

**After Body Donation for
Medical Education:
Identifying Good Practice in
the Interactions Between
Medical School Anatomy Unit
Staff and Families After
Donor Death.**

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Abstract

In this thesis I offer an account of the work that Medical School Anatomy Unit staff (AUS) do with the families of body donors in the UK after donor death. Body donation (BD) is the voluntary donation of the body after death for the purposes of medical education. Many still hold the unshakable conviction that body donors are integral learning tools for teaching anatomy. In this thesis I identify that much hidden family liaison (FL) work happens at the point of refusal and after acceptance. FL work at the initial phone call stage, where families or executors informed the AUS of a potential donor's death, was unexpectedly extensive due to the number of bodies which were refused. After acceptance FL work was a result of the families continued contacts, sending in items, special requests, and those issues which required mediation from AUS. In addition to this FL caused by the families of donors, the AUS also caused themselves extra work unintentionally and intentionally. I also discovered that there were several strategies to limit interactions and encourage closure to limit such FL work and bring this to an end. Although much FL work occurs there is very little recognition, support or training for such work; thus, deeming this work hidden. Thus, in this thesis I demonstrate that AUS have an indispensable, hidden and undervalued role in the smooth running of the BD process and I make practice recommendations related to this FL work.

For those hidden workers who go 'over and above'

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Author's Declaration

I confirm that this work is original and that if any passage(s) or diagram(s) have been copied from academic papers, books, the internet or any other sources these are clearly identified by the use of quotation marks and the reference(s) is fully cited. I certify that, other than where indicated, this is my own work and does not breach the regulations of HYMS, the University of Hull or the University of York regarding plagiarism or academic conduct in examinations. I have read the HYMS Code of Practice on Academic Misconduct, and state that this piece of work is my own and does not contain any unacknowledged work from any other sources. I confirm that any participant information obtained to produce this piece of work has been appropriately anonymised.

CHAPTER 1: INTRODUCTION

In this thesis I offer an account of the work that Medical School Anatomy Unit staff (AUS) do with the families of body donors in the UK following acceptance. Body donation (BD) or anatomical bequeathal is the voluntary donation of the body after death for the purposes of medical education. This is where medical students dissect the cadaver to learn gross anatomy. Medical professionals, such as surgeons, may also use such cadavers to practise surgical procedures, for example a hip replacement. This is very different to body donation for research (general), organ donation (live and deceased), and live blood donation. In this introductory chapter I first outline the rationale for this thesis, including a discussion of the importance of studying the work of AUS. I then provide context for this thesis, including an outline of the history and governance of bodies procured for medical education, and ways of dealing with the dead today. In this, I outline the process of BD today and the 'normal' timeline of routine work for the AUS. I then present the aim of this thesis and outline the subsequent chapters.

1.1 RATIONALE

Much is known of the work that AUS do with students, for example when introducing them to anatomical dissection, including a focus on the management of students' emotions and developing professionalism (and clinical detachment) when dealing with the specimens (Black, 2018; Goss, Viswanathan and DeLisser, 2019; Hildebrandt, 2010; Prentice, 2013). What is missing, however, is attention to their work with the families of donors after donor death and the role this work plays in ensuring the BD process continues. It is important to understand this because many still hold the unshakable conviction that BD is an essential part of teaching anatomy (Black, 2018). It is imperative that BD is a positive experience for the families of donors and that they are provided with the correct information and support. This is because the families are the ones who make the

phone call on death and facilitate the process and may go on to donate their own bodies, as BD runs in families (Bolt et al., 2010; Richardson and Hurwitz, 1995). While some recent inquiries have been carried out into BD and the bequeathal process, they have focused primarily on the exploration of body donor monuments and thanksgiving services (Bolt, 2012; Strkalj and Pather, 2017). It has been asserted that these monuments and services are a useful means of responding to the gift that donors made to the medical school anatomy unit (AU), and are a way of giving back to the donors' loved ones (Bolt, 2012). What is missing from the literature, however, is any attention to the family liaison (FL) work of AUS. Thus, in this thesis I examine the extent and nature of AUS FL work in the period following donation.

1.2 BACKGROUND

Now that I have explained the rationale for this thesis it is useful to outline the history and governance of bodies procured for medical education, and ways of dealing with the dead body today (2019). A complete historical treatise on the procurement of bodies for anatomical dissection is beyond the remit of this thesis. However, I provide here an outline which gives context for BD today (2019), and how this is facilitated and managed. For a fuller account, see Richardson (1988), Laqueur (2015) and Tarlow (2011). This helps to put this thesis into context as there has been a shift from 2004 where bodies are now voluntarily donated to AUs for the purposes of medical education.

1.2.1 A Brief History of Procuring Bodies for Anatomical Dissection

Laqueur (2015) illustrated a cultural centring of the *Proper* funeral and a marginalisation of the *pauper* funeral in early modern Britain (from

the 16th to the 18th century). This process is concerned with putting the body, or more importantly the person, in their social place in death as they were in life. This is the key premise which allows us to understand where BD for medical education and anatomical dissection sits within the Proper-to-pauper spectrum of disposing bodies. Historically, the dissected body is placed nearer the pauper end of the spectrum as dissection is seen as a punishment and something to be avoided. Laqueur (2015: 313) termed dissection an “antifuneral”. From this we can understand the social positioning of those bodies procured for anatomical dissection in early modern Britain. Bodies for anatomical dissection were conceptualised negatively, for example, they were considered “soulless” (Tarlow, 2011: 59) and the majority were criminals who were procured through official and unofficial means (*ibid.*: 61). One such unofficial means was the act of “burking”, a verb referencing the 19th Century ‘Burke and Hare’ murders committed for anatomical and financial benefit, which began in 1828, where people were murdered to give to the anatomical facilities (*ibid.*). Around the same time there was also theft from hospital morgues and grave robbing (*ibid.*). Tarlow described that the role of the anatomist and executioner were often confused, which further illustrates the social positioning of those dissected bodies. Tarlow (2011) asserts; “[t]o be an anatomist was to have total knowledge and thus total control, but to be the dissected subject of anatomy was to be fully exposed, to relinquish all secrets and all privacy.” (*ibid.*: 62). This demonstrates the pauper and negative status that the dissected had.

People in this early modern British society were terrified of being taken for anatomical dissection after death. The grave was considered to be “[...] “a fine and private place”, but anatomists intruded upon that privacy and threatened the continence and integrity of the body.” (Tarlow, 2011: 62). It is the intimate internal examination and the act of dissection that horrified people because many believed this would disrupt one’s appearance and passage to the afterlife. Individuals

actively protected their dead by erecting iron cages called “mortsafes” around newly buried coffins for example (Humphries, 2014). This again indicated the social position and pauper status of the dead that were taken for dissection as those who could afford to erect such extravagant measures were protected somewhat. The anatomist, as well as anatomical dissection, was something to be feared and was the fate of the poor, forgotten and criminals.

1.2.2 Governing Body Donation and Procurement for Anatomical Dissection

The criminal and publicly repugnant practices and public disrepute related to anatomical dissection led to the development of legislation to govern the procurement of bodies for these purposes. First, the Act for Better Preventing the Horrid Crime of Murder 1751, colloquially known as the Murder Act 1751, was put in place not specifically for the protection of bodies used for anatomical dissection, but more generally to deter people from committing crime. At this time even minor crimes such as theft were liable to a capital sentence. This speaks to Laqueur’s (2015) premise that the dead retain the social positioning they did in life. Tarlow (2011: 68) substantiates this claim by illustrating the public belief that “no murderer should be allowed a decent Christian burial.” Thus, the individual should be horrified enough at this prospect to not commit the crime. However, the Murder Act 1751 was not adequate as it was not specific to controlling bodies used for anatomical dissection. Therefore, The Anatomy Act 1832, also known as the Act for Regulating Schools of Anatomy 1832, was introduced. It “[...] recognise[d] the social and scientific necessity of anatomical dissection; its aim was to regularise the supply of bodies and put an end to the activities of grave robbers and remove the incentive of burking.” (Tarlow, 2011: 68).

Following a series of human tissue scandals and reports of mistreatment of human remains, including the well documented case at Alder Hey Children's Hospital in Liverpool, where organs and tissues were removed and withheld without the consent of the parents of the children, the Human Tissue Act 2004 was introduced to better govern the protection, use, and display of human tissue in England, Northern Ireland and Wales. Thus, people now sign up, before death, to donate their body for medical education. I will outline this process further in section 1.3. It must be iterated here that human remains cannot be owned. This causes much controversy around how human remains are dealt with, including processes of gaining consent, disposal and repatriation.

The Human Tissue Act 2004 simultaneously established the Human Tissue Authority (HTA) in 2005. The HTA's role and position is to "regulate organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public." (HTA, 2019b). The organisations dealing with human tissue under licence and public interests are central to the HTA's work, which is unique in bringing together these parties. Applying these premises to the BD context the AU and the donors and their family are at the centre of what the HTA do.

An integral part of governing and assessing the storage and use of human tissues are the HTA AU inspection reports that are completed at AUs in England, Wales and Northern Ireland. These reports focus on four main areas: the procurement, storage and use, display and disposal of human tissue. These HTA AU inspection reports will be analysed, in this thesis, to elucidate the statutory expectation of the work of AUS. The four-fold focus of the HTA AU inspection reports does not explicitly include FL, thus implying that FL does not form a central statutory concern for the HTA. However, it is clear from other sources that staff have contact with families during thanksgiving

services and at body donor monument ceremonies (Bolt, 2012; Strkalj and Pather, 2017). In this thesis I aim to understand the extent, nature and form of FL, and to what extent it is integral to the BD process in England, Northern Ireland and Wales.

1.2.3 Dealing with The Dead Today (Typical)

I will now outline the *typical* ways in which the dead are dealt with today (2019) in England, Northern Ireland and Wales to situate BD amongst those ways in which the dead are disposed. I move away from the historical perspectives presented in section 1.2.1 and focus on the popular disposal methods today. *Normal* and *typical* will be used in this section to convey how people in England, Wales and Northern Ireland most commonly deal with their dead today; of course, there will be outliers, and body donors are among these.

The *normal* post death process is considered to be a funeral service (religious or non-religious) around the time of death (normally within one to two weeks depending on religious and cultural affiliations). The funeral service will likely be held in a church or other religious building, crematorium or in some cases at a natural burial ground. Family and friends will attend the service. There will sometimes be a gathering after the service which can be formal or informal. In England and Wales, cremation prevails as the most common method in dealing with the dead (Laqueur, 2015). The ashes are either interred in the crematorium or they are taken by the family to scatter where they wish. In Northern Ireland a wake, where the dead remains within the house for a short period of time, is commonly held immediately after death and followed thereafter by burial of the body.

It is important to note that people in England, Northern Ireland and Wales are considered to have a necrophobic attitude, where the disposal of the body is viewed as an essential means of removing the dead from the realms of the living. Aries (1981) and Baudrillard (1993) describe the place of death in an industrialised West where a medicalised 'good death' is strived for. This has led to the dead being *hidden* in a quiet, controlled and private domain where death is *forbidden* (Aries, 1974) and *shameful* (Kellehear, 2008), marked by covertness and medicalisation, removing death from the public domain. The medicalisation of death and dying thus affects where the individual dies as most people now die in hospital or hospice care (Walter, 1996, 1999, 2009). This attitude has emerged through a fear of the dead transmitting illness and disease. For example, bodies were often buried outside of city walls in the 19th century (Laqueur, 2015). This necrophobic attitude may factor in an individual's choice to donate their body as they must consider the beliefs of their family. This could result in their wishes to donate not being discussed before death, or the family not facilitating the donation if they do not agree with their choice.

1.2.4 Body Donation Today (Atypical)

I previously demonstrated that in the 16th to 18th centuries dissected bodies were those of the poor, the forgotten and the criminal (Tarlow, 2011). Dissection and exhumation were deemed an antifuneral by Laqueur (2015), which is the conceptual antithesis to the *normal* funeral many individuals have. In 2019, BD for medical education still bears the same antifuneral and atypical connotations. Historically, this may be due to the removal of choice, as the funeral is chosen and the antifuneral is imposed upon the individual. However, with the introduction of the Human Tissue Act 2004, alongside the secularisation of society, perceptions of BD for anatomical dissection have gradually become more positive and people now voluntarily

donate their body. Therefore, because people voluntarily donate, it might best be seen as an alternative rather than an antifuneral in our modern age of dealing with the dead.

In this thesis I explore the proportion of the population donating their bodies for anatomical dissection per year in England, Northern Ireland and Wales as this is not known. Through this I am able to assert whether this is indeed an atypical post-death option in 2019 in England, Northern Ireland and Wales.

Historically, as I have already discussed above, dissection disrupted the transformative rite of passage of a funeral. This still holds true for BD today as the normal post-death process is disrupted. This is due to the delay in the disposal of the body for up to three years. Black (2018: 17) refers to this as a “[...] lack of the normal ritual of a funeral [...]”. Following the same line of thought, Bolt (2012), asserted that anatomical professionals give body donor monuments as a gift as a way of making up for this disruption. In this thesis I explore if and how gift relationships inform the AUS’s work.

1.2.4.1 The Body Donation Process

I have already outlined that BD is the voluntary donation of the body after death for the purposes of medical education. This section will outline the BD process for medical education today in England, Northern Ireland and Wales under the Human Tissue Act 2004.

First, the potential donor must request the consent and information forms from their local AU. AUs have catchment areas from which they accept bodies. Prospective donors can find their nearest AU on the HTA website by entering their postcode. In some rare circumstances the donor may go to another AU, but it is likely that they will still complete the consent forms for their local one. The forms can be

requested via email, telephone call when speaking to an AUS member, most likely the bequeathal secretary (BS) or mortuary manager (MM), or at some universities they can be downloaded electronically directly from their website. The potential donor will then read through the information sheet and sign the consent forms in the presence of a witness who will also sign to say they have witnessed the prospective donor signing them. The form is then returned to the AU and a physical copy is stored securely and the potential donor's details may also be kept electronically. These details are retained until the AU is informed of the death of the potential donor. If the potential donor would like to change any details, for example a change of address, they can contact the AU. Some individuals, if they have completed the forms a long time ago, may also contact the AU to complete the most updated version of the consent forms if they wish.

I have described the process of signing up and the AUS's role in facilitating the sign up. Now I will outline the BD process after the individual has signed up and then died. I have visually represented this process below in figure 1 indicating generally what happens at AUs in England, Northern Ireland and Wales. Alongside this I will deliberate the AUS's role in this process and highlight the points of contact throughout the process. I refer to this as the 'normal' timeline of routine AUS work.

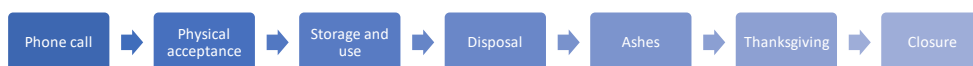


Figure 1: Flow chart showing the stages involved in the BD process after death

First, the phone call informing the AU of the death of the potential donor is received by the AUS. At this point the AUS make the decision

whether the body can be accepted. There are criteria for acceptance which are based on safety and the need for bodies to be anatomically 'normal' for teaching. The main reasons for non-acceptance are if: a Coroner's post-mortem is necessary; there is a severe infection, such as tuberculosis, HIV, MRSA, or hepatitis; an individual dies abroad; an individual has Alzheimer's disease or dementia of an unknown cause; an individual has bed sores, varicose ulcers or oedema; an individual has a wound that has not healed; an individual has severe peripheral vascular disease; or if an individual is obese. If the body is accepted it is transferred to the AU and typically kept for up to three years and parts of the body may be kept indefinitely if the donor has consented to this; this forms the storage and use stage. During this stage the body is most commonly embalmed or preserved through another method. Other methods of preservation include fresh freezing which is considered the most life-like method of preserving a body. This is where the body is frozen to be thawed out when needed for teaching. This method is usually used for short courses or for surgeons to practise techniques. Bodies preserved by freezing are ready for disposal sooner than other preservation techniques. Another common preservation method is the Thiel method, developed by Walter Thiel in 1992, which is a soft-fix embalming method which preserves the body in a realistic way (Ottone et al., 2016). This is often used for postgraduate taught courses.

After the period of dissection, a committal service is held, and the donor's remains are disposed of by cremation or burial. At most medical schools, families and friends, and in some instances staff, attend the committal service. This service is held at a local crematorium or natural burial ground and is paid for by the university. The ashes are then collected or delivered to the donors' identified next-of-kin if they have asked for the ashes to be returned. Ashes may be collected from the AU or from the relevant crematorium/natural burial facility depending on the AU.

Some AUs, but not all, will then hold a thanksgiving service to which the donors' families, friends, students and staff attend. Some schools also have physical memorials such as plaques, benches, books of remembrance, or dedicated plots at a local cemetery or natural burial ground. The AUS will then try to close the relationship with the family.

1.2.4.2 The 'Normal' Timeline of Routine Work

The magnitude of the work that AUS do with families throughout this BD process can thus be visually represented (see figure 2) alongside the BD process represented in the staged flow chart. This is an estimation. In this thesis I explore the reality of the FL work after donor death from the phone call stage.

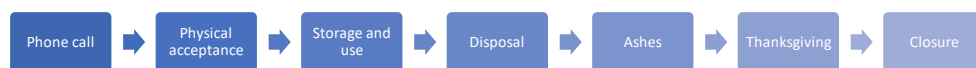
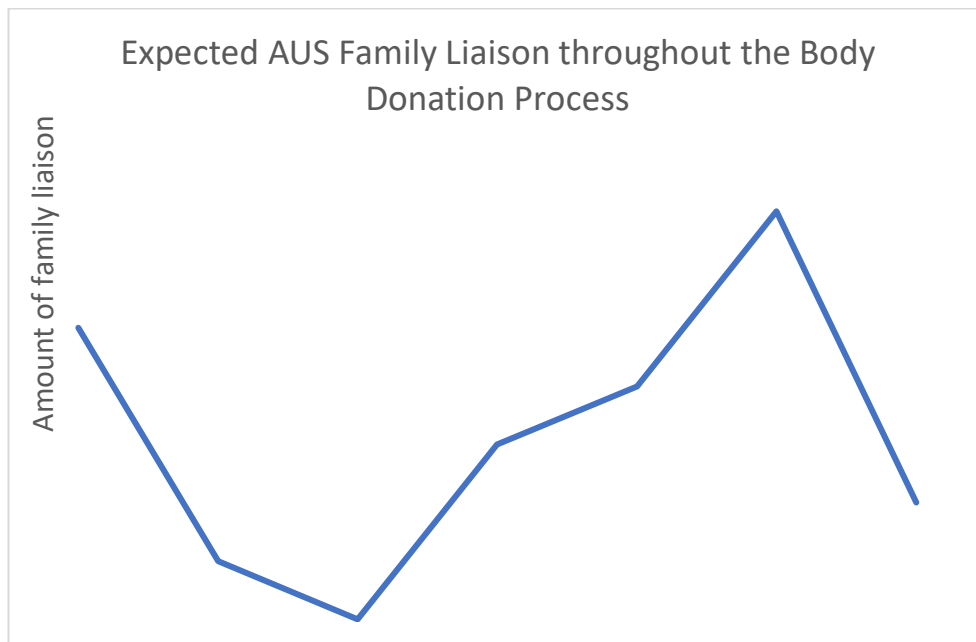


Figure 2: Flow chart and visual representation of the expected amount of FL AUS do throughout the BD process

The line visually represents the peaks and falls in the amount of FL that is expected to take place during the corresponding stages throughout the BD process. There is an initial peak in FL when the family member or person that has cared for the individual at the end of their life calls the unit to inform them that their loved one has passed away. The stages of physically accepting the body, which takes up to five days, and the storage and use of the body, typically up to three years, are considered to be the stages in which the least FL happens. Then there is a gradual increase in the expected FL from when the body is ready for disposal, usually after three years of the body being within the unit, through the collection and delivery of ashes, reaching a high at the thanksgiving stage. Strkalj and Pather (2017) and Bolt (2012) have demonstrated that FL work is completed around thanksgiving services and body donor monuments. The process then

comes to a natural closure point. In this thesis I evaluate how accurate an estimation this trajectory is in practice.

1.3 RESEARCH AIM

In this chapter I considered the historical context of procuring bodies for anatomical dissection and its governance. I examined typical ways of dealing with the body today and placed BD for medical education as an atypical, or rather alternative, post-death option. I outlined the process of BD which has been informed by its governing body, the HTA, since 2005. I positioned the AUS within this process as facilitators and outlined the 'normal' timeline of routine work that is expected to run alongside the seven stages of the BD process. In this thesis I aim to elucidate the work of the AUS in this process from the phone call stage. Thus, my overall research aim is:

To identify good practice in the interactions between UK Medical School Anatomy Unit staff and the families of body donors after donor death.

From this, support and training can be developed for AUS who interact with family members following donation. In the following chapter I will explore literature around three key aspects post-BD (the donor's family, the AUS and the AU) to generate research questions to be answered in chapters four, five and six to achieve this research aim. Now that the rationale and background to this thesis has been clarified I next provide an outline of the thesis before moving on to reviewing the literature in chapter two.

1.4 OUTLINE OF THESIS

In this chapter I have outlined the rationale and background for this thesis by positioning BD for medical education within its historical context, exploring its governance and outlining the process. I have also deliberated why I am researching AUS to achieve the aim of identifying good practice in the interactions between AUS and the families of donors from the point of acceptance.

Next, chapter two, considers the major theoretical issues that arise when thinking about the two main groups of people in this thesis (the donor's family and the AUS) along with the setting of BD (the AU). The main theories that underpin this thesis are: *emotional labour (EL)*, drawing on from Hochschild's (1983) coining of the term; *gift exchange* and gift relationships, drawing from Mauss (1990) and Bolt's (2012) study of the giving of monuments by anatomists as a reciprocation of the gift of BD; and theories of coping with bereavement, including traditional stage theories (Bowlby and Parkes, 1970; Kübler-Ross, 2009; Worden, 2009), *continuing bonds* (Klass, Silverman and Nickman, 1996) and *meaning making* (Neimeyer, 1998, 1999, 2001). From this point forward these theories will be italicised to emphasise their importance and signify when I refer to the theory. I will draw upon these theoretical frameworks throughout this thesis and extend upon them to develop knowledge of the AUS's FL work. This chapter will illuminate the research questions required to achieve the research aim.

A methodological discussion of researching the work of AUS follows in chapter three. To identify good practice in the interactions between AUS and the families of donors I researched the work of the AUS from their perspective. I describe the empirical data collected through an ethnographic multi-method approach, including document analysis, a national survey of UK AUs, an ethnographic case study of one UK AU,

semi-structured interviews with AUS, and participant observations of AUS at thanksgiving services.

The next three thematic chapters (four, five and six) will present, analyse and discuss the empirical data grouped into the key emergent themes in order to address the research questions posed in this chapter.

Although this thesis primarily focusses on identifying good practice in the interactions between AUS and families from the point of acceptance, non-acceptance at the phone call stage emerged as a key theme which made for much work, FL and *EL*, for the AUS at this early point. Chapter four then addresses research questions one, two and three. I will discuss the extent of bodies that are not accepted and the subsequent effect this has on the work that the AUS do.

Chapter five considers the period of time following acceptance and the FL work that AUS undertook during that time. It aims to elucidate who has contact with donor's families (research question (RQ) 2), the extent, nature and form of these contacts (RQ 1), and when these occur (RQ 3). I will highlight points of disruption of the 'normal' timeline of routine work to problematise this seemingly straightforward process. I will also aim to understand how FL is brought to an end if at all (RQ 5).

Chapter six will address the recognition, support and training that AUS receive in order to do their FL work (RQ 4).

From the thematic analysis of the empirical data, I will then make best practice recommendations (BPRs) with the aim of targeting the AUS's training and support needs. This will form part of the concluding chapter. I will also address the thesis' contribution to knowledge and offer reflections on *EL* and the gift relationships in BD. I will finally

discuss the limitations of the study and opportunities for further research.

CHAPTER 2: LITERATURE REVIEW

Having discussed the rationale, background and research aim for this thesis in chapter one, in this chapter I will critically review the literature with regard to the interactions between families of donors, the AUS and the AUs. Firstly, the process the family goes through post-death will be outlined and applied to the post-donation context. Secondly, attention will be paid to the theoretical underpinnings of the work of the AUS as they are identified as playing a key role in the post-donation process. Thirdly, theoretical underpinnings of the space and place in which AUS work is completed (the AU) will be deliberated.

