceased are presented to the family would be important. The personal items were very important to the family members. Great respect should be shown with how those items are presented to the family. I would recommend a small silk bag that is kept on the unit for just his occasion,

or a special memory box. Those items could then be placed gently in the hands of the family member.

The sixth category, the *collective dimension*, is important to both the staff and the family. Death is a social event. The medical team gathered its members and the families needed to also gather their members. The beginning of the social construction of death began immediately with the idea of ritual order. If the staff understood this aspect of the ritual act and social process I wonder if the extra family members would create such stress for the staff in the ED. Just as a staff needs many support members, so does a family in crisis. Keep the waiting time short. Do not separate the family from the dying person. Let the family see the healthcare team working desperately to save the life. Gather everyone for the delivery of bad news, so that all of the family can stand together, support each other, lean on each other, if that is what they want to do. Holding each other up when their world is falling down around them and they are in shock.

Hertz's theory concerning "collective consciousness" was very evident here and the place of the person in the community was very important to both the staff and the family members. The importance of the deceased person's role in the community was brought forth in the interviews by the family members coming, friends and also coworkers coming to the ED in the sudden death events. I think that if this idea was acknowledged by all of the professional staff at the time of the sudden death event, the stress level of all involved could be lowered.

### **Contributions to Healthcare Practice**

I realized quickly that the staff wanted to be involved in this study because they thought this research was very important. They also felt that what they had to say to this researcher was very important because they as staff members were on the front lines every day with families who were experiencing sudden death events. The staff in this ED, sadly, had much experience with sudden death and considered themselves to have “lots of practice in sudden death” but still felt that they were not experts in talking to or being with family members. They also felt that this research was giving voice to the importance of their work. This importance was verbalized to me frequently. One of the reasons that the staff was so willing to be interviewed was that these staff members wanted to do more for families that had experienced a sudden death event, however the staff still would like more training do not feel that they had enough training and information to do a better job with the families, so they would avoid the families or they would stay with the families and say nothing. Some of the families are satisfied with this human presence and some of the families, as I did, could see this silence as indifference.

I now understand this dilemma so much better than I did prior to doing the research. I had limited perspective of the ED staff and their roles in sudden death before doing this study. I also realize now that there is very little research that the professional team can draw from to improve and enrich their practice. The professional staff members that volunteered to be interviewed wanted to be part of this research hoping that it would lead to an improvement in their practice.

One of the areas in healthcare to which this research can contribute is the area of education. I think that both medical and nursing education can benefit from this research and affect health care. This research could certainly help in designing curriculum for professional health care providers. The residents wanted more experience with the attending in giving bad news. Several of the residents spoke to the role modeling that they had received from the palliative care physician on staff and one physician in particular in the ICU who had role modeled excellent communication skills when delivering bad news to family members. The residents wanted more time for lectures from the palliative care team. The educators will now have evidence to talk about in their lectures that will give their residents some confidence when they are talking to the families involved in a sudden death event. All of the professional staff members can benefit from curricula relating to more information on the differences between sudden death and deaths where there can be some preparation for the family members. Health care teams can be educated on the importance of rituals and how those rituals can help family members to find meaning in the aftermath of sudden death events. Important insights were gained, and improvements can be made to healthcare practice now.

### **Limitations**

The sample size of this study is 20 staff members and 11 family members. The overall sample size was a limitation. I was able to interview two family members of one family unit. I would have liked to have interviewed more members of each family to have compared different viewpoints of multiple family members. I saw this limited number of

family members per family unit as a limitation to the study. I also would have liked to have interviewed more family units.

The family members who were approached for consent to be called for an interview were approached for consent during the sudden death event in the ED at a time when it was considered “appropriate” by the social worker. Depending on the circumstances of the sudden death event some families were never asked for consent to be included in the study. This subjective selection of families although done for reasons that everyone defined as sensitivity was a limitation to the study. I am not sure how to overcome this particular limitation.

Even with these limitations important data was gathered in this study. Important insights were gained and changes can be made to healthcare practice now.