2.1 THE DONOR'S FAMILY

The disruption caused by body donation (BD) to the typical post-death processes, as described in chapter one, namely the funeral, cremation and memorialisation, may also extend to a disruption of the processes of coping with bereavement. In this section I will outline the typical processes in which bereavement is dealt with within a 'normal' post-death context for families of those who have not donated their body for medical education to explore whether these are applicable in the BD context. I first pay attention to those traditional perspectives on coping with bereavement, where the eventual goal is to let go of the bond with the deceased. Second, in contrast to these traditional stage perspectives, I re-interpret *continuing bonds*, which prevails today, where families hold on while letting go. These perspectives lay the groundwork for understanding such processes in donor families and thus the FL work that the AUS do in response to this. I now turn my attention to the first of these two areas for exploration: traditional perspectives on coping with bereavement.

2.1.1 Traditional Perspectives on Coping with Bereavement – Letting Go

I begin with Kübler-Ross's (2009) seminal work on the five stages of grief. I then explore other stage theories (Bowlby and Parks, 1970; Worden, 2009). Following this, I summarise the three key discourses on bereavement: the intra-psychic process model of mourning; the interactional model of mourning; and, the social model of mourning. These operate at different levels and overlap; however, I will address them in this order. I argue that these perspectives offer a way to explore how families cope with bereavement in the BD context and consequently a way to investigate how this effects the AUS's FL work. I call these the traditional perspectives on coping with bereavement. These focus on letting go of the bond with the loved one. Later in this section I contrast these traditional perspectives with *continuing bonds* in which Klass, Silverman and Nickman (1996) distinguish that instead of breaking bonds and letting go, bonds continue and shift.

2.1.1.1 The Five Stages of Grief

The five stages of grief, Kübler-Ross's (2009) seminal work, first published in 1969, is a key and significant theory on coping with bereavement in a breadth of contexts and is highly influential to those researching related subjects from 1969 across of range of academic disciplines. Throughout this thesis I will be referencing the 40th anniversary edition of this work which was published in 2009. The theory outlines the experiences of dying patients drawing upon interviews that Kübler-Ross (2009) completed with them. However, this theory extends beyond this in its applicability and is widely accepted as a response framework for any major life change or personal loss including bereavement. Kübler-Ross (2009) argues that these stages are not a linear sequence, nor are all the stages

experienced by all patients. Also, a timeframe for the five stages is not offered. Kübler-Ross drew upon Bowlby's (1969) attachment theory and argued that the bond with the deceased must be broken in order for the individual to let go and get over their loss. I challenge this key premise of bond-breaking as literature around *continuing bonds* (Klass, Silverman and Nickman, 1996) has since shown that bonds are indeed continued in many cases.

The first stage *denial and isolation* includes the initial denial (or at least partial denial) of terminal illness/impending death that patients experience (Kübler-Ross, 2009). They often seek reassurance and further explanations and evaluations from doctors in the hope that the original diagnoses will be rejected. Kübler-Ross argues that denial is not fixed, and the patient may later accept their impending death and talk this through with others readily (seen in stage 5: acceptance). She posits that “[d]enial is usually a temporary defence and will soon be replaced by partial acceptance.” (Kübler-Ross, 2009: 32). The amount of denial and the length of time this is experienced differs between individuals. Kübler-Ross (2009: 34) asserts: “[d]epending very much on how a patient is told, how much time he has to gradually acknowledge the inevitable happening, and how he has been prepared throughout life to cope with stressful situations, he will gradually drop his denial and use less radical defence mechanisms.” Denial is thus positioned as a coping mechanism and illustrates the multiple situational biases that may affect the extent of one's denial. This denial may affect families facilitating BD at the time of death as they may delay contacting the AU whilst still in denial of the death and its implications. This is particularly poignant as there is a short time period by which the body needs to be within the AU.

Linked to *denial* is the *isolation* that the bereaved may experience while they try to understand and deal with their condition (Kübler-Ross, 2009). Kübler-Ross (2009) stresses the importance of support

networks at this stage. What is still unclear is the involvement of AUS in these support networks. In this thesis I explore to what extent the AUS may form a part of the support network for bereaved families undergoing the denial and isolation stage of grief by asking the questions '**Who has contact with donors' families after donor death?**' and '**When do such contacts occur?**'.

The second stage *anger* replaces denial when it can no longer be maintained. This stage encompasses feelings such as "anger, rage, envy, and resentment" (*ibid.*: 40). This stage in particular is difficult for medical/hospice staff and family to deal with. Kübler-Ross (2009) explains that this may be because anger can be displaced to those around them. While this is clearly the case in patients in this stage, what is not clearly demonstrated is if a similar displacement of anger from donor family members onto AUS occurs. Kübler-Ross (2009) explains that empathy is an important tool used to overcome this anger; "[t]he problem here is that few people place themselves in the patient's position and wonder where this anger might come from." (*ibid.*: 41). What is not verified is if AUS use empathy in a similar way to overcome the anger that may be exhibited by donor families.

Bargaining is the third stage. In Kübler-Ross's (2009) account the patient is forced to reflect on their life which, in some cases, evokes feelings of guilt for wrongdoings within their life. Patients attempt to bargain and ask for their terminal illness to be cured. They aim to make up for such wrongdoings, give back and complete good deeds. Applying the notion of bargaining to the BD context, this may explain the motivation for donation as some people are said to donate because they want to give back or be useful (Fennell and Jones, 1992; Richardson and Hurwitz, 1995; McClea and Stinger, 2010). This may seem altruistic (Campbell, 2009; Titmuss, 1971; Sykora, 2009), but the donation may provide satisfaction for the donor and be recognised as a gift. Thus, this may not be a true gift but rather an implicit guilt

payment (Argyrou, 2013; Derrida, 1992). *Gift exchange* will be discussed later in this section.

Normally, after the individual has experienced denial, isolation, anger and bargaining, the fourth stage *depression* is evoked which induces feelings of loss (Kübler-Ross, 2009). Individuals have different ways of coping with their grief; therefore, many differing levels of depression will be experienced. Kübler-Ross (2009: 71) theorises that depression behaviours such as crying, refusing visitors or silence are used as tools to separate themselves from those people around them. Within the BD context depression behaviours may be expressed to AUS, as the AUS may form a part of their support network. However, to what extent this is apparent in the FL work of AUS is not yet identified. Kübler-Ross (2009) argues that the support network should simply act as a listening ear at this stage as talking through the situation is key in their contemplation and eventual acceptance of death (and/or donation in the BD context). For those individuals in Kübler-Ross's (2009) study this is the stage where individuals begin to come to terms with the physical and psychological hardships of loss and eventually aim to overcome the loss. This allows the individual to move on to the next stage.

The fifth and final stage *acceptance* happens when the patient has time to move through the various stages, and has had help to do this from their support network, and they finally come to terms with their illness and loss (Kübler-Ross, 2009). As previously mentioned, these stages can be experienced in a non-linear fashion and the person may not experience all the stages, but eventual acceptance is assumed (*ibid.*). The key element is time, as the bereaved need time to reach the acceptance stage and overcome their loss. There is an extended period of time in BD where the body is typically within the AU for three years. To what extent this prolonged period of time in BD, where the body is deceased but not yet buried, impacts the way in which families

interact with AUS and thus the FL work that AUS do is not yet recognised. Consequently, I question Kübler-Ross's (2009) premise of the undeniable eventuality of acceptance as in some cases the death (or donation) may not be accepted and overcome as she argued. Similarly, *continuing bonds*, discussed later in this section, contradicts the rigidity of Kübler-Ross's (2009) eventual acceptance hypothesis; it is argued that bonds continue and shift, therefore acceptance may not be the final point of grief for many (Klass, Silverman and Nickman, 1996). Thus, in this thesis I explore the extent in which the AUS play a role in helping the families to accept the death (or donation) or indeed continue bonds, as the AUS are the ones looking after the donor's body after death, by asking the question '**What is the extent, nature and form of contact with donors' families after donor death?**'.

Although the five stages of grief are useful in appreciating the changing needs of the bereaved, I argue that Kübler-Ross (2009) does not lend enough gravitas to the family's role in the process. Especially in those early stages, as she focusses primarily on the individual's experience of death. She converges unhelpfully instead on the family's negative role in exacerbating stress. For instance, in the *depression* stage, Kübler-Ross (2009) argues that the social network should be discouraged from trying to cheer the individual up. It is only later in the text that she recognises the importance of the family to the terminally ill patient, stating; "[w]e cannot help the terminally ill patient in a really meaningful way if we do not include his family. They play a significant role during the time of illness and their reactions will contribute a lot to the patient's response to his illness." (*ibid.*: 128). However, I argue that the patient and the family are inextricably linked and thus the family's role should be included throughout. I agree with Schaefer and Moos (1998) who argue that social networks, including family, friends and in the BD context possibly AUS, play an integral and unavoidable role in coping with bereavement. Similarly, in the BD context I assume that the family are key within the process and must be included throughout,

especially as they are typically the ones to make the phone call notifying the AU of the donor's death. The extent to which the family are key in the BD process and how this effects the AUS' FL work is explored in this thesis.

Kübler-Ross has been critiqued for a lack of empirical research, evidence to support her claims and lack of applicability (Corr, Doka and Kastenbaum, 1999; Kastenbaum, 1998). However, as Kellehear (2009: vii-xviii) in the introduction to the 2009 edition of *On Death and Dying*, highlights: "The fundamental value of this work lies in the dialogue between two people discussing the meaning of dying." (*ibid.*: vii). It does not claim to be representative of all dying patients, yet it is flexible and can be applied widely. What is important is the emphasis on the interactions between the living and the dead – much like mediator deathwork discussed in subsection 2.2. Accordingly, in this thesis I examine the dialogue between the donor's family and AUS to understand experiences and manifestations of bereavement in the BD context.

Furthermore, I argue that stage theories, such as Kübler-Ross's (2009) and those I go on to discuss next, are reductionist as they simplify complicated patterns of human behaviour and psychological phenomenon. I have recognised for example that the five stages of grief may not be experienced in linear succession and that time may influence how these play out in the BD context. Thus, in this thesis I explore how the BD context may influence the way in which individuals *do* bereavement. However, Kellehear (2009: xi) explains that "[...] these stages are merely a set of categories artificially isolated and separately described so that the author can discuss each of their experiences more clearly and simply." Thus, they are helpful tools as a way into understanding complicated phenomenon. Next, I will continue to explore stage theories.

2.1.1.2 Additional Stage Theories

There are also other stage theories in addition to Kübler-Ross's (2009) five stages of grief that may be applicable to the BD context. For example, Bowlby and Parkes (1970) describe four stages of grief after bereavement. Their first stage, which they define as *shock and numbness* comprises the family initially not understanding that the loss is real. Bowlby and Parkes (1970) argue that this stage needs to be overcome to progress to the next stage and communicate, accept and understand one's emotions. The second stage *yearning and searching* is where the family searches for their loved one to make sure that they are gone. The bereaved becomes aware of their loss at this stage. In the third stage *despair and disorganisation*, the bereaved accept the change that has occurred and feel despair, anger and hopelessness. The fourth stage *re-organisation and recovery* is where the individual starts to return to normal day-to-day life where they have a restored faith and set new goals. The grief is not completely resolved but moves to a less dominant part of one's cognition.

In the BD context families of donors may have similar experiences to those described by Bowlby and Parkes (1970). The AUS, as the individuals who have the body immediately after death typically for three years, may have to deal with such manifestations of grief. This may explain patterns of contact, for example in the first stage (shock and numbness) the family may not contact the unit because they have not understood that the loss is real. Then they may contact the AU to complete yearning and searching behaviours as the AU is where the body rests. The BD context is unusual because the individual is deceased but not yet buried as a body would be in a 'normal' post-death context. To what extent this influences the families of donors coping with bereavement and their contact with AUS is not yet identified. In the third and fourth stages the contact with AUS may be sporadic as donor's families move through these stages. Contact then

may lessen in the final stage as the grief occupies a less dominant part of the bereaved's cognition.

Despite the possible insight into the body donor's family considered above, I challenge Bowlby and Parkes' (1970) premise that all stages need to be progressed through in order to get over and move on from the loss. This contrasts to Kübler-Ross's (2009) five stages of grief as she argues that not all stages need to be experienced. Furthermore, Klass (1988) found Bowlby and Parkes' (1970) stage theory to be inadequate due to its focus on the "[...] disequilibrium in the social environment of the bereaved [...]" without accounting for "[...] a disequilibrium in the relationship between the bereaved and the lost object." (Klass, 1988: 13). In the BD context I especially consider the imbalance in the connection between the donor's family and the body as well as that in their social situation because the BD context is unusual.

Another key theory which could be usefully applied to the BD context is Worden's (2009) four tasks of mourning: first, to accept the reality of the loss; second, to work through the pain of the loss; third, to adjust to the void in the environment where the deceased once was; and finally, to find an enduring connection with the deceased while adjusting to one's new life. The first three tasks echo concepts that have arisen within the previous stage theories I have explored, for example acceptance and understanding the loss, working through and adjusting to the loss. However, it is the fourth task, finding enduring connections with the deceased, which I perceive as adding a unique perspective as instead of breaking bonds and letting go, a connection is sustained. This has common ground with *continuing bonds* (Klass, Silverman and Nickman, 1996) that I will discuss further in subsection 2.1.2.

I have given a brief overview of some key perspectives which could be useful in exploring the way in which donor's families cope with bereavement and the work that may result for AUS. I argue that no one of these theories, stages or tasks can be taken in isolation but instead certain aspects from each may be relevant. For example, that different experiences of bereavement happen at different times, that time and environment are important aspects in coping with bereavement, or the importance of working through the loss for clarity using support networks. In this thesis I explore the applicability of these perspectives in the BD context in chapters four, five and six. I will now move onto addressing other traditional perspectives of coping with bereavement that may be relevant to the BD context; the three models of mourning.

2.1.1.3 The Intra-Psychic Process Model of Mourning

The intra-psychic process model of mourning stems from Freud's (1917) seminal work *Mourning and Melancholia* which deduces that relationships with the deceased are dependent on how emotions are experienced. Freud asserts that intra-psychic processing is key to break bonds with the dead, as it allows the emotional energy invested in that individual to be re-dispersed when forming new relationships with others. Freud (1917) argues that there is a finite amount of energy which needs to be re-invested. However, the Freudian perspective states that grief is an experience which is developed over time during the post-death period and he considers that grief work requires effort and time. Therefore, detachment from the deceased in order to get over one's loss is a gradual and fluid process in which there may not be a decisive moment in which the bond is broken. This is contrasted by Kübler-Ross's (2009) work as she argues that it is in the final stage of acceptance that the attachment is severed. Drawing on *continuing bonds*, I challenge this key premise of the Freudian perspective as the

continuing bonds perspective proclaims that bonds are continued after death. Nonetheless, applying the intra-psychic perspective to the BD context is useful to appreciate the important role that emotion plays in the bereaved's experiences of emotions after death and donation; it is likely that there are individual differences in the way emotions are experienced. To what extent these differing emotional responses influence the work that AUS do is not yet known. Next, I will consider the interactional model of mourning.

2.1.1.4 The Interactional Model of Mourning

The interactional model of mourning stresses that the way in which individuals interact with others, and understand that interaction, are important factors in their experience of the loss of a loved one and how they cope with their bereavement. This perspective stems from psychological theories on stress and coping (Folkman, 1997; Lazarus and Folkman, 1984). This offers an explanation as to why individuals react differently to the same situation and appreciates how this may change over time for the same individual. Responses may switch between problem-focused and emotion-focused ways of dealing with the situation (Strobe and Schut, 1999). Thus, for those individuals who interact with the bereaved, like the AUS in the BD context, it is useful to understand the seemingly contradictory behaviours of the bereaved at different stages after the death and donation and react accordingly to individuals that may oscillate between ways of coping. Now I will move on to explore the social model of mourning which, rather than focusing on the way the bereaved interacts with others, deems the biographical aspects of the deceased and their loved ones, such as age, social status, and gender as most integral to interpreting their social reaction to death.

2.1.1.5 The Social Model of Mourning

In the social model of mourning society influences the person rather than the person's internally driven interactions with others. Thus, bereavement is viewed as a social process. This therefore has an effect on their interactions with others, how others interact with them and how they interpret this (Kellehear, 2008; Seale, 1995). Applying this to the BD context, it is how the body donor's family interprets their own and the deceased's position within society which are important to deduce how they interact with the post-BD process. In this interpretation process the relationship between the living and the dead and the experiences of bereavement can change over time as new narratives are formed. Therefore, it would be useful for the AUS to be aware that the social positioning of the donor, their family and their family biography are significant.

Drawing upon the focus on the biographical aspects and how these are presented to society within the social model I argue that it is integral for the family to develop a durable biography of their loved one. This, according to Walter (1996), occurs during the post-death period. Thus, the AU and/or the AUS, in the BD context, may have a role to play in informing and helping this biography to be formed. For example, it may be important for the families of body donors to interpret the final act of donation as altruistic or heroic. This is the case in organ donation where some bereaved families provide biographic information about their loved one to the organ procurement operators (Sharp, 2006) with the aim of re-creating their identity within their new environment or making meaning out of their donation (Bellali and Papadatou, 2006). It may also affect the post-donation process if the family narrative does not fit with that of BD. For example, if a family is not accepting of the BD, they may stop it from happening. Similarly, if BD runs in the family and the body is not donated this could disrupt the family narrative.

These traditional perspectives were seen as the key ways in which bereavement is experienced; however, it is now widely accepted that individuals continue bonds with loved ones after their death (Klass, Silverman and Nickman, 1996) rather than breaking bonds as traditional perspectives posit. In the following section I pay attention to the *continuing bonds* perspective on coping with bereavement.

2.1.2 Continuing Bonds – Holding On While Letting Go

In contrast to the traditional perspectives on coping with bereavement, *continuing bonds* postulates that families continue their bonds with the deceased in various ways rather than the breaking bonds, letting go and getting over that are the key premises of traditional perspectives. This is similar to Worden's (2009) fourth task, first written in the first edition of *Grief Counselling and Grief Therapy* in 1982, where Worden (2009) insists that an enduring connection is to be established between the deceased and the bereaved. In *continuing bonds*, the relationship between the living and the deceased changes over time; as noted in the social model of mourning. However, in *continuing bonds* the living as well as the dead are socially reconstructed and continue to be reshaped, creating new narratives and relationships. Klass, Silverman and Nickman (1996: 351) support this observing that;

“The bond may shift so that it is not central to the lives of the bereaved. The bond can take on a new form with time. But the connection is still there. [...] people may need help from their social support networks to keep their bonds alive. The social support networks may also help survivors let the deceased rest and be a part of the past. What has traditionally been called the mourning period may simply be the period in which the survivor is learning to live with this paradox.”

By “paradox” Klass, Silverman and Nickman (*ibid.*) are referring to the “irreconcilable tension” of “letting go and remaining involved” – holding

on while letting go (*ibid.*). The bond still exists yet changes over time to become a less consuming part within the life of the bereaved. This is similar to Bowlby and Parks' (1970) fourth stage *re-organisation and recovery* where the grief eventually moves to a less dominant part of one's cognition. Klass, Silverman and Nickman (1996) suggest that social support is integral to transforming the bond between the bereaved and the deceased. This parallels to the importance of support networks raised in Kübler-Ross's (2009) five stages of grief. Now that I have described the key premises of *continuing bonds* theory and demonstrated the key overlaps with traditional perspectives, I next move on to describing those ways in which individuals continue bonds.

2.1.2.1 The Funeral, Memorialisation and Physical Markers as Ways of Continuing Bonds

Valentine (2008) asserts that the funeral, memorialisation and physical markers have important roles to play in sustaining the bond with the deceased. These three ritual processes are disrupted or delayed in BD. I take each in turn and explore how they are integral to *continuing bonds* and how the disruption caused by BD may influence *continuing bonds* and the AUS's work. I begin with the funeral.

The Funeral

It is argued by Valentine (2008) that the funeral is an important ritual within the 'normal' post-death process. Thus, an absence or delay in this ceremony may affect the families coping with bereavement. In the BD process the funeral is arranged by the AU typically around three years after the death, although some families may wish to have a private service without a body at the time of death. It may thus be the job of the AUS to manage this situation where the body is not yet disposed of.

Similarly, the fragmented physical body of the deceased (through dissection) is not present at the eventual committal service or at the private service arranged by families at the time of death. Baker, Baker and Gentry (2016: 215) highlight “[...] the value of tangible, physical remains in helping people make sense of the deceased’s life and death.” Therefore, the lack of body at the service may cause difficulties for the body donor’s family, such as problems in sustaining, locating and *continuing bonds* with the deceased. In other contexts, such as when an autopsy is performed, McPhee et al. (1986) suggest that the difficulty in obtaining consent from relatives was reported to be in part due to the subsequent delay of funeral arrangements. This fear of delay in funeral arrangements is reported as higher in other contexts, such as in Arab Muslim countries (Mohammed and Kharoshah, 2014). Similarly, relatives of organ donors worry that donation may delay the funeral or memorial service (Wong, 2011).

Furthermore, Valentine (2008: 152) describes the funeral as a “platform for locating and sustaining the deceased person’s social presence.” The funeral is proposed as a means of representing the deceased’s unique selfhood, in which it is the responsibility of the living to represent them as they would have wished (Cook and Walter, 2005). Representing the donor’s individuality may exist within BD; however, it is unknown whose responsibility this is – the families or the AUS. To what extent these disruptions to the funeral effects the FL work AUS do must be explored in this thesis. Next, I consider memorialisation – the second way of *continuing bonds* asserted by Valentine (2008).

Memorialisation

Valentine (2008: 152) posits memorialisation as a public yet private form of “memory-making”; a method of creating presence in place of absence. There are numerous sites of memorialisation. One such site

is the cemetery, which is a unique type of bounded space, a true heterotopic space (Foucault, 1967), which is separate from everyday life, creating a place which is public yet private. Heterotopic spaces will be discussed further in section 2.3. The cemetery is a typical example of a place of memorialisation, although sites of memorialisation can be anywhere the bereaved chooses, such as a particular area their loved one enjoyed. A bench or a tree for example could be erected there. These memorial spaces provide a safe space to represent and reflect on the deceased's identity (Valentine, 2008).

Often it is the place in which the ashes are scattered which becomes the memorial space that can be revisited. Schafer and McManus (2016: 67) state that “[t]he placement of ashes following cremation was described by many participants as the most meaningful component of the post-mortem process.” Hockey and Kellehear (2005) claim that the material focal point of a physical memorial aids the living to feel the presence of the dead, forming environments of memory. It may therefore be disruptive if a space for memorialisation is not present for the families of body donors. Extending upon the importance of the material focal point, similarly there are various objects that can be used to memorialise a loved one such as urns, photos, items of clothing or jewellery. The importance of these items in memorialisation as ways of *continuing bonds* thus contradicts Kübler-Ross's (2009) premise that such items should be let go of in order to break the bond with the deceased. In the following subsections I explore the literature around the memorialisation of the donated body, including the integral physical memorial mentioned above.

Memorialising the Donated Body

I have demonstrated that memorialisation is a key method of *continuing bonds*. I will now focus on how the donated body is memorialised. The AUS FL work around body donor thanksgiving

services and physical monuments after acceptance (Bolt, 2012; Strkalj and Pather, 2017) are the only areas that have been examined in the literature. In this thesis I wish to understand whether the AUS FL work extends beyond the thanksgiving stage. First, I will focus on thanksgiving services.

Thanksgiving Services

Thanksgiving services are carefully constructed events for staff, students and donors' families and friends which acknowledge body donors and their friends and families (Strkalj and Pather, 2017). This is a highly controlled environment which the AUS mediate using props and actions. For example, there are readings, music, memorial boards and books, and floral tributes. Thanksgiving services vary in their style and content depending on the AU (*ibid.*). Thanksgiving services recognising the gift of body donors have a long history (Kooloos et al., 2010; McClea, 2008; Riederer, 2016; Tschernig and Pabst, 2001). Pather and Ashwell (2017) describe the thanksgiving ceremony at the University of New South Wales, Australia, and the impact it has for the families of body donors, the students and the staff that work with the bodies. Pather and Ashwell (2017) say that "[...] a public service within a year of the donor's passing provides the families with an opportunity to see the great good that has come from the donation and to hear how highly we regard their loved one's gift." (*ibid.*: 175). The service is instrumental in helping the family understand why their loved one donated their body and the use of their donation. Next, I will turn my attention to physical markers.

Physical Markers

In addition to this research exploring thanksgiving services, Bolt (2012) analysed memorialisation and the anatomical gift by studying the giving of body donor monuments by anatomical professionals. Bolt

(2012) presents that the monument is not only a place of memorialisation but also a physical marker. Bolt (2012) argues that the increase in monuments for body donors is due to the increased interpretation of the donated body as a person who has mourning loved ones. These monuments include outdoor engraved sculptures made from stone, marble, wood or metal, and/or engraved metal plaques.