### **Recommendations**

The family data showed some dissatisfaction with the viewing room and the staff data show more dissatisfaction with the physical set up of the viewing room. The room was very small, no chairs, and the body of the deceased was on a stretcher, which for me was not conducive for a family member to get into bed with the person. I would recommend from the data, that the room be more conducive, softer lighting, for the “viewing” which was stated in the data as being so important to the family members and whatever choice that family member made at that time.

The last recommendations are strictly for the benefit of the staff members, several of the staff stated in the interviews that they wish that they had some contact with the

family members after the sudden death event so that they knew how they families were coping. Several of the staff members wanted to institute some type of follow up phone calls. Other staff members stated that they wanted me to come back and discuss my data so that they would know how family members felt about the care that they had received in the ED. The data showed that the staff reported receiving little or no affirmation of their work.

I would recommend that ED professional staff members have regular debriefing sessions about their work with the management, and that the management spend time affirming their staff. When I entered the ED, the staff would come to talk to me to tell me about the “sudden deaths” that had occurred over the weekend or on the days that I had not been there in the ED. Some of the more experienced nurses would tell me all about the context of the death and then they would tell me about the stress that they did not have concerning the death. The younger nurses especially would talk to me about the stress that they carried home with them. They all stated that they needed to talk to other nurses about their stress. They expressed that debriefing with the social worker, although helpful, did not help as much as talking to another nurse. I observed, however, different kinds of professional staff reaching out and helping each other every day. But the data showed that the staff reported receiving little or no affirmation of their work. I assumed this lack of support was seen as lack of support from the organizational management and not from each other, but I never confirmed this assumption.

In conclusion, this secular ritual was important for the staff in this ED as it brought meaning to events that at the time appeared meaningless and chaotic. This ritual



process helped promote social interaction and teamwork. The professional staff in this organizational culture utilized a secular ritual to mark sudden death events as social acts and ritual events. The staff communicated to me when I asked the question about how sudden death was handled in the ED there that they did as much as they could that they did understand that there were limitations to the biomedical system and to technology.

This professional team approach was the best that they had to offer and they felt that this ritual did bring meaning to their work because they felt that they could make a difference to the family members. This process did bring meaning to the family members and to each of the staff members during the sudden death event and affected the social construction of the sudden death event in this ED setting.

## Chapter 9

### Epilogue

This chapter is being written following my dissertation defense. Many of my colleagues have congratulated me on my successful defense and have followed those congratulations with the question, “So are you finally done now?” My answer was as follows, “My committee has asked me to make a few changes and to write a final chapter that is reflective about the time period preparing for the defense, describing the defense and the time period following the defense”. My colleagues are surprised and their response is, “Isn’t that unusual?” “I guess” I tell them. I have never done this before. The following chapter comes from the request from my committee.

The defense process at my doctoral university is a public process, and several of the professional staff members that I had interviewed had requested that I notify them of the date of the defense. All of the family members during the family interviews had also asked me if they could have some information when the research was made public. I explained the dissertation defense process to each family and each family wanted to be notified of the date when I was defending my dissertation research.

I sent emails and invited the hospital administrators of the ED setting who had supported my research and who might be interested in attending my dissertation defense and asked them to generally notify anyone in the ED they thought might also be interested in attending.

I also called the families that I had interviewed to let them know the place and time. Making these phone calls was surprisingly just as difficult to do as the first time I

made them. This was a surprise to me. The first time I made the call I did not know the person on the other end and I was afraid on being rejected. This time I did know the person. I knew them intimately. I had to prepared myself and talk myself into it. I went into the living room and sat down on the couch and I started.

The first family member I spoke to was the grandmother whom I had interviewed. She was very happy to hear from me. She took down all of the information and told me that she was going to ask her brother to bring her; she reminded me that she did not own a car. She was also going to call her granddaughter (who I also met during the interview) to let her know that I had finished. She also told me some details about the criminal case surrounding her grandson's fatal shooting. She asked about my family and told me that she was proud of me. I could hardly speak to tell her good bye the lump in my throat was huge.

I took a deep breath and continued to dial the phone. I left a voicemail message for family number two, but I think that the number may have changed. The voice was not the voice of the family member that I remembered.