Bolt (2012: 623) asserts that “the gift from the Department of Anatomy had more impact than expected” for the bereaved at the Nijmegen unveiling ceremony. The monuments allow for private and public memorialisation. They act to create “a symbolic resting place in the absence of the deceased’s physical body.” (Bolt, 2012: 623). This is particularly poignant in the Netherlands, where Bolt’s (2012) study was based, as ashes are typically disposed at sea, therefore the monument is a recognition of the families need for a place to memorialise. Bolt (2012) shows that even after a significant time gap the family still found the monument meaningful and said they would continue to visit it and bring other family members with them. Furthermore, Bolt (2012) explains that the monuments can become a place for *continuing bonds*, as the monument and the connection with the AU and its staff allows for relatives and friends to maintain their relationship with the deceased. In some cases, bonds and relationships that had been broken were rebuilt. Conversely, Bolt (2012) found that there were some individuals that found little or no attachment to the monuments or the unveiling ceremony. It is thus clear that the monuments and the unveiling ceremonies were interpreted in a range of ways.

Bolt (2012) argues that the monuments are a gift given by the anatomical professionals to the donors and their relatives. This gift replaces, or at least goes towards filling, the void which has been left in the absence of a physical body and physical resting place for the dead. These physical markers are important as a means of *continuing*

bonds as they have a dual role; not only are they places of public and private memorialisation, they are also physical markers acknowledging the donors. Baker, Baker and Gentry (2016) discovered that failure to leave a physical marker (i.e. a gravestone) of the deceased may disrupt the mourning experience for the bereaved.

This gift was a result of an anatomical professional taking on duties as the secretary of the Department of Anatomy where the anatomical professional spoke to the potential donors and the families of the bereaved, a task which dissectors do not normally have. In this the anatomical professional realised that the donor is a person with grieving family members and appreciated the need to give a gift to the donor and their families. This contact with families and donors is a gem that is ignored in Bolt's (2012) study. In this thesis I uncover the work that the AUS do in their contact with donor's families to clarify what happens after donor death. Next, I will continue assessing the applicability of *gift exchange* to the BD process.

Applying Gift Exchange to the Body Donation Process

Bolt (2012) argued that monuments and memorialisation were a reaction to the burden of the unreciprocated gift that was initially given by the body donor. Reciprocation is the key element of *gift exchange* (Mauss, 1990) that is drawn upon by Bolt (2012). In the case of organ donation “[i]t is suggested that it was from the recipients’ acknowledgement and appreciation of this achievement that donor families received *reciprocity on behalf of the deceased*, and thus, potentially, solace in their grief” (Sque and Long-Sutehall, 2011: 85). This suggests that reciprocation may be a way in which the families of donors can cope with their bereavement. To what extent AUS reciprocate the gift, in addition to thanksgiving services and physical markers, is unknown.

Mauss's (1990) *gift exchange* was developed from his observations of potlatch (feasts given as gifts) in the Pacific Northwest, where giving, receiving and the obligation to reciprocate were central to the theory. Mauss (1990) argued that the way that objects are exchanged shapes the relationships between groups and individuals. Gift relationships, he argues, pervade all aspects of their society. Another key premise of Mauss's (1990) argument is that the gift is alive and carries a spirit which is powerful. He asked: "What power resides in the object given that causes its recipient to pay it back?" *Gift exchange* is a continuous cycle (Mauss, 1990), where reciprocation is obligatory and is repaid with interest. Thus, gift relationships are difficult to close. The refusal of a gift shows a fear that the receiver cannot repay and thus they lose power and dignity. Drawing on the Maussian framework, the social bond is dismissed in the refusal as "[...] to refuse to receive is to reject the social bond [...]" (Goldman-Ida, 2018: 341). To what extent gifts are refused within the BD context and the effect this has is not known as Bolt (2012) focussed only on the received gifts.

What is clear from Mauss's work is the social bonds, relationships and community that are created. Borrowing from Durkheim (1974) it can be comprehended that gifts create social cohesion through solidarity. Sykora (2009: 18) argues that one meaning of the gift is: "[...] a tool of social mutual relations based on reciprocation." It is this meaning of gift that I argue can be seen within BD, where a set of relationships are developed based on reciprocation. This creates a new complex community, a social network between strangers, underlined and controlled by gift relationships. In a similar guise Titmuss (1971: 277-8) argued that blood donation creates social cohesion between strangers in a society. As Titmuss recognises, it is the social relationships created by these gift relationships that are important, not the gift itself.

I am aware of the various critiques of Maussian *gift exchange* within the literature. First, I draw upon the literature to critique Mauss's (1990) premise that there is an *obligation* to reciprocate. Testart (1998: 97) speaks of the "natural antinomy between the fact of giving and that of exchanging." He argues that exchange is "to let someone have something against a corresponding return" and that this defeats the point of a gift (*ibid.*). Testart (1998) criticises Mauss (1990) for confusing gift and exchange and using them as part of the same process. Testart also criticises Mauss's premise that in all exchanges, transfers and gifts, no matter the context or society, there is an obligation to reciprocate. Testart (1998) uses multiple examples to critique Mauss's *gift exchange*.

First, Testart (1998: 97) draws upon an example, which he describes as a "free" gift, where money is given to a homeless man as a charitable donation with no obligation to reciprocate. Similarly, Testart (1998) argues that invitations among friends to dinner are also free gifts. In this type of interaction, the receiver may have a feeling of obligation but there is no binding obligation as Mauss (1990) described. Testart (1998) also unpicks Mauss's (1990) example of Potlatch, where food is given as a gift and the recipient is obligated to return the gift, or else they risk losing honour and the society would subsequently be reorganised. However, Testart (1998) argued that this is a social sanction and not a legal one. I propose that it is the jural distinction that separates true obligation to reciprocate, as this is not legally bound. Testart (1998) drew upon Malinowski's (1922) example of the kula, where the kula object (usually a soulava (necklace)) can be requested as a counter-gift on giving the vaga (initial gift) and thus seized if an object is not returned. The institution is geared towards seeking the counter-gift which can be forcibly taken. In the first scenario, where there is no legal right to demand or seize the reciprocation, Testart asserts: "[w]e are justified in speaking of 'gift': a gift is the act of someone who provides something without demanding

return.” I argue that BD falls within this first group, as BD is akin to a charitable donation; the donor and their family do not demand return or seek a counter-gift. The free disposal of the body is merely a “fringe benefit” (Titmuss, 1971: 88).

Applying this *feeling* that one should reciprocate that Testart (1998) raised to the BD context, I now briefly explore why the AUS feel they should provide a monument and thanksgiving service, or indeed free disposal of the body donor. In Bolt’s (2012: 621) study one anatomist initiated the monument’s erection because “[a]fter 40 years of teaching human anatomy he searched for a way to demonstrate the value of body donation to students [...] he also wanted to express his gratitude.” This is the anatomy staff member feeling that they should reciprocate the gift of BD. This is not an expectation or obligation but completed because the staff *feel* they should.

Furthermore, staying with the BD context, the different social setting in which BD in England, Northern Ireland and Wales takes place is crucial to explore the applicability of Mauss’s (1990) *gift exchange*. AUS will not lose honour like those individuals in Mauss’s (1990) study. These societal norms typical in non-economic groups should not be transferred directly to other groups when applying *gift exchange* as a template to understand gift relationships in other situations like BD in the UK. Testart (1998: 2) posits that “[t]he difference is that potlatch is a major, even crucial, institution of this type of society – whereas the invitation from one colleague to another, in our society, is not.” Here Testart (1998) discusses why one colleague is not obliged to the other to reciprocate the invitation to dinner in a society outside of that in which Mauss (1990) positioned *gift exchange*. This is the difference between public and private sanctions to reciprocate; it is a *feeling* that one should reciprocate rather than an obligation. The obligation to reciprocate potlatch is also ‘stronger and more serious’ (Testart, 1998: 2).

Another critique of Mauss (1990) came from Titmuss (1971) who argued that human blood donation is an altruistic act (Campbell, 2009; Sykora, 2009), a true and “free” gift (Titmuss, 1971: 88), which differs from other forms of giving because the recipient is anonymous and thus is not obligated to reciprocate. It is the anonymity and altruism that separates this type of donation from others. Titmuss (1971) argues that there cannot be a motive for this type of donation as no gratification is received. Although studies have identified body donors as altruistic (Fennell and Jones, 1992; McClea and Stinger, 2010; Richardson and Hurwitz, 1995) there are other motivations for body donors, such as a free funeral. They are receiving the “fringe benefits” of BD (Titmuss, 1971: 88). Titmuss (*ibid.*) critiqued the “fringe benefits” received in certain Communist countries as this was hypocritical and undermined the pure sense of altruism where no benefits were had. However, even Titmuss (1971: 89) himself writes later in his text that “no donor type can [...] be characterised by complete, disinterested, spontaneous altruism.” Thus, even those seemingly truest forms of “free” gifts (Testart, 1998) may not be so when their motivations are revealed.

In a similar guise to Titmuss (1971), Fox and Swazey (1978: 5) argue that “[t]he donation of an organ is one of the most dramatic and supreme forms of gift giving extant in contemporary society.” Fox and Swazey (1978) claim that organ donation has its own normative pressures of giving, receiving and reciprocation. I argue that gift giving in BD also differs from other forms of gift giving and has its own set of pressures, but these I theorise are driven by the AUS, students, family and friends wishing to facilitate the BD and feeling that they should reciprocate. This differs from the relationships seen in non-economic societies where there is an obligation to give, an obligation to receive and an object of reciprocity (Malinowski, 1922, 1926; Mauss, 1990; Levi-Strauss, 1990).

Other critics such as Derrida (1992), and extending upon Derrida, Argyrou (2013), questioned whether there is such a thing as a gift. Thus, aiming to abolish Mauss's (1990) *gift exchange* by contending the validity of its key premise; that the gift exists. Derrida (1992: 11) maintains that there is no such thing as a gift as the conditions, outlined in the next sentence, are never met. This is because the gift suggests something voluntary; something that someone intends, wishes and desires to give. There is no ulterior motive in this and the person giving does not intend to take. Argyrou's (2013) reading of Derrida (1992) postulates that the moment a gift is recognised as a gift, it is ontologically transformed into something else that is not a gift. Derrida (1992) posits: "*At the limit, the gift as gift ought not [to] appear as gift: either to the donee or the donor.* It cannot be gift as gift except by not being present as gift. Neither to the 'one' nor the 'other'" (*ibid.*: 14, emphasis in original). Thus, the gift is impossible as it cannot appear or be recognised as a gift. Derrida (1992) criticises Mauss (1990) for offering no way to conceptualise the gift. Furthermore, Derrida (1992), similar to Testart (1998), argued that gift-exchange is a contradiction in terms, and he criticised Mauss for not worrying enough about the incompatibility between *gift* and *exchange*. Derrida (1992: 41) argues that Mauss does not find "the distinctive trait of the gift" and presents a confusing argument where the reader is not sure what is a gift and what is not. Accordingly, Argyrou (2013) upholds that when we discuss the 'gift' we are not discussing it but the economy or aspects of it.

Finally, I pay attention to the issue raised by Argyrou (2007: 310) who said: "If the gift is impossible, any discourse that purports to speak about it as gift is doomed to failure. No matter how hard it struggles, it will always miss its target and end up speaking about something else." It is not the aim of this thesis to understand whether the donated body is a gift. However, I will use gift terminology as this is the way that AUS, donors and their families conceptualise it.

After consideration of these perspectives around *gift exchange* I argue that there may be some use in Mauss's (1990) key premises of gift relationships, most importantly reciprocity. However, I agree with those debates in the literature (Testart, 1998) that the social or legal obligation within the UK society in which my study is based is not likely to be as rigid as Mauss (1990) suggested. I further agree with Testart's (1998) premise that one reciprocates due to a *feeling* that they should reciprocate. Similarly, I agree in part that in the refusal of a gift one forgoes social etiquette and "[...] rejects the social bond [...]" that may be established in the receiving of the gift (Goldman-Ida, 2018: 341), however, I do not consider this to be as serious as Mauss (1990) contended. I also argue that the social bonds that Mauss (1990) presents as a key foundation of gift relationships are still present in those gift relationships outside of the context in which Mauss (1990) studied them. For example, when applying this to Testart's (1998) examples, for instance the invitation of a friend for dinner, I argue that social cohesion, social bonds and community through solidarity (Durkheim, 1974) are still present even if the gift relationship is not present to the same extent that Mauss (1990) presented. Thus, I dispute Testart's (1998) dismissal of the importance of social bonds in the examples he presented. To what extent gift relationships are applicable in the BD context is still unknown.

Further to these three methods of *continuing bonds* presented by Valentine (2008) (funeral, memorialisation and physical markers), other ways of *continuing bonds* include: conversation, information sharing and correspondence; narrative creation; and *meaning making* and sense making. These will be considered in the BD context below. First, conversation, information sharing and correspondence will be explored.

2.1.2.2 Conversation, Information Sharing and Correspondence

Extrapolating from the five stages of grief, Kübler-Ross (2009) is useful to help identify the importance of conversation as a way of *continuing bonds*. Kübler-Ross (2009) argues that by speaking with the deceased's relatives, empathising and tolerating emotions such as anger, one can help them diminish negative feelings, such as fear. Furthermore, Kübler-Ross (2009: 144) maintains that “[i]t is at this time [after death] that the family members feel most grateful to have someone to talk to, especially if it is someone who had recent contact with the deceased [...]”. It may be that the AUS take on the role of “someone to talk to” as AUS have contact with the physical body during the post-donation period. In this thesis I seek to clarify whether, when and/or how, the AUS facilitate this role for the families of the body donors.

Conversation with the deceased, with other mourners, and with family members is evidently useful in adjusting to bereavement (Klass, 2006; Walter, 1996). It must then be considered whether the AUS replace the *body/cadaver/person* as a point of interaction for the bereaved. Valentine (2008) reflects that the conversation itself, during her interviews with bereaved individuals, helped sustain and reinforce their *continuing bonds*. “Narrative[s] of rediscovery” are described as methods of *talking to* as well as *talking about* a loved one by Valentine (2008: 150). In this, relationships can be maintained or rebuilt when talking about the deceased. Thus, it would be beneficial for AUS to create a channel and environment where families can converse.

Walter (1999) describes private and public bonds (those which can be discussed in everyday conversation) with the deceased. He describes how Mutual Help Groups (MHGs) proved beneficial for bereaved individuals. These spaces created “communities of feeling” in which

the bereaved could speak with others who understand their situation, because they have experienced similar circumstances (Riches and Dawson, 1996: 143; Walter, 1999). AUS may act like MHG members, creating an open space or channel for the bereaved to talk. This differs from the clinical approaches of therapy and counselling where the bereaved may be less open. In this sense the AUS may provide a middle ground in which the bereaved feel that they can talk to the AUS as they understand their situation. This may be different from the support provided by their relatives and society. The AUS occupy a unique space and therefore may have to deal with the *EL* (Hochschild, 1983) that comes with their social position.

Similar to conversation, importance is also placed upon information sharing and correspondence to continue bonds. This can be seen within organ donation. Sometimes new relationships are formed between the organ donor's family, and the recipient and their family, as Sque and Long-Sutehall (2011: 83) posit; "[o]ne way of continuing the bond with the deceased may be through knowledge of the recipient and maintaining 'the connection' through correspondence." Likewise, Sque et al. (2008) assert that for organ donors' families it was important for them to receive news and updates about their loved ones. Thus, information from AUS about donors within the BD context may be useful in providing comfort for the donors' families. Sque and Long-Sutehall (2011: 83) speculate that non-correspondence from the organ recipient means that the donor's family "[...] were thus denied the opportunity of constructing a new relationship and integrating the deceased into their ongoing lives." The effect of non-correspondence from the organ recipient may be similar to not receiving correspondence from the AU to which their loved one's body has been donated. Therefore, information sharing and correspondence from the AUS may be important in the donors' families' post-donation experience; however, to what extent this manifests is not currently known.

2.1.2.3 Narrative Creation

Constructing narratives around the donated bodies may be an important way in which the bond is continued between the living and the dead. Valentine (2008: 169) established that, “[n]arratives thus emphasised the social, interactive, intersubjective nature of grief whilst at the same time upholding its very personal and individual dimension.” This suggests that narratives are created for the living as well as the dead and act as a means of understanding bereavement. Similarly, Neimeyer (2007: 203) argued that “[n]arrative methods can play a role in restoring or re-storying a sense of autobiographical coherence that has been disrupted by loss.” Furthermore, Valentine (2008) makes clear that it is the context in which the dying and death are contained which evoke the type of *continuing bonds* that are created. For example, in a context where death and dying have become medicalised, institutionalised and routinised, an increased concern with humanising the body within people’s narratives is found (*ibid.*). Walter (1996) focusses on the use of narrative in creating a biography for the dead, which is useful for the living too. He concludes that the deceased’s loved ones construct a biography of them which aids them to integrate the deceased within their continuing lives. In the context of organ donation Sque and Long-Sutehall (2011: 83) draw upon Becker’s (1973: 11-12) description of the hero as one who could enter the spirit world and return living. The connotation of hero that can be attached to organ donors may also be attached to body donors as their donation is seen as the ultimate gift; one which facilitates the training of medical students and practitioners. This affirms the worth and status of the bereaved (Seale, 1995). In light of the negative historical connotations attached to BD, as described in chapter one, it may be important to ensure it is known that the donor is a person who voluntarily donated their body.

2.1.2.4 Meaning Making and Sense Making

The bereaved also wish to make sense and make meaning of their loved one's death as a way of *continuing bonds* with them (Neimeyer, 1998, 1999, 2001; Neimeyer, Baldwin and Gillies, 2006). Neimeyer, Baldwin and Gillies (2006) assert that "[s]everal variables concerning the survivor, his or her relationship to the deceased, and the nature of the death functioned as risk factors for heightened distress, but their role was generally moderated by *meaning making*, often to the point of non-significance." Thus, reconstructing meaning may have a poignant role in the way in which donor's families cope with their bereavement and continue bonds.

In this section I have demonstrated that *continuing bonds* is the prevailing perspective on coping with bereavement. I have made a case for the importance of the funeral, memorialisation and physical markers for the families of the deceased as means of *continuing bonds*, drawing upon Valentine (2008). These are the processes which are affected by BD as they fall after acceptance. It is already known that AUS have a role to play in the thanksgiving stage of the BD process (Bolt, 2012; Strkalj and Pather, 2017); facilitating memorialisation and physical markers. What is not known, however, is if the AUS have a role outside of this stage in facilitating *continuing bonds* and aiding families in their coping with bereavement. I will adopt and apply *continuing bonds* theory and ways of *continuing bonds* going forward to explore the work that AUS do with the families of donors. However, I will also borrow elements of traditional perspectives to elucidate instances in which they may be applicable. These will be used in chapters four, five and six to clarify the impact that families coping with bereavement has on the work AUS do with families after acceptance. I have speculated that AUS may play a role in liaising with families after death, however the extent of this is not known. Thus, I must consider how such work is brought to an end. I

ask the question ‘**How is family liaison work brought to an end if at all?**’. In the next section I explore the theoretical underpinnings of the work of AUS which may be telling of the situation which occurs within BD in the UK.

2.2 ANATOMY UNIT STAFF

I made a case for the importance of studying the AUS’s work in chapter one, as little is known of the work they do with families after BD. The AUS are those individuals that facilitate the process of BD and complete FL work in order to do this. The main roles within the AU I will be focussing on are the Bequeathal Secretary (BS), Mortuary Manager (MM) and Designated Individual (DI). Further information regarding the AUS’s roles can be found in ‘notes on terms’ (page 359). What is not known however is the extent, nature and form of such FL work, when this occurs, how it is brought to an end, and if they receive recognition, support or training for such work. In this subsection I present the theoretical underpinnings to the AUS’s work to aid its exploration in the thematic results chapters that follow. First, I will outline the various aspects which make for dirty work; that abhorrent work that is considered polluting in public contexts (Douglas, 1966). Second, I will discuss deathworkers who are mediators between the living and the dead (Howarth, 1996). Third, I will present the theoretical underpinnings of the ontological state of the body and the changing position it has within a clinical/medical environment. Fourth, *EL*, emotion work and emotion management (*EM*) (Bolton, 2000) will be discussed, drawing from Hochschild’s (1983) analysis of flight attendants and bill collectors. Finally, I bring these theoretical lenses together to understand that these types of work are often invisible and hidden, which may explain the extent of the recognition, support and training that AUS receive for their work.

2.2.1 Dirty Work

The necrophobic attitude that many individuals hold towards death, as described in chapter one, can be explained through the lens of Douglas's (1966) work on purity and danger, order and disorder, in social life. The dead body is seen as polluting in public contexts; it creates disorder and danger and must be purified through its removal from society by traditional means by trained individuals to other spaces (Howarth, 1996). For example, the funeral home or AU (other spaces) are safe and sanitised spaces that allow for the body to be viewed and used. Douglas's (1966: 41) terminology "rituals of separation" can be applied here as these are needed to put in place "keystone[s], boundaries, margins and internal lines." The boundaries act as layers of purification which allow the impure object, in this case the donated body, to be used within a designated space. Howarth (1996: 95) supports this argument, positioning "the corpse as the site of death and source of pollution." Howarth argues that it is the polluting properties of the dead body which allow the deathworker to achieve custody of the body. Having custody of the polluting dead body, the deathworker becomes the one to carry out the dirty work.

Dirty work is defined as occupations, roles or tasks that are perceived as degrading or disgusting (Ashforth and Kreiner, 1999). In the case of funeral directors, they do the dirty work, acting to cover up and remove the horror and danger associated with the corpse by creating a purified social display ready for consumption by the family of the deceased. The physicality of the dirt (such as touch or smell) that we conceptualise when thinking about dealing with the dead and the people who carry out the tasks, lead to feelings of disgust and repulsion (Dant and Bowles, 2003). To understand the nature of the dirty work that is taking place one must explore "the identities, meanings, relations and spaces of dirty work and how the boundaries

between 'clean' and 'dirty' are negotiated and defined" (Simpson et al., 2012: 1).

Access to observing this dirty work is problematic as it is normally hidden. Simpson et al. (2012: 2) state that "[d]irty work can be seen to be invisible on several counts. Firstly, we try to create distance from the pollution of dirt and from those who deal with it." In this sense we distance ourselves, creating boundaries between impurity and purity (Douglas, 1966). This is because dirt stigmatises those associated with it and they in turn become tainted (Goffman, 1963). This means that identity management becomes difficult (Bolton, 2005; van Dick, 2016). Ashforth and Kreiner (1999) and Hochschild (1983) propose that shielding their status or identity helps those doing dirty work to lessen the stigmatisation. It must be understood how this stigma is managed (Bolton, 2005; Rollins, 1985) and the nature of the normalising practices that take place in order to make the job seem ordinary (Ashforth et al., 2007). Furthermore, Stacey (2005) argues that those individuals who undertake dirty work develop strong working cultures in order to gain satisfaction and pride from their dirty work. Stacey (2005) identified that the care workers she observed take pride in work that others are too squeamish to perform. It seems that pride and strong working relationships with colleagues act to overcome the stigmatisation that these dirty workers may experience. I have offered a lens to interpret the AUS as they too deal with the impure object of the donated body. Now, I turn my attention to framing AUS as deathworkers.

2.2.2 Deathworkers

Howarth (1996: 4) presents the funeral director as a deathworker; a person that possesses "an "outsider" status in society." The AUS can be compared to the funeral director as they too are social actors working to regulate the disposal of the dead; mediating between the

living and the dead. This may mean that they also possess a marginalised status in society. The role of the deathworker is deemed dangerous and may draw either status or stigma (for example, Parry, 1994). This is due to the dirty nature of their work as they are dealing with dead bodies which are deemed polluting within society as previously described. Howarth (1996: 65-67) explains how the undertakers learn their role, which can be a framework for other deathworkers, including AUS. This includes learning the *EL* that the role entails. This is dealt with through various coping mechanisms which allow them to perform their role effectively (Howarth, 1996).

The coping and neutralising tactics used by deathworkers are those such as humour, which is used to counteract the hardships within their work (Howarth, 1996). For funeral directors, Howarth (1996) explains that avoidance and dehumanisation are the most prominent strategies for coping. Other strategies used by deathworkers include distancing, professionalising, and validating the essential nature of the service. These coping and neutralising strategies may also be used by the AUS in response to different tasks within their role. The extent of this, and how this is perceived by the AUS, is explored in chapter six.

I have considered how deathworkers learn and cope with their role, I now deliberate how the relationships the deathworker has impact their work. Walter (2005) theorises that there is a triadic relationship between *the dead*, *the mediator*, and *the public*. He explains that it would be wrong to think of the relationship as between two entities (between the dead and the public or between the deathworker and the client (dyadic)) as it is the deathworker which conducts the situation (between the deceased, the deathworker and the public/client (triadic)). By “deathwork” Walter (2005: 383-4) means “specialised work following death” which “refers to those occupations that deal with specific dead people and/or mourners.” He contends that it would be wrong to think of a single definition for deathworker, explaining that

there is a wide range of roles. Within each role there are a multitude of elements and requirements. Walter (2005: 386) asserts that “[t]hese mediator deathworkers gather information in private, edit a story, and then perform this story in a highly public, ritual setting [...]” They are social actors controlling the situation for themselves and their clients. Walter (2005) argues that all the parties that are present in the post-death process have their own agendas, which is true for the mediators and the clients. Walter (2005) draws upon Aries’s (1974, 1981) work reasoning; “If Aries is right that it is lack of familiarity that makes death dangerous and wild, then mediator deathworkers re-tame it and enact this taming in public ritual.” (Walter, 2005: 408). It is their role to control and remove the polluting abilities of the dead from the public domain. To what extent this is true for AUS must be explored.

A main aspect of the British funeral director’s role, Walter (2005: 390) argues, is to “look after” the deceased and to comfort the loved ones of the deceased. Walter (2005) presents their role as barrier deathworkers; their job is to create and maintain a barrier between the living and the dead. This links to the belief that the dead are abject and polluting and that barriers must be erected to make them accessible (Douglas, 1966). Again, if this is also true for AUS is not yet known.

Walter (2005) outlines three key skills that mediator deathworkers must have. First that “[...] they do need to show unconditional positive regard to the dead. Showing respect to the dead is at the heart of mediatory deathwork” (*ibid.*: 404-6). This is a display for the clients, the families of the deceased, to legitimate their role as deathworkers and to express their respect for the deceased which gains the trust of the deceased’s loved ones.

Second, the mediators need to do *EL* (discussed in subsection 2.2.4). Walter (2005: 405) separates this from “rational, cognitive labour”, by which he means the marshalling of facts and commonalities. By *EL*

Walter (2005) refers to the work that is specifically done in the presence of mourners. Walter (2005: 405) states that this is especially required when the mourners “[...] are massed together in an unpredictable emotional mix”; which highlights the requirements of the deathworker to adhere to the wide range of emotions that are present, for example at a thanksgiving service or funeral. He states that the management of the emotions of this large crowd is the task of the deathworkers.

Walter (2005: 400) portrays the registrar, when speaking to the family member who is registering the death (as is customary in Britain), as a sympathetic listener. This is *EM* (defined in subsection 2.2.4) which goes beyond what is expected of the registrar and will be different depending on the case and requirements of the family member. The space/place and the actions of the deathworker during this interaction are controlled and arranged by the deathworker. Walter (2005) describes that the space/place of the registrar is a formal setting but not a ritual one; it still requires certain elements in order to discuss sensitive issues. When discussing the role of those who interact with family members at the time of death Walter (2005: 400) posits that “[t]hose who pass on bad news need to have good emotional and social skills, but they need not be ritual specialists: They are not required to edit and perform the story in a dramatic ritual setting.” A realistic, truthful, empathetic and sensitive approach is adopted, but the deathworkers are non-specialists.

Walter (2005: 408) highlights that “the profile of bereaved people and their emotional needs has been rising rapidly” in the UK since the 1990s. This increases the pressure put on the deathworkers to attend to these emotional needs and be trained to do so. When describing the trainees in civil funeral training courses, Walter (2005) explains that many of them were previously probation officers or police officers which equipped them with many of the skills required to deliver a

funeral tribute. Walter (2005: 408) argues that deathworkers should be taught about mediator deathwork and he questions whether they are “taught to be passive receptors”. Walter (2005) insists that there is a need to teach the relationship present in mediator deathwork, similar to the training that doctors receive regarding the patient-doctor relationship. Walter (2005) concludes that deathwork is a particular type of work which needs to be recognised, realised and trained for. It is the aim of this thesis to recognise and realise the work of the AUS, which may aid in developing guidance and training for them.

The third key skill Walter (2005: 406) proposed was that “[...] mediators need to be able to perform on a stage, [...] while keeping their own personality out of the performance.” Attention will be paid to Goffman’s (1959) dramaturgical metaphor in section 2.3, which explores this performance work on a stage. Walter (2005) also argues that; “[o]n stage, mediators are to be themselves, yet not to project themselves; to be authoritative, yet almost invisible.” (*ibid.*: 406). This is indicative of the separation that is needed in the personal and professional emotions that are part of their role. This is *EM*, emotion work and *EL* (Hochschild, 1983) which will be discussed in subsection 2.2.4.

When considering AUS in light of these three skills it can be seen that they fit the role of a mediator deathworker. They must use their skill set and tools to present to the donors’ loved ones their respect and gratitude for the donation. They have to adhere to the range of emotional clients that they interact with throughout the various stages of the BD process. The management of multiple emotional individuals comes into play when constructing and acting at the thanksgiving services that some AUs hold, as this is normally a collective event containing a large number of bereaved relatives. They must also endure the task of managing their emotions and personality during all performances that are required within their role. Overall the mediator

has authority, power and a special skill set which makes them able to deal with death and its aftermath. The mediator acts out their role on a stage which has been carefully constructed; this legitimates their power to the passive audience (Walter, 2005). In response to this, the dead's family hand over the body to the mediator as they believe they are legitimate. Despite the control which deathworkers have, there are still expected and unexpected interactions which they must deal with appropriately. To what extent respect for the dead, *EL* and performance is apparent in AUS's work must be recognised in this thesis. Next, I focus on another key aspect that may be applied to the AUS's work: ontological duality and the clinical gaze.

2.2.3 Ontological Duality and The Clinical Gaze

The AUS must also deal with the changing social position of the donated body, as it moves from person to cadaver. The bodies of donors are both persons and things (Prentice, 2013). Prentice (2013) described how dissectors switch between various terminologies while using the body after bequeathal. Prentice (2013: 35) uses the terminology "tactical objectification" to refer to "the ability to objectify the body or call forth the person as needed." The ontological duality of the cadaver is fluid and complex; it is imbued with emotion and calls upon a personal and sensitive reaction to the body and the context. This leads to a shift in how bodies are viewed. Personhood and humanity are stripped away through processes of objectification; however, the status of the bodies is fluid and can be redefined as person as opposed to thing when needed – for example, when speaking to families.

However, one must be careful of the agency of the body as Prentice (2013) proposed that the notion that objectification, in its reduction,

enables the body to have agency. Likewise, Thompson (2005: 179) agrees that patients are able to “[...] enact their subjectivity through their objectification.” Thompson (*ibid.*) also notes that “objectification is antithetical to personhood.” The ability to deem the cadaver an object is not without the realisation that the temporarily termed object is a person. This is a professional tool used to distance oneself from the cadaver, which is similar to the clinical gaze that doctors have when dealing with patients as opposed to people. These mechanisms allow the professional to function within their work. Thus, “[t]actical objectification is a means of managing the emotional needs of patient and practitioner.” (Prentice, 2013: 65-66). This is a coping and neutralising strategy (Howarth, 1996). However, as Good (1994) posits, for some students it is hard to think of the bodies as persons when they leave the anatomy context, suggesting that the emotional detachment that occurs may be fixed for some individuals.

Processes of objectification in an anatomical context may include removing the donor’s name, giving them an anonymised identification code and removing their bodily and facial hair (the later are also completed for ease of preservation and dissection). These are story seeds (Carrithers, 2009), which also include sun tan marks and tattoos (humanising features), which act to shape the body as a person. These are seen in relation to oneself. These story seeds evoke an emotional response. Through this liminal period (Turner, 1969; Van Gennep, 1960), where the donated body is in the AU, the family and the AUS may have several interactions where the AUS must eloquently switch between terminologies. Sensitivity, empathy and *EL* may be required of the AUS in order to do this.

Despite the ability to objectify the dead body a person can also relate to and empathise with it. Smith (1759) advocates that people positioning themselves in the place of the dead body evokes empathy and fear. It is this empathy that is important to the processes of

understanding the position of the objectified donated body, as a person can see their own body as an object too. It is by placing themselves in their position that leads us to understand their position. However, Black (2018: 18-19) asserts that a balance must be established for students who “[...] dissect a cadaver for the first time without experiencing crippling empathy, they must, while remaining respectful and ensuring that dignity is preserved, be able to train their minds into viewing the body as a depersonalised shell.” This ability to objectify is flexible, allowing for the individual to objectify and subjectify the same body which may explain the ability to re-person a donated body after their use; Prentice (2013: 35) refers to this process as “tactical objectification”. This requires some ontological choreography (Thompson, 2005), which is the ability to objectify a person’s own body.

As I have suggested, a key part of objectification is removing the person’s name. An individual’s name is important in personing the body, and in turn the removal of the name acts to objectify and effectively de-person the individual. The de-personing process is flexible and the individual may be re-personed. It can be deduced from Mauss (1985) that the act of naming a body locates the person socially. Mauss (1985) positions the idea of person and self closely which may explain the conscious link a person makes between the body of another with themselves and their ability to empathise with the dead body of a stranger (Smith, 1759). Similarly, Geertz (1973: 363) asserts that “anybodies” are converted into “somebodies” through the process of naming. A person’s name is integral within social interactions and is the keystone in understanding the body as a social being. As an example, Bodenhorn and Bruck (2006) highlight the horror of not being able to attach names to the victims of mass disasters, as naming the body, especially before disposal, is essential to the emotional send-off that we expect the body deserves. I would argue that this importance of naming before death is re-personing the

body as they have lost their identities during the mass disaster. Bodenhorn and Bruck (2006: 2) assert: “[...] the name reveals the profound political power located in the capacity to name; it illustrates the property-like potential in names to transact social value; and it brings into view the powerful connection between name and self-identity.” Furthermore, Bodenhorn and Bruck (*ibid.*) argue “[t]hat names are thought to have the capacity to fix identity [which] creates a tension with their capacity to detach from those identities.” It is the power that the name holds in creating an individual’s identity that makes it difficult to divide the name from the object. Thus, the ontological dissection of the social body into cadaver and person is where the hardship lies. Questions arise here around the ownership of the body and the political power that lies in the objectification process.

2.2.4 Emotional Labour, Emotion Work and Emotion Management

Giving the emotive context of the AUS’s work I expect that AUS would have some emotional aspects of their work, like the nurses that Bolton (2000) described, so I draw upon the seminal work of Hochschild (1979; 1983), from which the field of enquiry into *EL* stemmed, to theorise the type of emotion management AUS may complete as part of their work. However, I have not taken *EL* and the associated terms of deep acting and surface acting at face value as much of the literature from Hochschild (1979) onwards has, but I have taken on Grandey and Gabriel’s (2015: 20) encouragement for “[...] researchers to question and test assumptions about emotional labor.” I will first outline Hochschild’s (1983) *EL* and its key premises. Then I will present the main critiques of Hochschild’s *EL* in order to understand the *EL* or the types of *EM* (Bolton, 2000) that AUS performed, if any, as part of their FL work.

Hochschild (1983: 7 – emphasis in original) uses the term “emotional labor” to describe “the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has an *exchange value*.” In Hochschild’s analysis of flight attendants, *EL* is taught as good practice by the managerial staff of the flight companies. In her earlier work Hochschild (1979: 266) theorises that ““emotion work” refers more broadly to the act of evoking or shaping, as well as suppressing, feeling in oneself.” This is private emotion management. Later, Hochschild (1983: 7 – emphasis in original) uses the terms emotion work and emotion management synonymously “to refer to these same acts done in a private context where they have *use value*.” Hochschild (1990: 118) later clarifies the difference explaining that “[...] by “emotion work” I refer to the emotion management we do in private life; by “emotion labor” I refer to the emotion management we do for a wage.”

Hochschild (1983: 147) describes three characteristics of an *EL* role: “First, they require face-to-face or voice-to-voice contact with the public. Second, they require the worker to produce an emotional state in another person – gratitude or fear, for example. Third, they allow the employer, through training and supervision, to exercise a degree of control over the emotional activities of employees.” Hochschild (1983: 148) asserts that where self-interest is not present such as incentive schemes, then close supervision works best in promoting *EL* to take place. Also implicit in the *EL* role is that the worker completes both surface acting and deep acting. Surface acting is where naturally felt emotions are suppressed and organisational or fake emotions overrule these to present the desired face (Hochschild, 1983). Whereas deep acting is where the individual really feels the emotions required to present a desired face. These are both controlled by the worker’s organisation where feeling rules apply (*ibid.*). However, some theorists have argued that certain workers rely on naturally felt emotions, which contrasts to Hochschild’s surface and deep acting as the worker truly

feels the emotion as they are authentic and do not require regulation (Diefendorff et al., 2005; Randolph and Dahling, 2013). This has positive benefits for the worker such as job satisfaction (Cheung and Tang, 2010; Mesmer-Magnus, DeChurch and Wax, 2012).

Hochschild (1983: 190) emphasises the value put on “natural” feeling and being one’s “authentic self”. However, the “false self” is presented as a self which is me but not really me (*ibid.*: 195). A form of the false self is the altruist, where one is concerned with the needs of others, which is described as a product of culture which values altruistic actions (*ibid.*). If this is a product of culture, to what extent the altruistic emotional labourer recognises this as part of their role and if they deem this as part of their authentic self or their inauthentic (work) self is unknown. This may be key to appreciating the difference between the managed and the unmanaged heart, where the unmanaged heart may be something more akin to the natural, authentic (and naturally altruistic) self. There is a difference between the *real* and *acted* self where one must redefine themselves in accordance to their emotional labour-intensive roles in order to successfully complete their job and fit in with the company. This means that separating oneself from the company is complex and may not be possible in some roles; in this case the nonwork self is redefined too. Hochschild (1983) argues that for many, the real self is the nonwork self, meaning that the work-self is acted.

Hochschild (1983: 153) asserts that:

“[...] one-third of all workers experience a dimension of work that is seldom recognized, rarely honored, and almost never taken into account by employers as a source of on-the-job stress. For these workers, emotion work, feeling rules, and social exchange have been removed from the private domain and placed in a public one, where they are processed, standardized, and subjected to hierarchical control.”

According to Hochschild many workers undertake unrecognised *EL* as part of their role. It therefore comes into question whether the workers themselves, as well as their employers, recognise the *EL* that they are doing on a daily basis. The *EL* crosses the boundary between private to public (professional) life. To what degree aspects of the AUS's work are not recognised, supported or trained for is not known. Thus, I ask the question '**What recognition, support and training do staff get for this type of work?**' to be explored in this thesis.

This lack of recognition may be due to a shift in the ownership of this *EL* as Hochschild (1983: 189) argues that the emotional behaviour "[...] comes to belong more to the organization and less to the self." Similarly, the term transmutation implies that managerial emotion management is more powerful than personal emotion; whereby organisational pressures and boundaries transmutate workers' emotions which mean they are no longer their own (Hochschild, 1983). This view implies that there is no room for private emotion in one's professional role as if it is performed professionally it is owned by the organisation. However, it could be that private emotion, and the use of this as a tool when interacting with families of donors, may prove useful in mediating the relationship between them – especially when considering the role that empathy plays in the deathworkers' job, although the staff must be invisible, keeping their personality and emotions out of the performance, yet use these as tools (Walter, 2005: 406).

The redefining of oneself involved in *EL* may be a form of organisational loyalty. This adds to the organisational pressure that is put on their private lives. There is a sense of going beyond what is expected, as Bolton and Boyd (2003: 299) argue:

"They may feel empathy and compassion and, due to this 'attunement', decide to go beyond mere 'prescriptive' or

'pecuniary' rules of emotion management in order that they may reassure others of 'genuine' motives and commitments [...]"

Sharp (2006: 75) asserts that "[...] procurement staff walk a tightrope between respecting the emotional fragility of kin and remaining true to the ideological premises that drive their work." They must attend to comforting kin as well as supporting their professional duties. In BD the conversation needs to be concise and effective covering all areas that are essential to the family and to the AU's needs. There are multiple levels of fluidity between terminologies, attitudes and behaviours and staff must mediate this to lay people and professionals.

Above, when Bolton and Boyd (2003: 299) refer to *EM*, they are drawing on to Bolton's (2000) multidimensional typology of *EM*. In this, Bolton (2000) distinguishes that there were various types of work that nurses were completing. She thus contends that Hochschild's (1983) *EL* concept was not enough to capture the complexity and nuances of the nurses' *EM*. This *EM* is different to what Hochschild (1983) referred to as emotion management, as Hochschild used this synonymously with *EL* in her earlier work. Bolton (2000) differentiates *EM* into four types: prescriptive; pecuniary; presentational; and philanthropic, known colloquially as the 4 Ps. First, prescriptive *EM* is that which is commissioned by managers according to organisational rules of conduct (Bolton, 2000). Second, pecuniary *EM* is that which is completed for commercial gain. Third, presentational *EM* is completed in accordance with general social rules and relies on the workers' morality and being attuned to societal and cultural norms. Finally, philanthropic *EM* is that which is given as a gift. Bolton (2000: 156) illustrates "[...] that throughout a working day it is possible, using emotion management skills learnt throughout a lifetime's social training, to present a variety of "faces". These four types of *EM* can thus be completed in the same day or at the same time and are dependent on the situation to which the workers are responding. There

have been some studies analysing different workers that have suggested that some workers mainly completed philanthropic *EM*; for example, nurses (Bolton, 2001) and newspaper In Memoriam (IM) writers (O'Donohoe and Turley, 2006). Thus, workers may be using only one type of *EM* at any particular time. This highlights the importance of applying these theoretical lenses to various workers to understand their work and reveal the complexity of their *EM*.

However, Brook (2009) argues that Bolton (2005) was wrong to dismiss Hochschild's (1983) *EL* and critically defends Hochschild's original concept of *EL*. Brook (2009: 541) contends that "employers understand that the final service product, whether planned, enhanced or sabotaged, is their 'property'; a view shared by recipients, as those unhappy with their service experience will invariably seek redress from managers rather than the front-line culprits." Thus, all professional work, regardless of its nature, can be commodified. Even Bolton (2009) admits that she has moved on from the 4 Ps and understands that complex *EM* cannot be reduced to only four types.

I have provided a brief overview of the main standpoints within *EL*. These debates demonstrate that Hochschild's *EL* concept may not capture all of the nuanced *EM* that AUS complete. Thus, a flexible approach must be taken when applying these notions to the work that AUS do, if any, with the families of donors in chapters four, five and six. In this thesis I apply these concepts as a theoretical lens to the AUS for the first time, considering recent developments in this concept as well as Hochschild's original *EL*, to contribute to the current knowledge around *EL*.

2.2.5 Hidden and Invisible Work

Throughout this section it is clear that dirty work can be completed by deathworkers, where *EL* or *EM* is a key part of their role. I now bring

these theoretical lenses together to comprehend how such work may be hidden or invisible, which may be telling of the extent of the recognition, support and training that AUS receive for their work. First, I start with dirty work.

Dirty work is abhorrent and considered polluting in society and is thus removed (Douglas, 1966). Those individuals who complete such work are also shunned from society (*ibid.*) and considered outsiders (Howarth, 1996). Second, deathworkers edit a story in private and perform this edited purified story in public (Walter, 2005). There is a public-private divide where much of this work is completed in the private realm, behind the scenes and hidden from public gaze. Third, there is a gendered divide to who performs *EL* and it is often considered “invisible work” (Daniels, 1987: 403), which Daniels (1987) used to describe unpaid labour completed by women. Hatton (2017) draws upon the literature that followed Daniels’s coining of the term to suggest that this invisible work may include being overlooked or ignored (Anteby and Chan, 2013; Kristal, 2002; Otis and Zhao, 2016), physically hidden (Cherry, 2016; Macdonald, 1998; Nardi and Engeström, 1999; Otis and Zhao, 2016; Poster et al., 2016), culturally and economically devalued (Daniels, 1987; Nardi and Engeström, 1999), legally unregulated and unprotected (Pendo, 2016), and socially marginalised (Nardi and Engeström, 1999; Otis and Zhao, 2016; Star and Strauss, 1999). If AUS’s work is framed with such lenses it may be that their work too is invisible or hidden. Thus, in this thesis I explore the extent and nature of this hidden or invisible work for AUS. Combining these aspects as a way into exploring such work may be revealing of the recognition, support and training AUS get for this type of work.

This section has been useful in considering workers that complete dirty work, deathwork, *EL* and *EM*. There are various performative aspects and public-private divides in such work as it is generally abhorrent and

thus hidden or invisible work. Next, the context in which the AUS complete their work is explored.

2.3 THE ANATOMY UNIT

In addition to exploring the theoretical underpinnings of the AUS's work, it is important to consider the context in which this work takes place. Richmond (1922: 99) posits that the physical environment "becomes part of the social environment". Thus, investigating the AU is key to appreciating the social setting and social relationships that take place there. Three key theoretical underpinnings are described in this section. Firstly, I apply Goffman's (1959) dramaturgical metaphor to the AU to consider how the AUS as deathworkers and emotional labourers/managers are backstage workers performing on the stage of the AU. Secondly, the AU is framed as a liminal space, in which the space, bodies and AUS can be seen as existing within a betwixt and between state (Turner, 1969; Van Gennep, 1960). Third, the AU is explored as a heterotopic space, positioning the AU within Foucault's (1967) framework, in which the AU could be seen as a space which is other. These theorisations of the AU may illuminate the work that AUS complete within them; in particular their FL work. Now, I focus on the first of these three theoretical frameworks: the dramaturgical metaphor.

2.3.1 Front Stage / Back Stage

Hochschild (1983) linked the *EL* performed by flight attendants and bill collectors to dramaturgical techniques (Goffman, 1959) where these workers are seen as actors within their workplace. During face-to-face interactions the actor has an ability to guide and control the recipient. Bolton (2001: 87) also applies Goffman's (1959, 1961, 1967) work to understand nurses' presentations of self while performing their *EM*. Bolton (2001: 87) posits that "[...] Goffman's analysis of social

interaction as an approach to a sociological understanding of emotion assumes that emotions are actively managed by people according to the rules of a particular situation, set within a wider structure of cultural beliefs and values.” These actors have the ability to choose their props, stage and costume, which, unlike the rigidity suggested with the airline staff (Hochschild, 1983), the AUS may be able to innovate and respond to the family’s actions. This raises the question of the actors’ agency while performing such work. The performers thus can be seen to be in control of their emotions; however, they are affected by the context, society and culture. This is similar to presentational *EM*, defined by Bolton (2000), as she asserts that it is cultural beliefs held by those around which inform the way *EM* is performed. It may thus be the complex interplay between the place, the people and society which influences the AUS’s *EM*.

Goffman’s (1959) analogy of the theatre can be applied to the work that takes place at the AU. The front region is where the actor is performing on stage to an audience of engaged recipients. However, there is the back region behind the stage where hidden work takes place, where the actors are more likely to be their authentic selves. I expect that there is a series of behaviours, coping mechanisms and discussions that go on behind the scenes at the AU after the interaction with the families has ceased. The dramaturgical display also has the effect of distancing the individual from the body (Howarth, 1996). Dramatising the display and handling of the body may also help with the detached concern that is often used by deathworkers as a method of distancing themselves in order to maintain a happy personal and professional lifestyle (Lief and Fox, 1963). This includes mechanisms such as humour. These mechanisms are similar to what Walter (2005) observed for deathworkers. There is a public-private divide in their work; for example, funeral directors edit a story in private and perform this on a ritualised public stage (*ibid.*).

Drawing from Goffman (1959), Howarth (1996) attempts to explain the theatrical display of funeral directors. She clarifies that funerary rituals are a dramaturgical metaphor and it is the funeral director's role to conduct and coordinate the display effectively. Howarth (1996: 111) recognised that the funeral director, starting from the arrangements interview, plays a role, using "a personal front" and "the setting" to elicit a response during an in-depth discussion with the family of the deceased. This draws upon Goffman's (1959) terminology of appearance and manner, where the actor is key in the display. The funeral is rehearsed and performed, with props, which leads the audience to be swept up in the ceremony and fulfil their social roles within the ritual. Howarth (1996) draws upon Duvignaud's (1973: 86) description of society and theatre as distinct positions where death rituals are;

"[...] stratagems for averting or masking its hostile destructive force. In the theatre, death is something overcome and integrated, something that only remotely implies the real spiritual horror of actual annihilation [...]"

Howarth's (1996) explanation of the approach the undertaker takes can be applied to BD as an alternative method of disposal. The setting and circumstances differ, yet the core processes and ritual expectations may not vary substantially. The role of the undertaker and the AUS member are comparable in their dramaturgy and job requirements. Next, I turn my attention to the AU as a liminal and heterotopic space.