I also left a message for family number three; family number four and family number five.

Family number six, I spoke to his wife and left a message, later I spoke to the man whom I had interviewed and he said that he was concerned about parking. He had trouble walking, but he was going to come if the weather was good and he wanted to bring his brother to meet me. He stated that he was very happy to be included in the invitation.

Family number seven, I left a message, and the deceased man's wife called the next day after checking to see if she could get the day off of work. She said "I went to work and bragged about you, my nurse is going to get her PhD and she is giving a talk and she is going to talk about me and \_\_\_\_". I explained to her that I did use a direct quote from her on my PowerPoint presentation and I explained which quote it was. She told me that would be fine to use this quote in the presentation and that she told me that she needed some time to think about whether or not she could come. This widow stated that she did not know if she could go "back there". She told me a little about her life now, some changes that were going on and she asked about my family.

I spoke to family members in families 8 and 9. I briefly gave them directions and they told me they would think about coming. When I called Family number 10, she greeted me as family, told me that her daughter had just had surgery and she could not come. She wished me luck and also asked about my family and how we were doing.

Generally all of the families that I spoke to had moved emotionally from where they had been when I had interviewed them a year ago. I had interviewed all of the families close to the three months post sudden death event; they were very different even in these short phone conversations. They all said that they were doing much better. To me they did not seem to be in the time of "betwixt and between". For example, the family member who stated that she did not know if she could go "back there." I wondered was "back there" a time of confusion and chaos, a time of liminality?

The theoretical ideas I had used to analyze my data and write my dissertation seemed clearer; as I made the phone calls to the family members. Transition and

reintegration seemed to be occurring. What these family members were saying now seemed to indicate many were reestablishing themselves in their communities. They were able to be interested in my family. They had reached a time in which things were being finalized with the court systems if their loved ones had been involved in crimes. Family members seemed to be moving on with their lives in many different ways. I thought again about how much the temporal aspects appeared to matter in a sudden death event. The transition and reintegration was not clear to me in the ED as the families initially reentered into society as mourners and not clear in the case of the staff members. Even as I interviewed the family members three months later, the shock and disbelief was still very much apparent on their faces. I was struck by how much things had changed now in the current conversations.

In getting ready for my dissertation defense, I began to worry a little about talking about my research participants with their loved ones in the room. I did not want to seem technical or insensitive about a very intimate event in their life. I was analyzing data, data which were not data to them, but was instead personal intimate details of a life changing event. What if they were not ready for this public display of their lives? What if this presentation offended them? I wasn't sleeping. I looked at my quotes again, not from the eyes of a researcher but now from the eyes of a family member. I adjusted one of the quotes. I took out something that I thought could be perceived as too personal to share in a group and did not affect my analysis. I relaxed a little. The day came.

My friends and family from Pittsburgh were also beginning to arrive for the big event. My sister from Anchorage returned to support me. Many of our friends who were

with my family the night that Jessica died were there, and several of my colleagues from where I teach also came. We made lunch reservations for thirty five people. It was a social act, a ritual event, a rite of passage.

I was surprisingly relaxed. I had prepped my own family members about who might be there. I asked everyone to be on their best behavior. I wanted everything and everyone to be perfect. The weather was very rainy that morning and only one research family member came. The family members who were research participants knew that I could not introduce them as such. If they wanted others to know who they were they would have to let me know and give me permission to identify them. They had been told this on the phone ahead of time. I did my presentation and I held my breath waiting for the questions.

Most of the questions were actually statements regarding implications for future research. One question was from a faculty member who asked me to reflect on the difference between individual (at the level of family) and social (broadly community) aspects of the ritual process in the ED setting. The second part of the question was for me to think about the difference between routine and ritual on the part of the hospital staff. At the time, I did not really answer the question, and later thought about it and went back to the specific faculty member to talk about it. I realize now that the reflection time spent on the questions asked is a very important part of the defense process and that someone should be writing down the questions that the presenter receives for further reflection at a later time.

The questions ended and I left that room with my committee to discuss what would happen next in the process. One of my committee member expressed that I had done a “magnificent” job. I relaxed. We went into a conference room closed the door and began. Each member of the committee gave their response to reading my dissertation and hearing my presentation. One member gave me a sealed envelope and he told me that the envelope contained nine pages of single spaced comments. Some comments for incorporation into my dissertation now and some comments were for work at a later date.

Overall, I found the comments very supportive and encouraging. I was amazed with the amount of time that all of my committee members had put into reading and commenting on my writing. They had all invested so much time in guiding me through this process, especially the chair. The chair of the committee asked me to leave the room and later asked me back. We walked down the hall and my advisor introduced me to the group as Dr. Mitsch....we proceeded with the ritual, champagne, cake, photos, and toasts. I was in shock and disbelief. I still do not think it has all sunk in.

I asked the family member from my research who was present if she would like to be introduced to the group. She stated that she would like that. I introduced her and her friend and they left with my family for the restaurant for lunch. I hung back at the university to say good bye and to thank some of the people not able to go to lunch. I asked my family to make sure the family member who came and her friend had two seats directly opposite them saved for my husband and me. I did not want them sitting with strangers.

There was a bittersweet quality to the celebration that afternoon and no one knew it better than the four of us sitting across from each other at that table. We were thinking and talking of the sudden death events that brought our lives together and the people that were involved in those events. She was clearly going “back there”, taking me “back there” in my own personal situation and then coming forward to today talking about what was going on now in her life. As a social scientist I thought to myself, clearly I was watching integration now as I had watched integration evolve in my own family over time. Although van Gennep writes about his theory in a linear way, I would suggest that it is not linear. I will be thinking and writing about this topic more going forward.

I am beginning to understand when people tell me that they do not know if they can go “back there”, back to the day and time of the sudden death event. I think that this is how van Gennep’s theory fits into sudden death. Integration evolves over time. Soon, the death event is not a particular event, but it becomes so integrated that it becomes part of you, eventually becomes smaller and smaller something that you do not have to go “back to”. And, if you do go back to that space in time, it does not contain the same suffering and power over you that it once had. You have been through the pain and suffering, you have somehow survived the unthinkable. This process is true integration. In sudden death, I have read about, researched and experienced how this phenomenon is very different than in a more prepared death. Integration following sudden death takes more time, all of the integration occurs after the death. In a more prepared death, some of the integration may begin with the preparation for the death. The family may begin to



think about what life might be without this particular family member; in sudden death there is no preparation.

This dissertation research assisted me in the integration process. I had to continually go “back there” as I wrote about sudden death events and interviewed family members and professional healthcare staff. The entire process was always bittersweet. My writing was richer because I had had this very tragic experience that had opened my heart in a way that I never thought possible. I had a deeper understanding of suffering because of my personal journey.

There were also times when I thought that the data were too personal to analyze with a theory, that if I was listening to intimate personal stories and then placing them into a theory that I was somehow betraying the confidence that someone had placed in me to treat this story with the utmost respect. It felt intrusive and sometimes even contrived. This could be a limitation of auto ethnography. It could also be the most meaningful part of auto ethnography. The benefit of auto ethnography that Ellis and Bochner write about where the author and the reader both learn and create meaning through reading about the lived experience of the auto ethnographer.

I also think that a researcher needs to move away from her ethnography, to have time to reflect on not only the questions about where theory fits with the ethnographic data but where the theory does not fit. I think that this process takes not only time but that there needs to be distance between the researcher and the data. I think this aspect is especially true in the case of auto ethnography because the researcher is connected to the data in such a personal way. I think having the renewed social contact on the phone with

several of my research families gave me this new understanding. I gained even more of an understanding from the family member who actually attended my defense. I did not learn all there is to know during my dissertation research; I only started the thinking process. This is one step for me on what I consider will be a lifelong journey in this area of research.