2.3.2 The Anatomy Unit as a Liminal and Heterotopic Space

The AU is a liminal space as it allows for a transformation to take place. Van Gennep (1960) and Turner's (1969) descriptions of ritual processes can be used to understand the transition of the social and

biological body from structured society, defined by routine and social order, to a liminal space (the second stage) through separation (the first stage). This process can also be used to understand the movement of the people involved in a ritual situation, such as the medical students, AUS and families within a BD thanksgiving service. In this liminal stage the structural organisation of society disappears. Within the methods of dealing with the dead body, whether this is the typical funeral or atypical BD, feelings such as *communitas* are created. *Communitas* implies the shared experience of the individuals within a sacred or spiritual (broadly taken) event. I apply this to methods of dealing with the body in which the students, AUS and families take part in a shared experience. The qualities of this liminal state mean that new ways of dealing with the body may be introduced. The third stage of reintegration happens after the method of dealing with the body has ceased. In the typical funeral this is completed within a relatively short time frame, whereas this is extended within BD. After the disposal of the body, the family of the donor and the AUS and students may too leave the liminal context and return to normality. There is a complex interplay of experiences that take place within this liminal situation.

Heterotopias (Foucault, 1967) are “other places” within society which “describes a world off-centre with respect to normal or everyday spaces, one that possesses multiple, fragmented, or even incompatible meanings” (Dehaene and De Caeter, 2008: i). Its “role is to create a space that is other, another real space, as perfect, as meticulous, as well arranged as ours is messy, ill constructed, and jumbled” (Foucault, 1967: 8). This can be applied to the other, atypical spaces in which the body is dealt with, such as the AU. In their full operative state heterotopic spaces allow for a space-time break, where a deeper reflection upon the space and the objects contained within can be made by those who encounter it (that is, staff and students). It may be that the AU is a heterotopia for the family of donors; however,

is a normal space for the AUS and students. This is because families are rarely allowed to visit the dissection building (or are kept in a specific space such as a family room that some AUs have).

The cemetery is defined as a heterotopic space by Foucault (1967: 6); “the cemetery begins with this strange heterochony, the loss of life, and with this quasi-eternity in which her permanent lot is dissolution and disappearance.” The cemetery is a strange space, “unlike ordinary cultural spaces”, nevertheless is “connected with all other sites in the city, state or society or village etc.” (*ibid.*). The move of these sacred places from the centre of the city to the marginalised outskirts runs in line with the interpretation of death as an illness, through the medicalisation and individualisation of death and dying (Aries, 1981), which need to be purified (Douglas, 1966). These spaces are “indefinitely accumulating time” and are controlled by barriers which are “opening and closing” making it “inaccessible to its ravages” (Foucault, 1967: 7). To gain access to these spaces one must make certain gestures and gain permission. However, Foucault (*ibid.*) asserts:

“There are others, on the contrary, that seem to be pure and simple openings, but that generally hide curious exclusions. Everyone can enter into the heterotopic sites, but in fact that is only an illusion – we think we enter where we are, by the very fact that we enter, excluded.”

It may be that the committal and/or thanksgiving services that some units hold, the only accessible part of the post-donation process for the families and friends of donors, can be understood as simple and pure openings in that they are comparable to traditional death rituals that the families and friends of donors that attend may be accustomed to. However, they are unusual events which are transformed to fit to the requirements of the AU. The latter part of the above quote makes clear that within heterotopic spaces the public (or family in the case of the post-donation context) are disillusioned to think that they are entering

the space and understand the space. These are recreated and bounded spaces in which the outsider will never fully understand and will remain excluded.

It is clear from this section that there is a complex interplay of performance and spatial constructs that take place within liminal and heterotopic spaces. It must be comprehended to what extent these spatial conditions apply to the AU and how this affects the bodies, families and staff within them.

2.4 CHAPTER CONCLUSION

In this chapter I have considered the three main factors (the donor's family, the AUS and the AU) that influence the AUS's FL work after donor death and presented the theoretical underpinnings necessary to understand this work. It was clear from 'the donor's family' section that *continuing bonds* is the prevailing perspective on coping with bereavement. However, a flexible approach must be taken when applying theories on coping with bereavement to the families of donors in order to illuminate how this affects the FL work of AUS. It was clear that certain aspects, of both traditional perspectives and *continuing bonds*, may resonate in different contexts. I have also made a case for the importance of the funeral, memorialisation and physical markers for the families of the deceased as means of *continuing bonds* drawing upon Valentine (2008). These are the processes which are affected by BD as they fall after acceptance and I aim to understand how this influences the AUS's FL work. In particular Bolt (2012) and Strkalj and Pather (2017) highlighted the AUS's role in the thanksgiving stage. I develop this and explore the AUS's FL work throughout all stages after donor death. I will apply *gift exchange*, drawing from Mauss (1990), as this is key to understanding the AUS's role in the giving of physical monuments (Bolt, 2012).

In the 'anatomy unit staff' section I reviewed literature that could apply to the work of the AUS. In particular that they are framed as dirty workers and deathworkers who complete *EL*, emotion work and *EM*, much of which may be invisible or hidden work. They may use coping mechanisms, similar to other dirty workers and deathworkers, to complete such work. In 'the anatomy unit' section I explored the context of the AUS's work. I ascertained that there is a complex interplay of performance and spatial constructs that take place within liminal and heterotopic spaces. To what extent the particular aspects of AUS work and the spatial conditions apply to the AU and how this affects the bodies, families and staff within them is examined in this thesis. Overall, the gap in the literature is clear in this chapter. I will apply these theories around: coping with bereavement, the AUS and the AU in a new context with a group of workers in which these perspectives have not yet been applied. In the next chapter I will discuss the methodological approach I took to explore this.

CHAPTER 3: RESEARCHING THE WORK OF ANATOMY UNIT STAFF: A METHODOLOGICAL DISCUSSION

I delineated in chapters one and two that AUS played a pivotal role in the post-donation process. However, what it is not known is the extent, nature and form of this work, which AUS completed it, when it occurred, what recognition, support and training AUS received for this work, and how, if at all, such work was brought to an end. Therefore, I posed the following research questions in chapter two:

3.1 RESEARCH QUESTIONS

1. **What is the extent, nature and form of contact with donors' families after donor death?**
2. **Who has contact with donors' families after donor death?**
3. **When do such contacts occur?**
4. **What recognition, support and training do staff get for this type of work?**
5. **How is family liaison work brought to an end if at all?**

In this chapter I discuss the methodological approach I took to answer these research questions to achieve the research aim (**to identify good practice in the interactions between UK Medical School Anatomy Unit staff and the families of body donors after donor death**) presented in chapter one. I first outline and discuss the multi-method ethnographic approach I used to research the work of the AUS. Then I present the UK AUs that formed my case studies and the AUS that were participants in this study. After this, the data collection methods that formed the multi-method ethnographic approach will be detailed. This included: document analysis; a national survey of UK

AUs; an ethnographic case study of one UK AU; semi-structured interviews with AUS; and participant observations of AUS at thanksgiving services. Following this, attention will be paid to the approach I took to analyse these data. Finally, ethical considerations will be discussed. I reflect on these methodologies in practice throughout. I now turn to the multi-method ethnographic approach which informs all of my data collection and analysis.

3.2 MULTI-METHOD ETHNOGRAPHIC APPROACH

As I have established in chapters one and two there was little research around AUS's work with families after donor death. To this end I started with an inductive approach drawing on the empirical cycle (De Groot, 1961) [see figure three] which allowed me initially to take an open-ended exploratory approach into the work of the AUS. The empirical cycle, a continuous cycle comprising *observation*, *induction*, *deduction*, *testing*, and *evaluation*, which feeds back into the first stage of *observation* and thus begins the cycle again until data saturation. As Mietus (1994: 49) asserted, the empirical cycle is a useful approach for inductive-empirical research which at its premise is "lacking theory and insight into the nature of the problem. Typically, it is difficult or even impossible to specify hypotheses beforehand. The research questions put forward in explorative and descriptive research are therefore not aimed at testing hypotheses." The empirical cycle was the best fit for my approach to the research; I interwove multiple methods which informed each other, aided the construction of further questions and foci throughout, and informed the next round of the cycle. Furthermore, my position as an outsider, a spectator who did not have personal involvement, is an important characteristic of the empirical cycle because I had fewer preconceptions that could affect the data collection (*ibid.*).

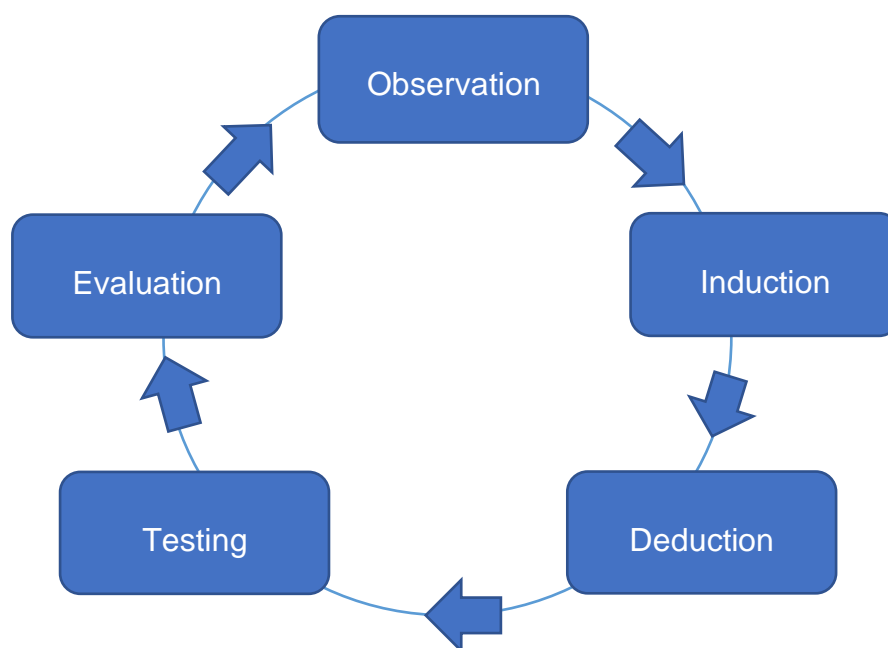


Figure 3: The empirical cycle (adapted from De Groot, 1961)

The *observation* stage comprised the initial narrative review of the literature, the review of the HTA AU inspection report documents that were available on the HTA website and the survey. This stage was concerned with collecting existing empirical facts present within the literature (Mietus, 1994). The stages of *induction* and *deduction* were then used to form a research aim and research questions from this literature by identifying the gap to be explored in this thesis. The *testing* stage in which I place the main methodologies of my ethnographic data collection (interviews; case study; and participant observations of AUS at thanksgiving services) were thus informed by the previous stages and by further round of the cycle as the cycle repeats due to a constant immersion in and emergence from and overlapping of data collection methods. This then provided new questions to be asked during the subsequent interviews and new areas to be focussed on during the case study and observations at thanksgiving services. For example, a qualitative survey of AUs, outlined in subsection 3.5, was an informative tool within the empirical cycle which was used to generate empirical facts and raise new questions to be explored within

interviews and ethnographic case study. I agree with Bernard's (2011: 252) observation that "Anthropologists are finding more and more that good survey technique can add a lot of value to ethnography." I too use a survey alongside an ethnographic case study in this thesis which was beneficial in exploring the AUS's work. The final stage of the cycle, *evaluation*, was interpretive by nature where the results from the data collected were used to generate new ideas, questions and foci. Now that I have described my way into the research area, I will next examine the ethnographic approach I took.

3.2.1 Taking an Ethnographic Approach

The ethnographic nature of this research approach was key to developing an in-depth all-encompassing view. It allowed me to gain access to areas that were previously unexplored and understand and outline the work AUS completed with families after donor death. Geertz (1973) asserted that ethnography is not a research method; it is a process of gaining and processing knowledge through multiple means. Traditionally ethnography is "[t]he recording and analysis of a culture or society, usually based on participant-observation and resulting in a written account of a people, place or institution" (Simpson and Coleman, 2019). However, *doing ethnography* (Geertz, 1973: 6) is "establishing rapport, selecting informants, transcribing texts, taking genealogies, mapping fields, keeping a diary, and so on." Theoretically, Geertz (1973) argues, using Goodenough's (1957) idea that "culture [is located] in the minds and hearts of men" (Geertz, 1973: 10), that culture is instead a "theoretical muddlement" in which it and the study of it (ethnography) should not be defined easily (*ibid.*). Geertz, (1994: 218) instead contended that "[t]hough ideational, it does not exist in someone's head; though unphysical, it is not an occult entity. The interminable, because unterminable, debate within anthropology as to whether culture is "subjective" or "objective," [...] is wholly misconceived." Geertz (1994) favoured meaning (semiotics)

over ontological status. This informed my multi-method ethnographic approach to this study as I was aware that I needed to explore all aspects of the culture and the meanings imbued in the participants' actions, relationships and their environment.

Likewise, Hammersley and Atkinson (1995: 1) took a capture all approach, describing ethnography as; "a particular method or set of methods" which "[...] involves the ethnographer participating, overtly and covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research." I take on elements of both Geertz (1973; 1994) and Hammersley and Atkinson (1995) in my approach to data collection in that I took a capture all ethnographic approach, completing overt participant observations, adopting ethnography both as an approach and a method. This approach comprised "*doing ethnography*" including establishing rapport and selecting informants (Geertz, 1973: 6).

As I mentioned above, I adopted ethnography as a data collection method too, discussed in section 3.5. This was an integral part of the multi-method design. For example, when I attended thanksgiving services, it was useful to have spoken to the AUS who arranged, facilitated and took part in the service beforehand. I used observational methods during the ethnographic case study to gain a natural and real-life understanding of one UK AU and in observations of thanksgiving services. This was in addition to the interviews in agreement with Mason's (2012: 85) argument that "not all knowledge is for example articulable, recountable or constructable in an interview." I have discussed the use of ethnography as an approach and a method. Next I consider the timeframe of such research.

In traditional anthropological practice, fieldwork was completed over a long period of time, recording cycles within the field using multiple ethnographic methods; however, there has been a move away from this in modern anthropology (Gupta and Ferguson, 1997). In the ethnographic case study, discussed in section 3.5, I stayed in ‘the field’ for six months for several reasons. First, because this was the point where I had reached data saturation and observed practices over two academic terms. Second, as this was a natural point to close the ethnographic case study in coordination with the move out of the AU building during summer of 2017 while refurbishments took place. Third, since the timeframe fitted alongside my other data collection methods within the remit of PhD funding and data collection period. Now that the timeframe has been deliberated, I next explore the characteristics of the field.

Clifford (1997: 53) asserted: “What mattered was not simply the acquisition of fresh empirical data. [...] What made this fieldwork was the act of physically *going out* into a *cleared place of work*.” “*Going out*” (*ibid.*) created a divide between the researcher’s base and the field. “*A cleared place of work*” (*ibid.*) signified that the field was predefined; the researcher realised the barriers to the field and what they were collecting. In my practice this was more complex than it seemed here; the field was a fluid space, even though the AU had clear barriers to dictate when one was entering and leaving the space. The spaces inside were transitional and sometimes relocated for refurbishment purposes. The properties of the field, for example the inaccessibility, meant that the way I collected data had to alter according to the environmental constraints. I picked a field which was “*cleared*” in Clifford’s (1997: 53) sense, as foreign bodies were already restricted from my field site as only AUS were allowed through the physical barriers, as a key card was needed to enter the AU. This was similar to De Certeau’s (1984) argument that space was not an ontological given, it was dictated by people’s practices within the

space. This was what made the field, the interaction of people within the space, but it was not a given, it needed to be constructed. In this subsection I have discussed the importance and characteristics of ethnography and the ethnographic approach. I next turn my attention to the case studies in which such an approach was employed.

3.3 CASE STUDIES: UK ANATOMY UNITS

In this study eighteen UK AUs were identified. The inclusion criteria were a UK AU (excluding Scotland) that had a BD programme that procured bodies for their own use or was a central office which represented a collective group of AUs and completed gross anatomical dissection for the education of students. I did not include Republic of Ireland and Scotland in this study as they are not governed under the Human Tissue Act 2004. I anticipated that they might have different BD practices on account of the differences in governance and legislation. There were sixteen AUs in England, one in Northern Ireland and one in Wales that meet these inclusion criteria. Of these there was one central office that represented seven AUs within their local area. One AU which was considered exemplary of FL in the UK (identified through the HTA AU inspection reports) was used as a case study. Although generalisations cannot be drawn from this case study it will be used to gain an in-depth insight into one UK AU. In total eighteen units were contacted, and a response was received from seventeen. Of those seventeen AUs, fifteen AUs completed the survey and AUS in fourteen AUs completed at least one in-depth semi-structured face-to-face interview or telephone interview. Next, I discuss the participants.

3.4 PARTICIPANTS: MEDICAL SCHOOL ANATOMY UNIT STAFF

Medical school AUS are those individuals who work in the AU and do one or more of the following tasks: facilitate BD, complete FL work, dissect, and work with students. I was specifically interested in staff members who completed FL work during the post-donation process and therefore only included these staff members as interview participants. For the ethnographic case study, I included all AU members of staff as I wanted to gain an understanding of all the individuals who worked at one AU. At thanksgiving services, I observed both AUS who completed FL work as part of their everyday work and those AUS who completed FL work only at thanksgiving events. By making AUS the key informants in my study I hoped to understand who had contact with donors' families and what was good practice in their interactions with families. I also wished to understand what recognition, support and training, if any, they received in order to do this type of work.

For the purposes of this thesis, post-donation FL was defined as the interactions and communications which occurred between AUS and the families of those who had donated their bodies for medical education. Such communications could be verbal, via telephone or face-to-face, or textual, via email or postal letters. To this end the AUS which were most likely to perform this type of work were the BSs, MMs and designated individuals (DIs). In some of the case studies the technical staff completed FL work; however, this was normally on a part-time basis as they filled in when the staff that usually completed the FL work were absent. One to four AUS participants were interviewed per unit. At the unit where the ethnographic case study was completed, all seven AUS were participants. Through the various data collection methods, I have been able to explore the role and work

of the AUS which provided a comprehensive view of the post-donation interactions between AUS and families.

I have already demonstrated, in chapter two, that the FL roles of AUS and those of funeral directors are similar. I use Howarth's (1996) work here to aid in investigating how the individual came into the role, the role itself and the work the AUS completed. Howarth (1996) asserted that there were several premises in which funeral directors *become*. Most useful of these premises was the individual who has no family connections to the trade, but actively wished to join the funeral industry. This was most akin to the position of the AUS as it was not often that they came into their role through family connections or unemployment (the other two ways of becoming a funeral director described by Howarth (1996)). It must be explored how the AUS have *become*, and what previous academic and professional backgrounds they had which equipped them for such a role. Furthermore, it must be examined whether they expected the work they did when first accepting their role. The requirement of the "right frame of mind" was necessary for funeral directors (and AUS) as this indicates to the employer that the individual had the ability to assimilate into their role (*ibid.*: 70). Howarth (1996) also explained the requirement of the individual to be able to withstand the "personal trauma" that may be caused by "the nature of the work" (*ibid.*: 71). When discussing the recruitment of staff Howarth (*ibid.*: 70) substantiated:

"Successful assimilation into the industry, some funeral workers argue, can only be achieved by a particular type of person with specific qualities conducive to deathwork. When recruiting staff, Adrian preferred to employ people with no previous experience of deathwork."

This indicated that the nuances of the work at each institution may differ and any preconceptions carried with an employee from previous work in the same industry may be detracting. This may be similar for the AUS as each unit may differ in the work that was expected of its

staff (including *EL* (Hochschild, 1983)) and may have requirements of a different skill set from each employee. Similar to the funeral director, the clients vary for AUS and they must respond accordingly, learning from experience, not a rule book. The deathworkers must alter the format in which the individual was approached, which required emotional sensitivity. Furthermore, I assumed that there was little or no movement of peoples between AUs as the employees' previous preconceptions may create conflict in the way in which the unit is run. I next discuss how these participants were recruited to the study.

3.4.1 Sampling

I took a practical sampling approach (Henry, 1990), aiming to include all AUs within the study. I first used the HTA website to identify a contact at each unit; this was either the DI or the BS. This individual then acted as the gatekeeper to each unit. The HTA website provided a name, contact email address and telephone number. I compiled this contact information ready for one of my supervisors, the DI at The Hull York Medical School, to email the identified contacts. As my supervisor had worked in the field for a significant period of time and had built rapport with the individuals that were contacted, it made initiating contact and entering the field easier. Participants then either contacted me directly, or they replied to the initial email with me copied in, or the email was forwarded to me by my supervisor. I received five out of eighteen initial responses through this approach.

I then replied to this email outlining the study, giving further information, sending the survey, asking for documents and setting up an interview date, and for them to identify if they had a thanksgiving service and if they were happy for me to attend. During this step there were multiple emails back and forth over several months in order to gain the data required. The recruitment process took a long time and much effort, as some units were more difficult to recruit than others

due to time and workload pressures. I appreciated that the AUS were extremely busy and I tried to be flexible in how I would complete the data collection. At four units I completed telephone interviews as it was difficult to arrange a suitable time to visit for interviews at these units.

The gatekeeper (typically the DI or BS) then identified, and put me in contact with, other AUS within their unit in which I then interviewed, observed during the thanksgiving events, and received documents from via email or hard copies when I visited the AUs. This method of snowballing (Goodman, 1961) was useful in the recruitment of other AUS within the unit. I was able to coordinate with the AUS so I could interview multiple AUS during a one-day visit to the AU, which was more productive and convenient for me and the participants. For those who had not responded to my supervisor's initial email I sent an email to the same contact and the process followed that of the previous step. Table one outlines the participant recruitment process at all eighteen sites.

Step #	Outline
1	Contact was made with the participant (HTA body donations contact) via email from supervisor.
2	Participants replied to initial email from supervisor.
3	I replied to this email outlining the study, asking for AU documents, setting up an interview date, identifying if they have a thanksgiving service and if they were happy for me to attend and send a survey. Email and telephone calls were exchanged until all data collection methods completed for each unit.
4	I sent an email to those who had not responded to my supervisor's initial email (then step three was repeated until all data collection methods were completed for each unit).
5	I followed up via telephone and email for those who had not responded to either step one or four. This step was repeated until contact was made.

Table 1: Outline of the participant recruitment process at all eighteen sites

Difficulties in recruitment to the study meant that only data was collected from England and Northern Ireland and not Wales. However,

overall the study had a high response rate with data being collected from fifteen of eighteen AUs.

For the AU where I completed the ethnographic case study, a different sampling approach was used. I discuss this further in the next section. I completed the other stages of the data collection process at this AU in the same way described in table one above. Now that I have examined the case studies and participants I next outline and discuss the methods of data collection used.

3.5 DATA COLLECTION

First, a narrative review was completed to understand the literature around this topic area. Second, document analysis was carried out on the HTA AU inspection reports available online, and AU documents (information letter and consent form that are sent to potential donors, letter of refusal of acceptance upon donor's death, letter of invitation to memorial service, notification of funeral/disposal of remains, and any other documentation that the units may provide). Furthermore, a national survey of UK AUs was carried out along with in-depth interviews with AUS and participant observations of AUS during thanksgiving services.

I sent an email to the identified participants (either the DI or the BS) inviting them to complete the survey. The survey and consent form were attached to the email. This email explained the intentions of the whole study. After completion of the survey I sent a thank you email which de-briefed the participants of the survey and invited them and other staff they wished to identify to interview. I arranged a good time to visit them to conduct interviews and visit their unit. An information sheet was presented to the participants prior to the interview and a consent form was signed.

A semi-structured interview using an interview topic guide (see appendix B) was conducted. I completed between one to four interviews per unit; this included the DI, MM or BS as the main interviewee and other staff such as FL personnel, and anatomists/embalmers. It was up to the lead participant to suggest and decide on the final one to four participants per unit. I then provided a de-brief form and answered any questions the participant(s) had. I discussed with the lead participant after the interview if I could attend and conduct participant observation of AUS during their thanksgiving ceremony if applicable (as some units did not conduct thanksgiving ceremonies or their service did not fall within my study period). Before the service I asked the AUS to read an information sheet which explained my research and reason for my presence at the thanksgiving ceremony and complete a consent form. Overall there were six telephone interviews, six group interviews and eight interviews with single members of staff.

Table two outlines the data collection visit dates, location by anonymised site number and the research activity completed there. These are only for the interviews, case study and participant observations at thanksgiving services.