I end this dissertation now with returning to the theoretical framework from Hertz. His theory is one that considers the body, soul and the living involved with the death event. This theory then considers all involved in the sudden death event in the ED, and the individual meaning involved at the level of the family, social meaning of the ritual process more broadly involving the professional staff, and the meaning to the larger social community. Hertz pointed out that death rituals were social in nature and were performed to reorganize social order that became disorganized through death of a person who had a role in that community. I would argue that his theory is particularly important to consider in sudden death because sudden death appears so random and tragic that the social order is particularly threatened, as was seen over and over again in the data that were presented in the preceding findings chapters. The social order was unexpectedly and suddenly changed. The rituals were important to the social group to give meaning to the event and to give time for the social group to give support to each other. The ritual processes following sudden death in the ED helped me to see how survivors know that they will survive, the deceased person's role in society will eventually be replaced, and that society as a whole will continue to exist. The permanence of social order is very important in the aftermath of the sudden death event.

The unexpectedness of sudden death is particularly tragic to the survivors as the social meaning of randomness is emphasized. Hertz also writes about timing of the rituals that occur at the moment of death and then a final burial later following an intermediary time.

I would draw a parallel to sudden death in the ED here relating the family getting the bad news in the family room and then viewing the body in the viewing room in the ED as the beginning ritual. All of the family members and many of the staff members interviewed stated that this initial step was a very important part of the ritual process. The family then leaves the ED as mourners and enters into the intermediary time that Hertz talks about. The family then decided on a final resting place for their family member. The final burial then would take place when the body was buried later in its final resting place. In Hertz's theory, the body, after being buried in the final burial place, takes its place in its permanent position in the next world, society is restored and grieving ends. In our culture, the family then moves into a period of personal grief work that is culturally appropriate for them. Society moves on.

I began this dissertation research with this statement "This is the story of how I learned about death as a social act and a ritual process", and I have learned so much more. Now, as a social scientist, I have a different charge. I have lived through the study as a social act and a ritual process as a mother and more generally as a mourner and a researcher. Death in the ED as I discovered was socially made and I also saw this ED as part of larger society. I first responded as an auto ethnographer. Then my thinking began

to change as I reflected further less “about” my ethnography and more theoretically “with” my ethnography.

This research demonstrated the contextual piece of how death is constructed in the social setting of the ED: the stages of how the people, both staff and family gather together for the death ritual, the transition of becoming dead in the ED, the telling of the news, the viewing of the body and leaving as mourners and reentering society to contribute to that society through their roles and their new status as mourners.

I gained an understanding of this individual and collective community event in the social setting of the ED. I felt that I was able to give “voice” to a vulnerable group of people that perhaps would not be asked to tell their story. This was difficult research to conduct and to complete. The following is an email sent to me by one of my committee members following a meeting after my defense which prompted my thinking in this direction:

After my own dissertation defense, my committee co-chair said to me that people were asking me questions about theory and I kept "retreating" to ethnography in my responses. I told Sherri that at times, our meeting yesterday reminded me of this.

First, it is to encourage you to think about the questions that I put to you in my lengthy feedback in a certain way: not just as questions about "what happens with your research participants in this ED" but rather, as questions about the theory also. The goal is partly to use ethnography to address questions raised by theory, but also, to use ethnography to raise new questions about theory, and to further a dialogue between theory and ethnography. That's part of what I meant when I said you don't have to just "apply" theory in a mechanical way where it seems to fit, nor just leave theory aside where it doesn't seem to fit; you can talk about the ways they do and don't fit. Second, the point is that as scholars, we are embarked upon a continual, even lifelong process of intellectual growth, and our sense of the broader implications and deeper meaning of our own project -- that is, of how the ethnography relates to theory -- takes time to develop. I thought I had some pretty good theoretical stuff worked out when I defended my dissertation, but of

course I was very close to the ethnographic material I had been immersed in for the past several years and most comfortable talking about it, maybe sometimes not seeing the forest for the trees. Only later, after some years of further writing and thinking, did I gain a fuller sense of what people were asking me and how I might answer. You will be taking another step in developing some reflections over the next couple of weeks; I was encouraged and delighted to hear you say that all of the questions I raised in my feedback were things you were already thinking about. I am looking forward to reading your further reflections. (Email communication B. Lyons)

This “moving away” from my own ethnographic experience is a very important element in the academic ritual; it is important somehow to have an etic view of the data.

It is hard for me to move from my auto ethnographic approach, but it was also very important mainly because I had utilized traditional methods of analytic ethnography. I had a revelation soon after my defense while talking to a colleague. She was saying how important it was to teach our nursing students to talk to patients about dying. I realized, as a nurse, that of course it was important to talk to nurses about patients who would die. But, that as a social scientist it was important to talk to nursing students and patients about more than the physical aspects of dying, including sudden death. There was much more to teach them. It was also very important to teach healthcare workers about the context of the social construction of death. Practitioners needed to understand how people become socially dead in many different kinds of healthcare settings. All clinicians needed to understand that death was a social act and a ritual process in order to deliver high quality health care. All clinicians need to hear about the process of gathering for the death ritual, transitioning into becoming socially dead and reentering society as mourners.

I believe the ritual process that I observed was a social response to the need for the professional staff to make meaning in this ED setting and to assist family members to in meaning making activities. This research provided me with the chance to see how, for all involved in the randomness of sudden death events, there is the opportunity to understand the larger social meaning of death and dying events. This is the immediate contribution that this research has to offer healthcare practice.

I conclude for now. I have memories of all of my transcripts being spread over my family room floor and how long it took me to organize those data into coded themes and charts on the computer. I will be back there again sorting for the next projects. I need to rest, renew, reflect and then begin again. There is much to be done.

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**Abstract****A RITUAL INVESTIGATION OF SUDDEN DEATH EVENTS IN AN URBAN  
EMERGENCY DEPARTMENT CONTEXT**

By

**Mary Eleanor Mitsch****May 2012****Advisor:** Dr. Sherylyn Briller**Major:** Anthropology**Degree:** Doctor of Philosophy

This study investigated sudden death as a social act and a ritual process (Hertz, 1960) in an urban hospital emergency department (ED) in the United States. An analytical auto ethnographic approach was utilized by the author who is a nurse-anthropologist and a bereaved parent. In sudden and a more “prepared for” death, the dying person goes through a *rite of passage* van Gennep (1960[1909]) and enters into an area of *liminality* Turner (1967). A key transition from life to death occurs and crossing a threshold where the dying person cannot cross back.

The aims of the study were to: 1) Identify and describe the meaning of social rituals to families and healthcare staff involved in sudden death events, 2) Discover the organizational culture and power structure involved with the formal and informal rituals

in a sudden death and 3) Analyze the data collected regarding the social rituals and organizational culture in sudden events in an urban ED in the U.S. to contribute to the anthropological literature on death and dying and ritual processes.

In a yearlong ethnographic study, these research activities were conducted: 1) extensive participation observation in the ED setting, 2) twenty in-depth face-to-face interviews with staff members who worked with families experiencing sudden death events and 3) ten in-depth face-to-face interviews with eleven family members who experienced a sudden death event. All interviews were audio taped, transcribed and analyzed for themes.

Findings included identification of ritualized activity by hospital staff in sudden death events despite the lack of official policy in this area. Staff and families' stories about the ritual process as the sudden death event progressed in the ED were analyzed in terms of six key properties of secular rituals (Moore & Myerhoff, 1997). The stages of the ritual process analyzed in detail included gathering in the ED and coming together for the death ritual, the transitional social time of becoming dead in the ED, leaving the ED and re-entering society as a mourner and final rituals.

It was concluded that the ritual process overall gave structure and meaning to staff and families involved in sudden death events.

## **AUTOBIOGRAPHICAL STATEMENT**

Ms. Mary Eleanor Mitsch is a Ph.D. candidate in the Department of Anthropology at Wayne State University in Detroit, Michigan. She received her Master's of Science in Nursing from the University of Pittsburgh in Pennsylvania and her Bachelor's of Science Nursing from Villa Maria College in Erie, Pennsylvania. She has over 30 years of nursing experience, and is currently teaching nursing at a university in southeast Michigan. Following the fatal car accident of her 24 year old daughter Jessica she developed a passionate interest in the area of sudden death research. Ms. Mitsch presents nationally on issues related to sudden death. She resides in Michigan with her husband and two adult sons.