Date of research visit	Location – site #	Research Activity (# of participants)
22/11/2016	7	Telephone interview (1)
23/11/2016	7	Telephone interview (1)
24/11/2016	2	Interview (1) and AU visit
24/11/2016	7	Telephone interview (1)
29/11/2016	14	Group interview (3)
29/11/2016	14	Conversation (1)
01/12/2016 - 02/06/2017	2	Anatomy unit case study (7)
13/12/2016	3	Interview (2) and AU visit
13/12/2016	3	Conversation (2)
20/12/2016	9	Group interview (2)
21/12/2016	4	Group interview (2)
01/02/2017	17	Interview (1) and AU visit
01/02/2017	17	Interview (1)
01/02/2017	17	Interview (1)
08/02/2017	11	Interview (1) and AU visit
08/03/2017	14	Thanksgiving service
09/03/2017	9	Thanksgiving service
23/03/2017	8	Thanksgiving service transcript
24/04/2017	10	Interview (1)
28/04/2017	18	Group interview (2) and AU visit
10/05/2017	2	Thanksgiving service
12/05/2017	4	Thanksgiving service
05/06/2017	2	Interview (1)
06/06/2017	2	Group interview (2)
28/06/2017	6	Interview (1)
14/09/2017	13	Telephone interview (1)
15/09/2017	16	Telephone interview (1)
11/10/2017	6	Thanksgiving service
13/10/2017	8	Telephone interview (1)
08/11/2017	17	Thanksgiving service
01/11/2017	11	Thanksgiving service

Table 2: Data collection visit dates, location and research activity

The following sections will explain in greater detail the data collection methods used. I begin with document analysis.

3.5.1 Document Analysis

Bowen (2009: 27) described document analysis as “a systematic procedure for reviewing or evaluating documents – both printed and electronic (computer-based and Internet-transmitted) material.” Documents are examined to gain understanding and generate empirical knowledge (Corbin and Strauss, 2008). Mason (2012: 106) asserts that “we can trace or ‘read’ aspects of the social world through them.” They are a silent source of data that can elicit meaning about the question at hand. Documents are data created for other means without the researcher’s intervention. Atkinson and Coffey (1997: 47) explain that documents are “social facts” which are used, made and distributed within the social sphere.

In this thesis I analysed two types of documents: HTA AU inspection reports and AU documents. These added meaning to the other research methods and add another dimension of insight into the work of AUS. First, the HTA AU inspection reports were publicly available on the HTA website (HTA, 2019c). A total of twenty-one HTA AU inspection reports were collected covering the eighteen AUs included in this study between the years of 2010 and 2016. The HTA carried out these inspections “to assess if the Designated Individual (DI) is suitable to supervise the activity covered by the licence, as it is their responsibility to ensure that: 1. other staff working under the licence are suitable; 2. suitable practices are used when carrying out the activity; and 3. the conditions of the licence are met” (HTA, 2019d). A representative from the HTA visits the establishment to meet with staff, review policies and procedures, and view the premises and facilities (*ibid.*). As these documents were publicly available, I was able to search on the HTA website and download the available HTA AU inspection reports for the eighteen AUs that met the inclusion criteria.

Second, the AU documents included: information and consent forms sent to potential donors; acceptance/refusal letters; invitations to memorial services; order of service; notification of funeral/disposal of remains; and any other documentation that the units may provide. I requested any available AU documents via email from the main contact at the AU. I asked if they were happy for me to have access to the documents either sent as attachments via email or as hard copies when I visited the AU. Eight AUs agreed to send the available documents via email before I conducted the interviews. Four AUs agreed for me to receive hard copies of the documents when I visited the unit. One AU allowed me to view hard copies at the unit but did not allow me to take them away.

The analysis of the documents generated themes which informed the other data collection methods, for example the interviews, as I had some knowledge of the practices at the AU before the interviews. Bowen (2009: 28), summarising Labuschagne (2003), postulated: “The analytic procedure entails finding, selecting, appraising (making sense of), and synthesising data contained in documents. Document analysis yields data – excerpts, quotations, or entire passages – that are then organised into major themes, categories, and case examples specifically through content analysis.” I have adopted content analysis to understand these documents combining literal and interpretive readings. However, as Mason (2012: 107-108) proclaimed, “[l]iteral ‘readings’ of [...] documents should not extend to treating them as though they are direct representations or reflections of ‘reality’ or straightforward ‘factual records’.” There were multiple factors which influenced what can be derived from documents. The context in which the documents were used, produced and their meanings, was important in how the documents were “read” (Mason, 2012: 108).

The HTA AU inspection reports highlight what the HTA were observing when they visited the AU, what they looked for, what standards they

expected and what their key foci were. The AU documents made clear what documents were distributed to the families of donors, what language was used in the documents and to whom they were aimed. Both of these sources made clear the similarities and differences between the AU's practices. Of course, as Mason (2012) highlighted, I had to take into account the nature of these sources; who produced them, why were they produced and for whom are they produced in order to understand the context of the information within them.

Mason (2012: 108) advised the use of documents "alongside several other methods of data generation" as they "[...] may provide an alternative angle on, or add another dimension to, your research questions" (*ibid.*: 109). This supported my use of documents within my multi-method approach. Furthermore, Mason (*ibid.*) argued that "[s]ometimes, documents are used to verify or contextualize or clarify personal recollections and other forms of data derived from, for example, interviewing and observation." This further substantiates my use of documents to supplement other methods within my multi-method approach. Again, this gives a well-rounded understanding of the whole process and all that is involved. Next, the national survey of UK AUs will be outlined and discussed.

3.5.2 National Survey of UK Anatomy Units

In this thesis I applied the observation stage within the empirical cycle (De Groot, 1961), which comprises the initial narrative review of the literature and the look over the HTA AU inspection report documents, to develop areas of enquiry within the survey. There were four main areas of enquiry that I wanted to investigate; *logistical data*, such as how many bodies are received per year, if this number met their needs, and how many bodies were not accepted per year; *involvement of AUS following body donation*, including contact with families; *the funeral service*, covering what disposal options are offered, what option was

most often chosen, what facilities were provided (for example coffin, urn), who attended the funeral, if the families collected the ashes and what happened to those that were not collected; *memorialisation*, including the thanksgiving service – if they held one and if so how often, and the physical memorial – if they had one and if so what this was, where this was and who visited this. Finally, there was room for comments to be added. In total there were ten closed questions (questions 1-4, 7, 7(b)-7(c), 8, 9, and 10) and ten open questions (questions 5-6, 7(a), 7(d), 8(a), 9(a), 10(a)-10(c), and 11). See appendix A for the survey.

In all the units in which I conducted interviews, the survey was collected prior to the interview(s), which was useful to understand a unit before I visited for interview. I then referred to and built upon the questions asked in the survey and asked them to discuss and explain some of their survey responses. This data collection method fitted into the latter end of the *observation* stage within the empirical cycle (De Groot, 1961). This stage was concerned with the creation of empirical facts Mietus (1994), which then informed the other data collection methods and further stages and rounds of the cycle.

In total, surveys were distributed to seventeen AUs and fifteen were received. The survey was sent along with an information letter and consent form. After the survey was received, a debrief via email was sent to the respondent. The debrief reiterated the purpose of the study, explained how their responses would be used and gave them my contact details if they wished to ask any questions. Next, the in-depth semi-structured interviews with AUS will be deliberated.

3.5.3 In-Depth Semi-Structured Interviews with Anatomy Unit Staff

A total of eight face-to-face interviews were conducted at six units. They were completed one-to-one between me as the doctoral researcher and the participant. These face-to-face interviews lasted between 34.29 minutes and 86.24 minutes.

I conducted six group interviews at six units, which were formed of two to three participants. They were completed between me as the doctoral researcher and the participants. This was due to the demands of the AUS who felt that being interviewed together would be more productive both in terms of data and time keeping. This was representative of the working relationships between the AUS. These group interviews lasted between 55.45 minutes and 232.58 minutes.

I conducted six telephone interviews at four AUs. They were completed one-to-one between me as the doctoral researcher and the participant. These telephone interviews lasted between 38.10 minutes and 59.09 minutes.

Before the interviews began, I explained the process to the participant(s), gave them the opportunity to ask questions and outlined that they could pause the interview at any time or stop the interview completely. I gave them the information sheet and asked them to complete the consent form. After the interview I stopped the recorder and gave them the debrief material and allowed them time to ask any further questions off record.

Using Bernard's (2011) framework, the 'interview guide' (see appendix B) consisted of sixteen open-ended questions which were divided into five topics. These were influenced by the literature review and initial

overview of the HTA AU inspection reports. The interview guide was developed alongside the survey. The first topic '*the unit*' aimed to understand the interviewee's role within the AU, any training they had received and their training needs. The second topic '*death and the family*' explored the FL work completed by AUS. The third topic, '*the donation process*', explored the process of BD at the institution and the process if the body was unable to be accepted. The fourth topic '*disposal of remains*' covered the disposal process and AUS FL at this point. The final topic, '*thanksgiving services*', asked the interviewees to describe the thanksgiving service and the physical memorial at their institution if applicable. The interview came to a close with two questions asking the interviewee if they felt OK about what we had discussed during the interview and if there was anything else that they thought we might have discussed. I transcribed the interviews verbatim as soon after the interview as possible (Poland, 1995). Although I am aware of the debates around verbatim transcription where time, accuracy and necessity was taken into consideration (Halcomb and Davidson, 2006), I argue that my open-ended exploratory approach required a word-for-word reproduction of the conversations in order to analyse the data, discussed further in the next section. The transcripts were anonymised and pseudonyms were used. The pseudonyms selected reflect the participants gender but not their ethnicity.

Open-ended questions were used to allow the informant to lead, which permitted additional questions to originate. Further questions or issues that were not highlighted during the interview were discussed at the end of the interview which were normally stimulated by the final two questions asked, allowing the interviewee to ask me questions and take the lead. The silent, echo, uh-huh, tell-me-more and long question probes were used within all interviews (Bernard, 2011). The interview guide acted as a guide only, as it was expected that the informant would lead, and I would ask subsequent questions as a result of their

comments. Some questions were not asked, the order of the questions were at times rearranged, and the phrasing of questions were altered according to the interviewee. The choice of alteration was dependent upon the interviewee's role within the unit as some questions were not applicable to some participants. The interview guide was also useful to help steer the interview back in the right direction if it appeared to be going off track.

During my visit to the AUs for interviews, seven AUs gave me a tour of the AU either before or after the interview(s). I did not ask to have this tour, but some participants felt that they would like to do this and that it would be beneficial for me to understand how their unit was managed. I allowed for the participant(s) to lead this. We engaged in open-ended discussion during the tour. It was extremely productive for the AUS to give me this tour and introduce me to their colleagues. Oftentimes it was the pre-interview tour, or coffee that provided data as well as the semi-structured interviews. This formed the participant observations I undertook when visiting the unit for interview which were supplementary to the other methods I undertook.

The in-depth semi-structured interviews were successful in the amount of data I was able to gather. I employed a strategy which I argue influenced their success. For example, the time I allowed at the beginning of my visit to the AU to have an informal conversation with the interviewee(s) and a cup of tea where we discussed my project and their work was integral in building rapport, making them feel relaxed and produced supplementary data. Their showing me around the AU and introducing me to their colleagues before or after the interview indicated the rapport I had built with the participant. In creating an open and supportive space and building rapport, I allowed the AUS to share sensitive and emotive information which was integral in understanding how the AUS were affected by and dealt with their work.

Another strength of the interview process was that it often made the AUS think differently about what they did. For example, Anthony at unit two said, "I've not really thought about it that way before." The interviews and questions around their work made them aware of their own work which generated a productive tangent in the interview and was useful in understanding how aware the staff were of the FL work that they were carrying out. It was also clear that the interview process allowed the AUS to talk through situations that they had not had the chance to before. This was useful for them to understand a situation and consider best practice on reflection. Next, I consider the ethnographic case study.

3.5.4 Ethnographic Case Study

Initially my supervisor put me in contact with the MM of the AU and I arranged a visit to the unit to meet the AUS that worked there. This initial meeting took place over coffee with five of the seven AUS. I explained what my intentions were, and we discussed if they would be happy for me to complete the ethnographic case study at their AU. They agreed for me to complete the ethnographic case study at their AU and agreed to let me work within the AU during the time of the ethnographic case study. They arranged a desk and computer for me in the same office as the DI and the BS. I spent six months in this AU from 1st December 2016 to 2nd June 2017. In coordination with the move out of the AU building during summer of 2017 while refurbishments took place, I decided to finish the ethnographic case study observations. I discussed this informally with the AUS and sent an email on 2nd June 2017 thanking them for their participation along with the debrief material.

When starting the case study, I asked all seven participants to read the information sheet and complete the consent form. When all seven consent forms were returned, I began the ethnographic case study.

The observations were overt. I explained at the start, when I distributed the information sheet and consent forms, what I was going to be doing and gave them the opportunity to ask any questions. I observed the day to day happenings at the unit, kept a diary, made field notes, drew and sketched, recorded spatial elements and layouts, I asked questions, drank numerous cups of tea and coffee and ate lunch with them, attended a group picnic, participated in activities and discussions, visited the crematorium, and attended meetings. Whenever I attended a meeting, I would ask for permission from the AUS and other participants in the meeting to attend and take notes. I explained that I was only observing the AUS and would therefore not need to gain consent from any other participants in the meetings.

I identify my approach to the ethnographic case study most closely to that described by Hammersley and Atkinson (1995: 1) as they took a capture all approach to ethnography which “[...] involves the ethnographer participating, overtly and covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research.” As I was stationed in the same office as the DI and BS this made the field accessible. It was therefore easy to take notes either by hand on a notepad, on a word document on my computer, in my diary, or on my mobile phone. I defined my field as a combination of spaces which were fluid and connected. These spaces were contained within one building within the AU and the area immediately outside where the memorial bench was located. This area was predefined by the university as several barriers had been erected to restrict access, such as needing an access card to enter particular areas in the AU.

The ethnographic case study was extremely useful in understanding in practice what happened day to day in a UK AU. The extended period of time I spent within the AU meant that I developed rapport with the

AUS which allowed me to get a realistic behind-the-scenes understanding of the AUS and AU. I was very fortunate to spend some time with the AUS at the AU before the ethnographic case study period began; this allowed me to develop rapport before the study period began and to explain my purpose at the unit in great detail before I began to gather data, which permitted me to gain informed consent. However, I had to manage my dual role, being careful to separate my role as researcher from my personal life. Next, I move on to discuss the overt participant observations I completed at thanksgiving services.

3.5.5 Overt Participant Observation of Anatomy Unit Staff during Thanksgiving Services

Mason (2012) posited that participant observation is often one element in a broader ethnographic approach. I used observational approaches to explore the work of the AUS at thanksgiving services as I agree with Mason (*ibid.*: 85) that “knowledge or evidence of the social world can be generated by observing, or participating in, or experiencing ‘natural’ or ‘real-life’ settings, interactive situations and so on.” Thanksgiving events were an opportunity for the AU to give thanks to the donors and their families for their donation and support (Pather and Ashwell, 2017). It was assumed from the literature (Kooloos et al., 2010; McClea, 2008; Pather and Ashwell, 2017; Riederer, 2016; Tschernig and Pabst, 2001) that FL work took place during the services that the families were invited to and it was this, as well as the content and process of the service, that I observed. I directed my gaze particularly at the FL that was taking place before, during and after the thanksgiving services.

I attended seven thanksgiving services. I was invited to the service by the AUS with whom I was in contact. Before the service I asked the AUS in attendance to read the information sheet and complete a consent form. At all but one service I attended as a guest and experienced the service as would a family member or student. At one service I was invited to sit with the AUS. I was interested in observing behaviours, conversations, interactions, spatial elements and layouts, procedures, and processes at the services. I made my identity clear at the service and I told anyone who asked what my purpose was in being at the service. Now that I have discussed the various data collection methods, I will next identify limitations to these methods.

3.5.6 Limitations of the Data Collection

Methods

Despite the success of the data collection methods in producing data from the AUs there were some limitations. First, I will address the responses to the survey. The majority of answers given to the survey questions regarding the numbers of bodies accepted and refused were an average per year/estimation of the numbers, which may mean that there is a slight discrepancy from year to year. However, some AUs provided exact numbers over the previous years from which I took an average. These averages were then combined to make an overall total. However, only fourteen out of fifteen units responded to the question regarding how many bodies were accepted per year and for the question regarding how many bodies are refused per year only thirteen out of fifteen units provided answers. Thus, it is expected that the number will be higher than discussed in section 4.1. This non-response to questions, such as how many bodies were refused per year, suggested that some units gave information selectively and were not comfortable sharing some information. However, the majority of AUs were forthcoming to such questions. This is also likely to be true

for responses to interview questions as AUS may have wanted to show their AU in a positive light.

In addition, another limitation in the survey data is that the number of bodies refused per year included those which were transferred to another unit so there may be some disparity between those that are refused at one AU but accepted at another. However, it was difficult to know to what extent, although it was not expected that this would alter the numbers dramatically as the referral of bodies, although something that was described by AUS as a key way in which non-acceptance of an acceptable body was avoided, was not something that occurred regularly.

Furthermore, another limitation to the information received from the survey was the way in which the surveys were completed. The ones completed by hand and posted, or scanned and sent by email, often had more explanatory and extensive responses, whereas those completed electronically and sent via email normally made for more succinct responses. This was worrying, especially with the increasing popularity of e-surveys. Thus, where possible, non-e-survey responses should be sought after. However, I appreciate that the ease of return may mean that more e-surveys are returned. Some non-e-surveys may also be illegible. Thus, the researcher should weigh up the advantages and disadvantages for their particular research.

Second, I will discuss the limitation associated with the telephone interviews. The telephone interviews missed out on rich ethnographic data, such as when the AUS would show me items that the families had sent in, such as photographs, and talk about the family member and their FL work on showing me the photograph. However, the telephone interviews proved to be shorter, on average, than the face-to-face interviews and I found it easier to stick to the interview schedule during telephone interviews. This meant that they were more concise

and were more direct in answering the questions. Now that I have discussed the data collection methods and their limitations, I will next discuss how I analysed the data collected.

3.6 DATA ANALYSIS

Data analysis, following a cross-sectional thematic approach using NVivo, where “a consistent system for indexing [/coding] the whole of a data set according to a set of common principles and measures”, was applied (Mason, 2012: 150). I applied a set of coding categories consistently and systematically to the whole data set; this then established common principles, patterns and themes. As Mason (2012: 153) outlined, a cross-sectional coding approach was useful in giving “analytical ‘handles’” on the data, or ways into the data. This helped to focus the data analysis and develop arguments and explanations. These “handles” (*ibid.*) were useful when making connections and comparisons between data. This approach was especially useful in the initial stages of data analysis in creating analytical categories and themes. This helped in me in my analytical and theoretical thinking and aided me in framing my fieldwork questions. As a result of the multi-method approach there was much qualitative data collected through multiple methods and the cross-sectional thematic analytical approach was useful in bringing together a wide range of data.

I used NVivo to organise, code and analyse the data after processing and transcription. The data set was then analysed using thematic content analysis (Boyatzis, 1998) to extract key emergent themes. Boyatzis (1998: vii) asserted: “A theme is a pattern found in the information that at the minimum describes and organizes possible observations or at the maximum interprets aspects of the phenomenon.” Representative excerpts from interviews, ethnographic case study, thanksgiving observations, and documents were selected

to evidence the key emergent themes. My field notes, diary and survey also supported the extraction and write up of these themes. This approach aimed to uncover patterns and aspects of the phenomenon at hand. Themes were generated inductively from all primary data by establishing a series of codes, based on Boyatzis' (1998: x) description of a good code as "one that captures the qualitative richness of the phenomenon", which were organised to form general themes and cross-case comparisons of interrelated themes evident across all eighteen sites.

A combination of textual and content analysis was used to analyse the data from the documents. I used initial inductive line-by-line coding, then focused coding, then grouping into significant themes (Boyatzis, 1998). The data was clustered into categories/themes and relationships were made between themes. I combined the three ways of reading data outlined by Mason (2012): literal, interpretive and reflexive. Some of the survey data, for example responses to closed questions, sections of interview transcripts and documents, can be read literally. This was combined with interpretive readings, which Mason (2012: 149) defined as: "constructing or documenting a version of what you think the data mean or represent, or what you think you can infer from them." Mason (*ibid.*) continued: "You may be mostly concerned with what you see as your interviewees' interpretations and understandings, or their versions and accounts of how they make sense of social phenomena, or you may place emphasis on your own interpretations." The interpretive reading was the one I most identified with in my approach as it was important to understand the process from my participants' perspectives. There was also an element of reflexivity in my reading of the ethnographic case study data as I believed that I was inevitably entwined with the data generation and interpretation processes. My reading then of this data was concerned with capturing and expressing those relationships.

Data analysis and discussion will be arranged over three chapters; chapter four, chapter five, and chapter six. The data will be organised thematically, analysing and discussing the findings throughout. Next, I will review ethical considerations.

3.7 ETHICAL CONSIDERATIONS

Ethical approval was gained from The Hull York Medical School (HYMS) ethics committee. Data was kept secured in locked cabinets within the postgraduate research office and password protected within the HYMS IT system. The audio recordings were deleted after transcription and transcribed data was password protected within the HYMS IT system and will be deleted after ten years in compliance with HYMS policy. Pseudonyms have been used for AUS members and AUs have been assigned a random unit number. Participants were made aware that their data will be anonymised. For the ethnographic case study, the AU was not named to preserve the participants and their organisation's anonymity. Even though the HTA AU inspection reports were publicly available documents, I made efforts to not include any potentially identifying material or information. Only I and my supervisors had access to the raw anonymised data.

I was aware of the ethical issues involved with this project and I recognised that the topic was sensitive and emotive. The thanksgiving services were a particularly emotional space. An action plan was set up to respond to any issues that arose for the participants of my study. In the first instance I was contacted, then this was passed to my supervisors, then it followed the HYMS complaints procedure.

I also considered the possible risks for myself. I consulted the institutional lone researcher guide and I had access to a project-specific mobile phone which was to contact my supervisors, my mentor and the HYMS complaints board when necessary. I had frequent

supervisory meetings, mentor meetings and attended institutional monthly workshops and Thesis Advisory Panel meetings where any issues were raised. I was an experienced researcher in this area and had dealt with similar sensitive and emotive topics previously; for example, I had conducted semi-structured interviews with bereaved individuals during a public exhibition. Furthermore, I was subject to travel fatigue; however, I managed the timing of the interviews, observations and attendance to thanksgiving services in order to minimise these potential risks. There were potential risks within the lab setting, such as the presence of toxic materials, where some of the interviews or observations took place. I consulted the University of Hull health and safety guidelines and put these into practice when I conducted the research. Next, I will reflect on these ethical considerations and my own rite of passage as the doctoral researcher.

3.8 REFLECTIONS ON ETHICAL CONSIDERATIONS AND MY OWN RITE OF PASSAGE

Although there was some consideration of my wellbeing in the difficult and emotive subject area I was researching, I felt like 'I' was missing. This came down to the departmental differences in ethics and those that sit on their ethics committee. Coming from an anthropology department I felt that the ethical process at the medical school was very different to what I had previously experienced. Overall, I felt that certain issues around me as a researcher were overlooked by both the ethics committee, by my supervisors and by myself. This was around the practicalities of doing the research. I was used to researching the dead in public and private contexts within my previous research, I was used to sensitive conversations around this topic, and I was also used to osteological material. However, what I was not used to was

cadavers in their fleshy reality. The closest I had come to a cadaver was possibly what are colloquially known as bog bodies, but this was in the safe and sanitised space of a museum. I was not used to the personalising features such as flesh, skin, hair, nails, nail varnish or tattoos. I certainly was not used to seeing fresh bodies that came into the units. I saw bodies in multiple stages of preservation too; from bodies at the start of the embalming process, right through all the stages of preservation to embalmed prosections. It was unexpectedly difficult for me; I found it unusual and it took some getting used to.

I underwent my own rite of passage in being around the bodies and cadavers and also seeing the families of the donors at the end of the process. This was similar to the AUS and I closely identified with what some of the BSs had said during the interviews, namely that seeing the bodies and cadavers was strange. I also had a first-hand understanding of using the coping strategies; for example, I found that dark and gallows humour was useful in conceptualising what I had seen (Mitchell, 1996; Joyce, 1989). I also found myself using detachment behaviours (Prentice, 2013), for example when I would have to eat my lunch and have coffee breaks in the office next to a coffin which could be empty or occupied depending on the time of the day. I found that particular bodies re-personalised themselves where I felt a pang of realisation and understanding of the cadaver as a person. This was particularly apparent during a visit to an AU, when completing the participant observations while an AUS member was giving me a guided tour of the facilities, where there was a particular young woman who to me was not an objectified and anonymous cadaver at this point. She was in the embalming suite on a raised table with various tubes of embalming fluid pumping into her body. Her skin was pale and perfect and the way she was positioned presented her body as alive in a sense, she could have just been sleeping. Her head was slumped backwards, and I stood in front of her. Her hair had just been shaved but her face was pale and alive too. This for me brought

back the personhood of this young girl and because she was very close in age to me it made me think about my own mortality. However, after spending much time in the AUs, especially for the ethnographic case study, I got used to seeing and being around cadavers; it became a normalised part of my day to day life and the pangs of shock eventually ceased.

3.9 CHAPTER CONCLUSION

In this chapter I have evidenced the need for an inductive, exploratory and multi-method ethnographic approach to this thesis, as I focussed on an area where little literature existed around the work of the AUS with families after donor death. The following three chapters thematically discuss and analyse the findings from this methodological approach.

CHAPTER 4: REFUSED GIFTS? WHAT HAPPENS WHEN ANATOMY UNITS CANNOT ACCEPT A BODY DONATION?

It was evident from the data that there were various points throughout the BD process where FL occurred. The first point was at the phone call stage (stage one) where AUS dealt with the acceptance or refusal of bodies following the death of the donor. Figure four depicts the post-death process, including the refusal of bodies and in some cases the referral of bodies to another AU if applicable and those stages following acceptance. This differs from the flow chart showing the stages involved in the BD process after death (figure one) depicted in chapter one as the refusal of bodies was an unexpected but substantial part of the process.

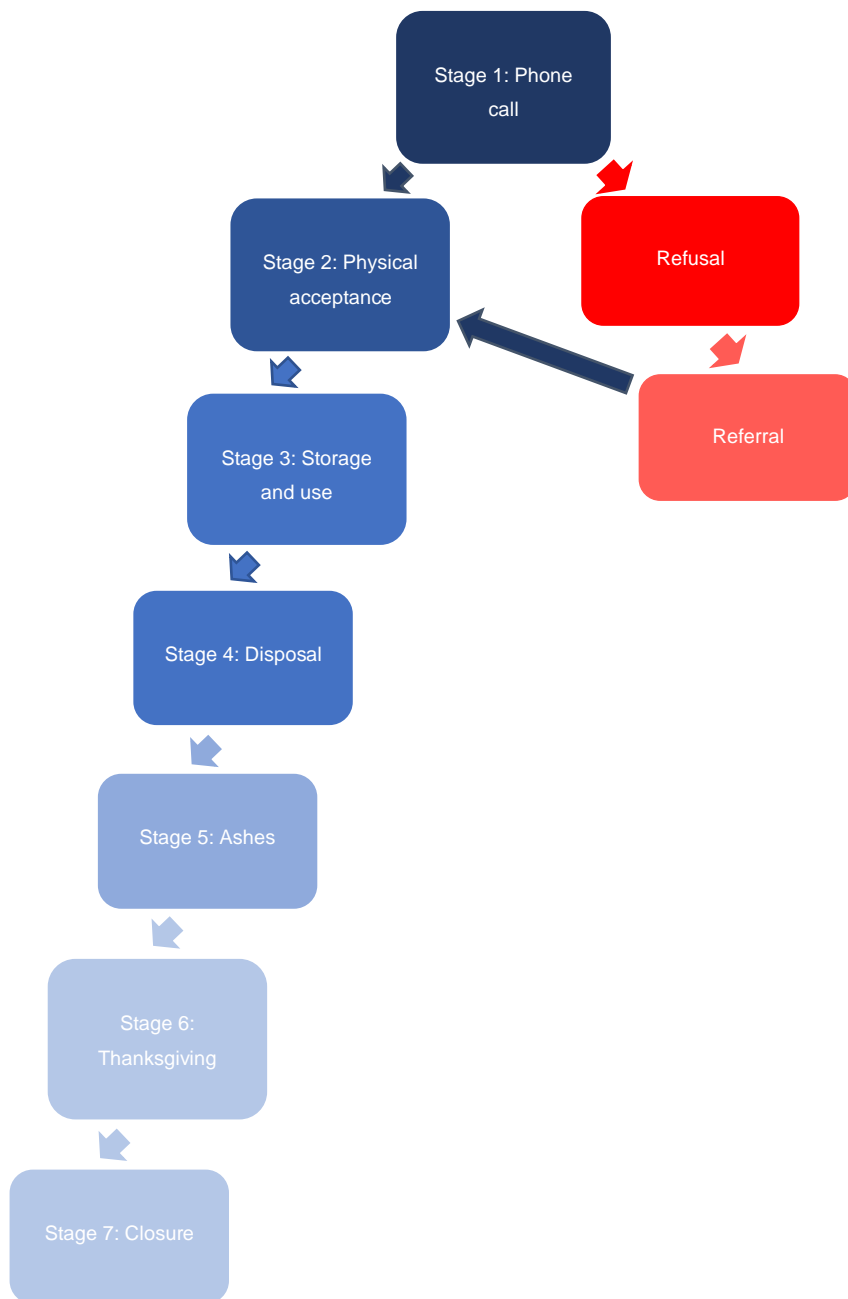


Figure 4: Flow chart showing the stages involved in the BD process after death including the refusal of bodies

In this chapter I investigate the refusal of bodies and how this emerged as a key, albeit unanticipated, theme for analysis. I draw upon the survey of UK AUs and interviews with AUS to explore this theme. It was apparent from the survey that refusals were unexpectedly high; nearly as many bodies were refused as accepted. These body

numbers will be explored in section 4.1. This meant that AUS (BSs, MMs, DIs and technicians) completed much FL work at this stage (stage one in the 'normal' timeline of routine work outlined in chapter one). In section 4.2 I consider the impact of refusals on families and family reactions from the perspective of the AUS. After this, in section 4.3, I discuss the FL work that AUS did with the families of donors due to refusals. Included in this was much *EM*, which I argue was mainly philanthropic (Bolton, 2000) in nature. Finally, in section 4.4, I present the four main ways in which refusals might be managed both before and at the phone call stage. In this chapter I address research questions one (what is the extent, nature and form of contact?), two (who has contact?) and three (when do such contacts occur?). Throughout this chapter I also consider how *gift exchange* could help to understand why the AUS did this FL work at this early stage in the process.

4.1 BODY NUMBERS

In this section I discuss how many bodies were accepted, aimed to be accepted and refused per year in AUs in England (thirteen units) and Northern Ireland (one unit) drawing on data from the survey of AUs. I explained in 'The Body Donation Process' in chapter one that there were several reasons why a body may not be accepted. For example, if a post-mortem had taken place, or if the individual was obese or had certain morbidities, such as Alzheimer's disease. Table three shows the number of bodies which were accepted and refused per year across all fourteen units. The maximum and minimum overall total number of bodies accepted and refused have been calculated as some units provided an annual range. It can be seen in table three that approximately as many bodies were refused as were accepted. This meant that a large amount of FL work was involved in dealing with and managing these refusals at this early stage in the BD process. The FL work at this stage is discussed in section 4.3. The range in the

numbers of bodies accepted and refused can also be seen in table three which demonstrated the differences in body numbers between AUs. In the next section I explore this further.

	Total (max)	Total (min)	Range
Accepted	882	832	15-315
Refused	878	851	6-204

Table 3: Total number of bodies accepted and refused per year across 14 UK anatomy units

4.1.1 Explaining the Differences in Body Numbers Between AUs

Figure five depicts the evident differences in body numbers between AUs. There were a number of factors which affected this which are examined next.

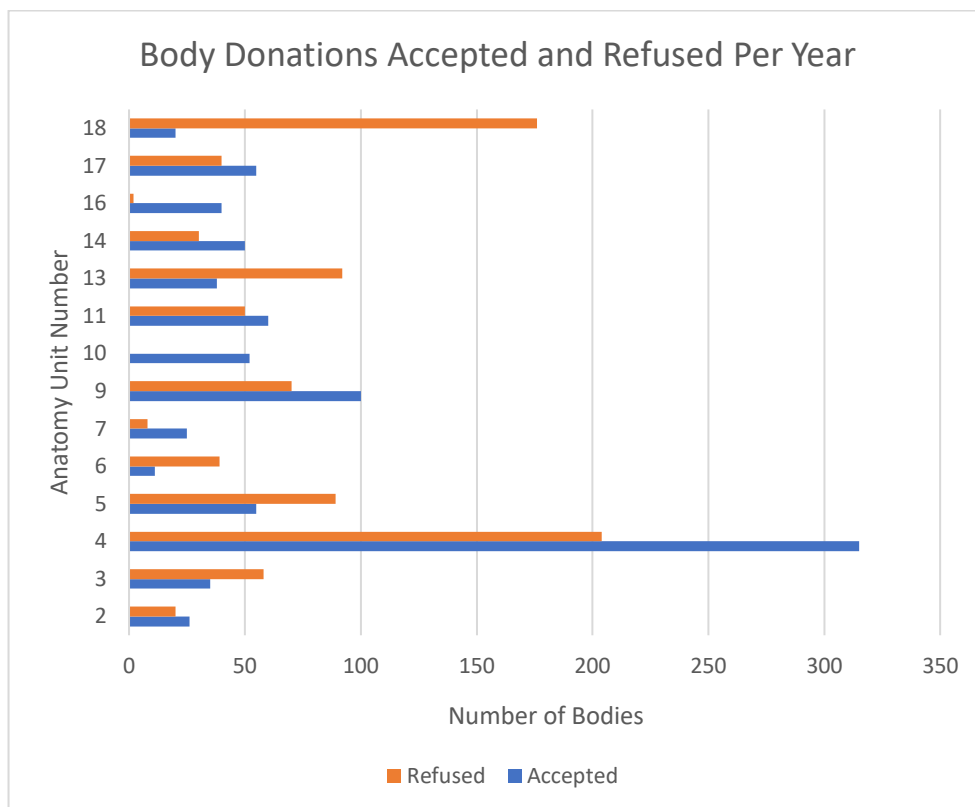


Figure 5: Body donations accepted and refused per year across 14 UK anatomy units

The first factor was due to the varying capacities of the AUs; for example, their storage space. This was dependent on the second factor, their catchment area, as each AU was offered bodies from within their geographical area determined by the donor's postcode. It was the case, for unit four and eighteen, that their catchment areas and the number of donors on the register within the area were high in comparison to other units. For unit four, because they had a large capacity, this did not affect their ability to accept more bodies than they refused. However, for unit eighteen, a small capacity AU, this had a substantial effect on their ability to accept as many bodies as they were offered; the number of bodies accepted per year is between fifteen and twenty, but they refused one hundred and seventy-six bodies per year. For unit eighteen this meant that they completed an even larger amount of FL work at this early stage in the process due to refusals. It can be seen in figure four that this was also the case, although to a

lesser extent, for five out of fourteen AUs as they too refused more bodies than they received per year. There was an unmistakable disparity in the relative amount of FL that each AU's AUS completed at this early stage in the process.

The third, fourth and fifth factors were interlinked as the type of courses (such as undergraduate, postgraduate or external), preservation technique (such as, Thiel, fresh frozen, or embalmed) and teaching approach (for example, full cadaver or prosection) offered by the AUs all influenced the number of bodies that were accepted. For example, a greater number of bodies were accepted for postgraduate courses, as full cadaver dissection was required. These bodies were fresh frozen or preserved using the Thiel method (described in 1.2.4.1) and were often used more quickly than the embalmed bodies for undergraduate prosection teaching. Prosection teaching was where an experienced anatomist dissected parts of a cadaver after preservation to demonstrate anatomical structures to students. The number of students and surgeons requiring education from the bodies impacted the AUs ability to accept bodies, as some AUs had a higher number than others. It was clear from the survey that AUs aimed to receive as many bodies as possible when they ran surgical training courses. It was also the case that some causes of death that could not be accepted for undergraduate teaching may be accepted for postgraduate and surgical courses. For example, courses that open the calvaria (the skull) could not accept donors that had Alzheimer's disease. However, for those courses that did not require access to the brain, for example when surgeons were practising hip replacements, these bodies could be accepted.

4.1.2 Factors Affecting Refusals

In addition to those factors that influenced the differences in body numbers between AUs there were some issues that complicated the

ability to accept bodies from year to year across all AUs. First, there were fluctuations from year to year in the number of bodies offered to AUs. For example, in the survey, unit thirteen said that they accepted thirty-eight bodies and refused ninety-two bodies on average per year, yet in the interview Nikki reported that they accepted forty-four and refused one hundred and seventy for the current academic year. For some units the number of refused bodies may increase while the number of bodies accepted may remain similar. However, it could not be predicted how many bodies would be offered to AUs and thus AUs could only accept the numbers they required and had space for and consequently some bodies were refused.

Secondly, there were changes in the acceptance criteria which meant that AUs were unable to pre-empt refusals in a standard way, so there were differences in their ability to manage refusals. For example, the ability to accept some morbidities, such as Alzheimer's disease, altered from year to year because of the perceived danger for the students and AUS associated with such conditions. Accordingly, AUS usually advised donors to remain on the donor register as the decision is made at the time of death. However, in many cases, this led to FL work at the phone call stage due to the refusal of these bodies that could not be pre-emptively refused.

Overall the key emergent factor for the large number of refusals that was discussed by the AUS was the growing donor population. This meant increased refusals for schools that remained at the same capacity. Even though some AUs did run extra courses, such as surgical training courses and postgraduate courses, this did not counter the substantial increase in the donor population. It was assumed by some AUS that this rise could be due to an increased coverage in the media in the UK, including printed and online journalism, and television documentaries, such as *Body Donors* (Channel 5, 2015) and *Gift From Death* (BBC Northern Ireland, 2016).

Social media also had an impact of raising awareness as Dawn, an AUS member, asserted:

[...] because of the increased donor population that we have because of social media – because of everybody knowing [...] we have a much higher proportion of donors that are being offered to us, and therefore we are fulfilling our quota a lot quicker [...]

(Dawn, unit 10)

However, it was clear that many body donors were of the older age group and it was unlikely that this population group used social media as much as younger people. Therefore, the link that Dawn made to social media may reflect the change in donor age-ranges, as AUS noted that younger people are signing up to donate. It may also be due to the increased engagement between the younger and older generations when families are discussing their post-death wishes. These factors affecting refusals were beyond the AUS's control. Those ways in which the AUS could manage refusals before the phone call stage and at the phone call stage will be discussed in section 4.4. Next, the shortfall in bodies will be considered.

4.1.3 Shortfall in Bodies

I have discovered that the number of refusals was unexpectedly high. However, it was clear in the data that there was only a total minimum shortfall of six bodies and total maximum shortfall of fourteen bodies per year across all fourteen AUs surveyed. By 'shortfall' I refer to the number of bodies that AUs aimed to accept but did not manage to accept in the academic year. AUs in England and Northern Ireland are therefore meeting their needs or just meeting their needs. The reason for this small annual shortfall, despite the large number of bodies offered and refused, was those absolute reasons for non-acceptance, such as obesity, if a post-mortem had taken place or certain medical

conditions. Thus, it was the large number of bodies offered that meant that AUs could maintain this small shortfall. Furthermore, there were regional differences in shortfall which was why referrals (discussed in subsection 4.4.2) were important to fill the regional gaps and account for regional discrepancies. Now that I have illuminated the large number of refusals that occurred, the factors that affected refusals and established that refusals did not have a detrimental impact on AUs meeting their quotas, I next consider the impact that these refusals had on the families of refused donors.

4.2 FAMILY REACTIONS TO REFUSALS

I demonstrated in section 4.1 that a large number of refusals occurred. I now focus on family reactions to refusal. There were a wide range of family reactions to the refusal of their loved one that were described by the AUS. Although many families found the refusal difficult and some found this unexpected, some found relief in the refusal as they may not have wanted their loved one to donate their body. For some this affected their altruistic family narrative. I begin by discussing the negative reactions to refusals.

4.2.1 Negative Family Reactions to Refusals

AUS described that the majority of families found the refusal of their loved one difficult. Practically the family (and the physical body of the potential donor) were left in a liminal period (Turner, 1969; Van Gennep, 1960) for up to a week after death while they waited for the decision of acceptance or non-acceptance. They were 'betwixt and between' (*ibid.*) as they did not know which post-death path they would

need to take. Holding the body in this liminal position caused a disruption to the immediate post-death/bereavement process, even if the body was not accepted, because, as AUS described, some families put their grieving on hold while they waited to see if their loved one would be accepted. The AUS described that families focussed on the practicalities of what would happen to the physical body, which overshadowed the emotions of grief. This may be similar to, or included within, the first stage of grief described by Kübler-Ross (2009) where the family were in denial and isolation, which Kübler-Ross positioned as a defence mechanism.

Sometimes the family reacted angrily to the refusal as Charlotte described.

[...] sometimes you get them and they are really angry, especially if you have to turn down, and again I guess you've just got to be calm and reasonable really and not get upset about it because you know they are just reacting out of emotion really. Yeah they might be really mad that we can't accept them but as long as you've got a valid reason for it and you can explain it to them then they're usually, they usually accept it even though they might not be very happy about it (laughs).

(Charlotte, unit 11)

The phenomenon Charlotte described fits into what Kübler-Ross (2009) termed the second stage of grief, anger, which replaced denial. Kübler-Ross (2009) explained that anger could be displaced to those around them and the environment; in this case the AUS. Kübler-Ross (2009) asserted that “[t]he problem here is that few people place themselves in the patient’s position and wonder where this anger might come from.” (*ibid.*: 41). Charlotte used empathy to understand the family’s anger and allow her to do her job. She realised that this was not directed at her personally, it was a product of their grief. This was a management strategy that AUS used in such situations as they appreciated that it was best to be calm empathetic listeners which

acted as an antidote. I use *management strategy* throughout this thesis to denote the strategy used by AUS to manage and cope with their work. Further information regarding management strategy can be found in 'notes on terms' (page 359). The AUS also justified the family reaction to reduce the negative impact that it had on themselves.

In these situations, AUS had to manage their own emotions and the emotions of others. Charlotte remained "calm and reasonable" in the face of angry family members and she reminded herself that the family's reaction was not personal and that she was validated in making the decision to refuse the body. I argue that Charlotte completed *EM* (Bolton, 2000) in a professional capacity here – for which the AUS member received a salary. I argue that this was more nuanced than Hochschild's (1983) definition of *EL* allowed for as it was not simply deep or surface acting completed on instruction; this was not directly completed because of the managers' influence but rather, I argue, because the AUS wished to make the process of BD as positive for the families as possible, even at this difficult time around the refusal of the body.

There were several cases where the family had a negative reaction because they felt there had been a promise of guaranteed acceptance when their loved one joined the BD register. Nikki described a case where multiple upset siblings contacted her as they believed that the AU had "[...] let [their mum] down badly by not accepting when the time came."

[...] even though we try to be as clear as possible that there's no guarantee, they feel that when their mum or dad or whoever it is registered with us that somehow we made a promise that we would accept them when the time came [...]. I had different siblings on the phone (laughs) sort of upset in different degrees

because they felt that we had entered into a contract with mum by adding her to our register [...]

(Nikki, unit 13)

The language used by Nikki, such as “promise” and “contract”, lends this to be akin to a gift relationship (Mauss, 1990), where a social contract was entered where it was expected that the gift would be accepted. Perhaps the most severe case of this, highlighted during the ethnographic case study, was when a family member contacted the local mayor to insist that their loved one should be accepted. Some interpret signing up for BD as a legally and socially binding contract. There was a lack of understanding, which could be avoided by the potential donor speaking to their family about potential non-acceptance and making non-acceptance clear in the paperwork. These methods of managing FL around refusals will be discussed in subsection 4.4.1.

The negative reaction for some may have been due to the funeral costs that they would incur due to the refusal. Steve problematised:

[...] sometimes you can get some relatives who are very very disappointed who say I don't know what I'm going to do then, or I don't know how I'm going to pay for a funeral [...]

(Steve, unit 3)

However, most AUs made it clear in the bequeathal information provided to potential donors at the time of signing up for BD that an alternative post-death plan should be in place in case of non-acceptance.

In most cases where families reacted negatively it may have been that their altruistic family narrative was damaged by the refusal. This was because donation often ran in families (Bolt et al., 2010; Richardson

and Hurwitz, 1995). For example, I explore the phenomenon that some families of bodies that were refused still donated (in subsection 4.2.3), which was likely to be a result of their family donation narrative. But first I consider positive family reactions to refusals.

4.2.2 Positive Family Reactions to Refusals

Although the majority of families found the refusal difficult, some found relief in the refusal as they may not have wanted their loved one to donate their body. For example, Lynne (unit four) outlined such responses to refusals: “[...] sometimes they're relieved because they weren't happy with it but they were trying [...].” These families followed through with their loved one's wishes despite their reservations about their loved one's choice to donate. This demonstrated the influence that potential donors' wishes had on their families' efforts to facilitate the donation. Similarly, Nikki theorised:

[...] for some people they may have been carrying out the wishes of their loved one because that was their wish, but haven't really got their heads around the idea of body donation and weren't really up for the idea of not having a normal funeral so they make the call (laughs), I think hoping deep down inside that we're not able to accept because they just want things to be normal, and so sometimes you can hear a sigh of relief if you're not able to accept.

(Nikki, unit 13)

Nikki interpreted this positive reaction as being rooted in wanting “normal” post-death arrangements. Such families could cause complications after acceptance if the donation was accepted; such cases are explored in chapter five. Thus, it was in the AUS's best interests to detect at the phone call stage (stage one) when families may not want their loved one to donate to reduce potential FL work

after acceptance. However, it was difficult to detect as families did not often come forward and say that they did not support their loved ones' wishes.

Steve drew upon his previous experience to detect when families did not support the BD, which not all AUS had the ability to do.

[...] within a few moments you normally get the gist, having been a police officer thirty-one years, a coroner's officer etc., you get the sort of er impression of how they feel about the process really.

(Steve, unit 3)

This put the AUS in a difficult position as they did not want to be seen to push for donation if it was apparent the family did not wish for donation. This could result in bad public relations and negative publicity for the AU. Now that I have analysed negative and positive reactions, I next consider those rare reactions where non-donor families still wished to donate something.

4.2.3 Non-Donor Family Donations

Building on the family reactions to the refusal of the body there were some cases where non-donor families gave monetary donations in lieu of the body. By 'non-donor families' I refer to the families of individuals that wished to donate their bodies but were refused. This demonstrated the importance of the donation for some families and their wish to give to the AU even if they could not give their loved one's body. In one case a donor's family made a bequest of money that had been collected at the refused donor's funeral.

I argue that the family was *continuing bonds* (Klass, Silverman and Nickman, 1996) with their loved one's donation narrative. This alternative financial donation and contact may be a way in which the

bond is shifting and taking on a new form (*ibid.*). It may be that the AUS were viewed by the family as being a part of the social support network, aiding the family in dealing with their mourning. These families continued to have contact with the AUS, and thus their loved one's donation narrative. This may also be a way that families were making meaning of the donation (Neimeyer, 1998, 1999, 2001). For example, the family may consider that the death had not gone to waste as the monetary donation was useful for the AU. This, I argue, as Neimeyer, Baldwin and Gillies (2006) likewise do, was an attempt by the family to "(a) make sense of the loss, (b) find some sort of "silver lining" or benefit in the experience [...]" (*ibid.*: 718). This fitted within the timeline that the literature around *meaning making* presented, as it was argued that such processes occurred within the early stages of bereavement (Holland, Currier and Neimeyer, 2006). However, Holland, Currier and Neimeyer (2006) made the distinction between types of meaning reconstruction that occurred within the first two years of bereavement. They argued that sense-making happened first, and benefit-finding occurred over time. However, I have demonstrated that both sense-making and benefit-finding may happen early in the BD process.

I further discuss the complexity of this monetary gift, in light of the refusal of the gift of the physical body, in chapter seven. I highlight how these refused gifts, and the AUS and families of refused bodies behaviours that surrounded these, may be comprehended using *gift exchange*.

I demonstrated in this section that refusals had varying impacts on the families of donors; however, the majority of these reactions were negative. It was therefore unsurprising that these required FL work from the AUS at the phone call stage (stage one). Such work happened frequently due to the high number of refusals that I presented in section 4.1. It was unexpected that such copious

amounts of FL work would be completed at this early stage. This FL was integral in making the process as positive for the families as possible. In the next section I examine this FL work in more detail.

4.3 FAMILY LIAISON INVOLVED IN REFUSING BODIES AT THE PHONE CALL STAGE (STAGE 1)

In this section I explore the large amount of AUS FL work involved at the phone call stage (stage one) as a result of the two factors revealed in the previous sections (refusals and the negative impact refusals had on the majority of families). AUS were completing this work in addition to their work involved in the acceptance of bodies. For five out of eighteen units, who refused more bodies than they accepted, this was more time consuming. However, even for those units who reported the lowest number of refusals in the survey (see figure five), for example unit sixteen, much of their FL work was around refusals. Sean revealed:

[...] most of our contact with families will be to say that we can't accept the donation, which is a shame, but you know it happens more frequently than not at the moment so.

(Sean, unit 16)

Sean's comment also demonstrated that there were periodic fluctuations in the amount of FL work involved in refusals. This led to negative feelings in AUS towards such work as they were completing a large amount of refusal FL work at one time and because this work was often negative.

Implicated in this FL was much *EM* (Bolton, 2000). The AUS must manage the positive and negative emotions of the families as well as

managing their own. This was similar to what Hochschild (1983) termed *EL*. However, I argue that *EL* does not fully capture all the nuanced *EM* involved in the FL work that the AUS were completing as I argue AUS did such work because they wished to make the process as positive for the families as possible. I thus deem Hochschild's (1983) *EL* inadequate in this context. I instead adopt and develop Bolton's (2000) multidimensional typology of *EM* to separate the types of work that AUS were completing and to demonstrate the nuances and complexity of the AUS's *EM*. I explore this nuanced *EM* further, as well as the impact this FL work had on the AUS and their ways of managing such work, in the following subsection.

4.3.1 Impact of Doing Family Liaison Work Around Refusals on AUS

Completing refusal FL work was described as particularly difficult by AUS.

That is awful actually. I hate having to tell someone we can't accept [...]

(Sheila, unit 17)

[...] there are times that I've been quite upset, moved by it, umm I found it very difficult when we have to decline, and the family are upset, that always bothers me.

(Alice, unit 9)

This was in part because most families had a negative reaction to the refusal. I also argue that it was because AUS empathised or sympathised with the families that it affected them. This can be appreciated through understanding the nature of their *EM*. I assert that the relatable and personally significant nature of the AUS's work triggered strong responses in empathetic people. I argue that they

reacted to naturally felt emotions, which were conceptually different to the surface acting and deep acting components of Hochschild's (1983) *EL* as these emotions were authentic and did not require regulation (Randolph and Dahling, 2013). Part of this I argue was due to "person-job congruence" (Grandey and Gabriel, 2015: 20) where the "person matches the emotional requirements" of the role; AUS were often empathetic, caring and moral individuals. In this, "[o]ne assumption is that people who are a better fit will need to do less emotional labor." (*ibid.*). Thus, I argue that AUS, by reacting to naturally felt emotions, were performing a type of *EM* that was different to *EL* or at least were required to do less *EL*. However, this meant that difficult FL work impacted the AUS negatively because they had an emotional reaction to this work.

It was also evident that the AUS's responses to different cases of refusals varied depending on the emotional reactions of the family. Annie commented that it was those cases where the families took it badly which were sadder.

[...] if you had to turn one down and they took it badly [...] sometimes it's more sad [...]

(Annie, unit 17)

This demonstrated that the AUS were informed by the families, not solely by their organisation or managers as suggested in Hochschild's (1983) *EL*. The AUS had agency (Bolton and Boyd, 2003), a trait which is assumed to be missing in the emotional labourers in Hochschild's (1983) definition where employees were controlled by organisational feeling rules (Bolton and Boyd, 2003). This further disputes the applicability of Hochschild's (1983) *EL* in this context. AUS used this agency to respond to particular families on a case-by-case basis. Furthermore, Annie considered the wider social norms of the group of donors; that they were altruistic people. In refusing the body, AUS felt

responsible for hindering this altruistic act which negatively affected the AUS. Accordingly, AUS needed to manage their refusal FL work which is explored next.

4.3.2 Managing Family Liaison Work Around Refusals

AUS found various ways of managing their difficult FL work around refusals. This FL work around refusals was not explicit in their job descriptions, in the recruitment process or in the timeline of routine work outlined in chapter one. I also demonstrated in section 4.1 that the extent of refusals was unexpected. The first example of a method of managing FL work around refusals came from Nikki where she successfully navigated a situation.

[...] if you can navigate that successfully, you know, as in they appreciate and understand that you have done everything that you can do, and you've assured them that they've done everything that they can do by carrying out their loved one's wishes, and they feel sort of content with that and that's quite an important process really.

(Nikki, unit 13)

It was the family having knowledge that they and the AUS had done everything they could to avoid the refusal which was important. Reassuring families was the approach that many AUS took to reduce the negative impact of the refusal on families. This was derived from their own efforts and agency to complete this *EM*. AUS went 'over and above' to provide this reassurance when families contacted them.

Nikki used the term, to "break bad news", which is a professional term used by bereavement officers or medical professionals (Watson et al., 2009), to denote the type of work she was completing to navigate refusals. Nikki did not however have training to do such work or

acknowledgement for this; I discuss this further in section 6.3. It must be recognised here though that this was not always bad news, as I previously discussed that some families were relieved by the refusal. Thus, AUS adjusted their tactics according to the family's reaction.

Approaching the refusal professionally and practically was key to the FL around refusals as Sean explained.

[...] sometimes I end up having to speak to a relative that might be upset about [the refusal] just to explain why fully so that they understand that we just can't accept everyone [...] I do get involved when I need to and obviously if there are any complaints I'll deal with them along with our DI [...]

(Sean, unit 16)

Sean was a senior member of AUS (MM) at unit sixteen which demonstrated that there was a hierarchy in dealing with negative cases. An authoritative figure was required where the family reacted badly and did not accept the reason for refusal that the BS, a junior AUS member, had given. This was similar to a shop assistant asking their manager to deal with a difficult customer who would not accept the response from a junior AUS member.

Likewise, Ben, the MM at unit eighteen, made the final decision on acceptance. Thus Ben, as an authoritative figure, made the decision that was likely to cause a negative reaction. This was true for all of the AUs interviewed, apart from unit four where the senior BS made the decision. This meant that MMs had a particular burden to bear in the process of refusals. When the MM was absent, bodies were refused at the majority of AUs. However, bodies were still accepted in some cases where the phone call was passed to an equally senior member of AUS who had a specific role in acceptance decisions.

Annie prioritised the bad news within the refusal conversation. Through her use of negative language such as “hate” and “loathe” in the quotation below it was clear that Annie found this to be a negative situation. She was thus managing her own and the families’ emotions by being up front with the refusal. Annie attested:

I hate letting people down, I hate saying to people I'm sorry we can't accept, I loathe that, but if you're going to say that I always feel that it's better to say it as near to the beginning of the conversation as you can so they don't get any false hopes [...]

(Annie, unit 17)

She made sure to check formalities, such as consent being in place and cause of death, to exclude the possibility of non-acceptance early in the conversation. I observed in the ethnographic case study that the BS would collect all of the relevant information in the phone call and then double check this with the MM to clarify the non-acceptance. With this approach the family were left awaiting the response. It was understandable then why Annie felt it best to prioritise the non-acceptance decision in the conversation when contacting the family. However, some AUS took another approach by allowing the family to lead the conversation as families sometimes used this as an opportunity to discuss their loss. AUS felt that they should comfort them during this discussion before revealing the bad news. It was at the AUS’s discretion to decide the opportune moment to do this.

However, Annie’s approach did not always work. She described how some families left the essential detail which led to non-acceptance until the end of the conversation, after the AU had essentially made the decision that they could accept. Annie stressed:

[...] There's nothing worse when you've been through the whole caboodle and you get to the end and somebody casually jumps in a sentence and you suddenly go “oh no, oh God I can't do it

anymore” and then you’ve got to ring up and say “I’m sorry we can’t accept them” and it’s awful.

(Annie, unit 17)

Therefore, the way in which the families revealed information informed the way AUS completed their FL work.

AUS who had experience in refusing bodies, due to working at the AU for many years, found the FL work around refusals came easier. Charlotte, a BS, who had worked at unit eleven for fifteen years asserted:

It’s just experience for me [...] Dr P who is our DI, he deals with all of the body donor calls when I’m not here and he absolutely detests it [...] I think it’s just a personal thing of how you deal with that kind of thing and experience.

(Charlotte, unit 11)

It appeared that the DI at this AU had less FL experience and consequently found it difficult when families had a negative reaction. It was also clear at other AUs, particularly unit four that employed temporary staff to complete FL work, that less experienced AUS found refusals difficult. It made sense that those more experienced and senior AUS, like Sean or Ben in previous examples, were better placed to deal with refusals and were more resilient to such work.

Similarly, Monica, a technician at unit two who took on refusal FL work in absence of the BS and MM, found refusals particularly difficult.

At first I found it quite daunting, it’s quite difficult, the most difficult is when we can’t accept, [...] the one time I really found it the most difficult is when they hadn’t consented [...] then just

having to tell the family no we can't do that for them because they haven't consented [...]

(Monica, unit 2)

Monica found some instances difficult, that other AUS such as Sean and Annie, found easier because they could take a practical approach. For example, Annie would have checked that consent was in place immediately and the conversation would not have had a negative effect to the extent that it did for Monica. This supports Charlotte's premise that it was experience that mitigated against the negative effects of the refusal on AUS.

The various AUS reactions highlighted in this subsection demonstrated that personality traits and individual differences had an impact on the approach taken to manage refusal FL work and the impact it had on the AUS. For example, it was confirmed in the literature that traits such as empathy, while having a positive effect on the ability to complete their work, elicited negative emotions in workers (Kerasidou and Horn, 2016; O'Brien and Linehan, 2018).

In this section I have addressed research question three (when do such contacts occur?) and demonstrated that a great amount of FL work occurred at the post death phone call stage (stage one). Responding to research question one (what is the extent, nature and form of contact?), I have demonstrated that the nature of much of the FL work was negative. I have revealed that this had an impact on the AUS who completed such work due to their empathetic nature and them acting on naturally felt emotions. This laid the groundwork to appreciate that the AUS completed their *EM* not because they were prescribed to do it but because they felt it was necessary. I argue that this impacted the AUS and may be something that they took home or discussed with colleagues; this is discussed in chapter six. Answering research question two (who has contact?), I have shown that it was

BSs, MMs and DIs who dealt with these contacts; especially MMs and DIs who became involved because of their authoritative position in difficult cases. Next, I focus on ways in which these refusals were and could be reduced.

4.4 REDUCING REFUSALS

I have made clear the high number of refusals, the negative impact that refusals had on most donor's families and the AUS, and the large amount of FL involved around refusals. The question then is: can some refusals be avoided? I have already discussed in section 4.1 those factors affecting refusals and reasons for differences in body numbers between AUs that could not be controlled by the AUS. For example, the type of courses the AU provided or the capacity of the AU. This section will, however, address the two ways that AUS could actively reduce refusals. First, by managing refusals before the phone call stage; and second, by referring bodies to another AU at stage one. The first way is discussed next.

4.4.1 Managing Refusals Before the Phone Call Stage (Prior to Stage 1)

Some AUS made efforts to manage the refusal *before* the phone call was made by making non-acceptance clear in the paperwork and encouraging potential donors to speak to their families about their wish to donate. This resulted in a reduction of the amount of FL AUS were doing at stage one. I also argue that pre-empting the refusal from conversations prior to death could be another way of managing refusals. These three strategies for reducing refusals will be discussed in this section in order of implementation. Most of this work could be deemed 'over and above' work as it was initiated by the AUS's interpretation of the upset refusals would cause for families, and out of

a duty of care to the donor. Next, I focus on the first two of these three strategies.

4.4.1.1 Making Non-Acceptance Clear in the Paperwork and Encouraging Potential Donors to Speak to their Families Regarding their Donation

Lynne exhaustedly said:

One of the hardest things is trying to get people to understand that we don't accept everybody.

(Lynne, unit 4)

It was clear from the data that many families or executors were unaware of the possibility of non-acceptance at the time of death. Thus, the first effort to manage refusals was by making non-acceptance clear in the paperwork that is sent to potential donors and their families before death. This in turn reduced the FL work AUS completed at the time on death due to this misapprehension.

The HTA provided basic information and consent form guidelines which the individual AUs amended to suit their needs. There were some variations evident in the language used and information given, especially around the possibility of non-acceptance. In this section I focus on the content analysis of documentation that was given to donors and their families from twelve AUs to discover how many units made non-acceptance clear in their paperwork and how this was approached.

I outlined in chapter three that a total of thirteen out of eighteen AUs allowed me to access the documentation they sent to potential donors.

However, one AU did not allow me to access hard or electronic copies and was consequently not included here as content analysis could not be completed. The main two documents that were distributed were the information pack and the consent form. There was some variation in the types, number and titles of the documentation sent; for example, some AUs named this “bequest booklet” while others named this “body donation information”. Some AUs also gave a summary or frequently asked questions sheet. These documents were sent to potential donors by AUs and were in most cases intended for the families to read; however, AUS did not always make this clear. Family access to documents was also dependent on the potential donor giving the documentation to their families. Table four summaries the information given in the paperwork around non-acceptance, whether it advised the donors to speak to their families and/or give the paperwork to their families, and further to this whether it mentioned the possibility of referral.

Unit #	Makes non-acceptance clear	Explains reasons for non-acceptance	Advises donor to speak to their family	Asks donor to give paperwork to family	Allows for referral/ makes referral clear
2	Yes	Yes	No	No	No
3	Yes	No	No	No	Yes
4	Yes	Yes	No	No	No
6	Yes	No	No	No	No
7	Yes	Yes	No	No	No
9	Yes	No	No	No	No
10	Yes	Yes	Yes	Yes	No
11	No	No	No	No	No
13	Yes	Yes	Yes	No	No
16	Yes	Yes	Yes	No	Yes
17	Yes	No	Yes	No	Yes

18	Yes	Yes but no mention of logistical reasons	No	No	No
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Table 4: Content analysis of body donor documents for non-acceptance and referral

Eleven AUs made non-acceptance clear in their paperwork. However, there were differences in how this was presented such as in bold, underlined, or a different colour of text; these all emphasised the importance of the information. There were also differences in when the possibility of non-acceptance was mentioned in the paperwork, although it was clear in interviews that many AUS believed that it should be mentioned as early as possible. Of these eleven, only seven reiterated this both in their information pack and their consent form. Unit eighteen also restated that acceptance was not guaranteed in their acknowledgement of receipt letter. Furthermore, of these eleven AUs, only seven explained the reasons for non-acceptance. The lack of logistical reasons to explain possible non-acceptance at unit eighteen may be misleading for the families. Even though non-acceptance was made clear in eleven of the twelve AU's documentation, many AUS noted that this was still overlooked by donors and their families.

It was surprising that paperwork from only four units encouraged the potential donor to speak to their families. It would be useful for this to be included in the paperwork of all AUs. Further to this, only one unit's documentation encouraged the potential donor to give the paperwork to their families. This too would be beneficial to make it clear to potential donors the importance of their families reading the paperwork. It may thus be better to address the paperwork to families as well as donors, as was evident in unit ten's documentation.

Although this analysis only captured the information given in the paperwork, it was clear that many AUS made efforts, when in contact

with potential donors via telephone or email, to encourage potential donors to speak to their families about their wish to donate, including the possibility of non-acceptance, and encouraged the potential donors to give the paperwork to their families. Dawn explained:

I stress if I get to speak to them on the phone, I say “show it to your family” [...]

(Dawn, unit 10)

This was useful because refusals sometimes occurred because the family did not know or agree with their loved one’s wishes. Jo (unit eighteen) said: “[...] we always emphasise at the appropriate times in our conversations with the public that there's no guarantee.” Jo was managing emotion in her understanding of when was an appropriate time.

However, some AUS tried to avoid mentioning the possibility of non-acceptance because this was a negative thing to raise when the potential donor initially contacted the unit to receive the information pack and consent form. Dawn elucidated that this could be negative for some potential donors.

We got a complaint. A lady wrote to me saying I've just had your booklet and it's so negative, on every page you say that [you may not be able to accept] (laughs). I've never had a complaint about being honest (laughs).

(Dawn, unit 10)

This further highlighted that individuals wished to overlook the possibility of non-acceptance when registering as a body donor. However, as Dawn highlighted, the AUS were just being honest and this should not be an issue to avoid as it was important for the families to comprehend.

Thus, despite the AUS's efforts to make non-acceptance clear in the paperwork and to encourage potential donors to show the paperwork to their family, this advice was not always followed.

[...] you would be surprised at just how many people don't read it [...]

(Dawn, unit 10)

[...] It says it in the information, there's no guarantee, but somehow that can be sort of skimmed over.

(Jo, unit 18)

Therefore, AUS could only go so far in making non-acceptance clear in the paperwork and in encouraging potential donors to discuss non-acceptance with their families. Next, the third strategy is explored.

4.4.1.2 Pre-Empting Refusals

The third way in which refusals were managed before the phone call stage was by pre-empting refusals. On many occasions, during the interviews and ethnographic case study, it was clear that potential donors, or their family members, had conversations with AUS before death about their medical conditions. I argue that with the knowledge of those medical conditions, and thus potential causes of death that could not be accepted by AUs, the AUS could pre-empt the refusal by explaining to the potential donor before death that they would not be accepted. However, AUS felt that unless the potential donor asked directly, something like: "*does this mean my body will not be accepted for medical education at your medical school?*", that this was not the time to say as the decision was made on death. This was because the acceptance criteria may change over time; for example, Alzheimer's disease had been added to the reasons for non-acceptance due to a

general acceptance that the prions involved may be harmful for those dissecting.

One AU pre-empted the refusal in the paperwork sent to donors by encouraging them to discuss medical conditions that they were concerned may result in their non-acceptance. Unit six wrote:

“If you are concerned that you have a medical condition that would prevent us accepting your offer, please contact us and we will be happy to discuss it with you.” (Information on donating your body for anatomical examination: and instructions for the next of kin, unit 6, page 7).

This was a sensitive approach to pre-empting refusals as the potential donors that were removed from the BD register were self-selecting.

During the ethnographic case study, I overheard a voicemail and subsequent telephone conversation between the BS Katie and a potential donor’s wife discussing the husband’s wishes to donate his body. The wife described that he had cancer. It was made clear to Katie that the cancer was currently in the man’s liver and lungs and she said: “right, as things stand, if we were in a position to accept, going on what you’ve said now, we would be able to accept.” Katie adopted a positive approach to this conversation only mentioning that they could accept in his current medical situation if the other circumstances, such as ample storage space, were in place on death. Further to this positivity Katie recommended that he completed the consent form to give them the option to donate on death, if possible.

Carrie said that she had conversations with potential donors and hospice staff regarding the acceptance of the body before death.

[...] there are a lot of questions about conditions that preclude acceptance [...] there are some conditions which preclude acceptance from the start umm but I always say to people that

I won't make- I make the decision ultimately, when somebody dies and I'm informed of the death.

(Carrie, unit 17)

Carrie made clear that even if a condition made for non-acceptance, she would still emphasise that the decision was made at the time of death; thus, the individual should remain on the donor register. However, this could be an apt opportunity to pre-empt the refusal, remove the individual from the register prior to death and avoid future refusal FL work at stage one.

In contrast to Katie and Carrie, Ben took an up-front approach when speaking to potential donors. He found that individuals were grateful for his honesty around non-acceptance as they could make alternative arrangements. Even if their current condition would not prohibit them from donation Ben still made clear that acceptance was not guaranteed.

I've had questions: [...] "I've got a certain condition now, is that going to impact your ability to accept at a certain time?", and I'll be very frank and honest and if it is a condition that is likely to very negatively affect our ability to accept, I will say, and they're always thankful and say "well thank you for addressing that, that'll save me the trouble of going down this route with the family; I can look at other alternatives instead." [...] there's other people that we'll say "well actually your condition at this stage will not necessarily prevent us from pursuing it, but you may well die in twenty years time when your medical condition will be showing a different picture, so you have to be aware of that, so there is no guarantee."

(Ben, unit 18)

It was clear that AUS took varied approaches to pre-empting the refusal; however I argue that it was best, despite the negative connotations, to be honest about the possibility of non-acceptance, to prepare the potential donor and the family. This would reduce the FL

and potential upset caused at stage one. It was understandable why AUS wished to be positive when potential donors enquired, but they could strike a balance between being positive and encouraging and being honest about the process and possibility of refusal. This positive approach could be comprehended by applying Maussian *gift exchange* (1990) as the AUS, as future receivers of the gift offered by the potential donor, wanted to say they would accept the gift and avoid losing face by pre-emptively refusing the gift. They did not want this to be negative for the potential donors at this early stage before the post-death phone call. These three strategies for managing refusals before the phone call stage are presented as best practice in chapter seven. I next move on to those efforts made to reduce refusals *at* stage one by referrals to other AUs.

4.4.2 Referrals

AUS also made efforts to avoid refusals by referring bodies to another AU where possible. The efforts in seeking referral differed between AUS as it was the AUS who chose to complete this work. Referral work thus accounted for a large amount of the FL at the phone call stage. However, regional alliances, exchange relationships and geographical priorities arose, which complicated the AUS's efforts to refer bodies. There was also the extra cost of transportation, which in some cases needed to be covered by the family or the donor's estate. These issues are discussed later in this section.

I argue that referral work can be deemed 'over and above', as AUS went out of their way to facilitate acceptance even if this was not possible at their own AU. I assert that this was an outcome of the gift relationship initiated by the proposed gift of the BD. As I asserted in the previous subsection, the AUS were presented with a duty of care to accept this gift due to the implied social contract (Mauss, 1990). AUS *felt* that they were obligated to receive and reciprocate (Testart,

1998). I demonstrated in sections 4.2 and 4.3 that refusing a body on death can be fraught with difficulties. It was thus in the AUS's best interests to avoid these difficult situations in order to make the process positive for the families of donors.

Monica declared:

Yes, refusals are the most difficult and the referral lessens the blow.

(Monica, unit 2)

It was clear that referrals were the main way AUS overcame this difficult situation when the body could not be accepted for non-medical reasons. For example, it may be that the original AU did not have enough storage space or the AUS to embalm the body. Thus, another AU may be able to accept the body. There were also certain medical conditions that were not accepted at some AUs yet were at others, such as Alzheimer's disease. As Ben explained:

If there is a chance I would normally call [unit 9] and describe to them that there's a medical criteria issue for us, are they embarking for any specific fresh frozen courses where that might not have an impact. So, there's always a small chance that we might be able to refer you even though the medical criteria are not right for our purposes.

(Ben, unit 18)

However, there were variations in the AUS's efforts to refer bodies. This was due to individual differences and time constraints. At some units the general practice was to refer the family to the HTA website to seek referral; this was part of the AU's working practice and most AUS at the AU took this approach. The onus to seek referral was therefore on the family. When a suitable AU was found by the family then the

AUS transferred the documents to permit acceptance. For other AUs it was the AUS who made the effort to seek referral.

[...] we work really hard if we aren't able to accept for any other reason that may be a general medical criterion which institutions would be reluctant to proceed on, we work hard to still place our donors in institutions, Jo or I will ring around other institutions.

(Ben, unit 18)

Similarly, Dawn explained that if it was a logistical reason, essentially if it was the fault of the AU why the body could not be accepted, then AUS made extra effort to refer the body.

If we are not accepting because the DR [Dissection Room] is closed for any reason, then we nearly all try and muck in and help each other out.

(Dawn, unit 10)

Dawn described that BSs from multiple AUs worked together to find referral options for such individuals.

At some units it was both the families and the AUS who made efforts to facilitate referral. For example, Tom described that at unit two both he and the families rang AUs to seek referral. Tom was balancing the time constraints of needing the body to be accepted within five days and his work duties by relieving some of the efforts to the families.

Some AUS also completed referral work outside of BD for medical education. For example, when a body could not be accepted to unit ten, Dawn referred to a brain bank.

I do a lot of referral work to say the brain bank and I will explain to the family, "look it's not the same as full body donation, [...] but if you are interested here is the number of the research

nurse down there.” I use that particular project because I know it's ongoing and they're not going to close their doors.

(Dawn, unit 10)

Many AUS suggested external studies that may accept the refused bodies. This is a particular example of ‘over and above’ work which I argue was performed because AUS felt obligated to accept or find an alternative means of acceptance.

Ben and Jo elucidated this ‘over and above’ work and why they performed it.

Ben: [...] it's just a duty of care to help, not just the donor but also the next-of-kin and the families, to place, to place our donors elsewhere if possible.

Jo: Yeah that's part of the job really, we've made that part of the job, it wasn't necessary - it's not in our job description to do it, it's not written anywhere, but that's part of doing the job well and going home at the end of the day and thinking yep we couldn't place that donor but we tried, we spoke to the family, they understood and we've closed that one off.

(Ben and Jo, unit 18)

By recognising that they were unable to accept the gift of the physical body the AUS *felt* (Testart, 1998) they had a “duty of care” to refer the body where possible. They recognised that they were doing ‘over and above’ work. For Jo this was “part of doing the job well”; eliciting job satisfaction and enjoyment (Theodosius, 2006), and the ability to leave work at work, as she felt satisfied that she had done all that she could. It may also be an effort to avoid bad publicity. This reiterates the difference in approach to referral work. Again, I argue that this work was initiated by naturally felt emotions (Randolph and Dahling, 2013) rather than organisational feeling rules (Hochschild, 1983). This was influenced by individual differences, personality traits, experience, or

AUS backgrounds. For instance, those who were ex-funeral directors or police family liaison officers who had previously worked with bereaved people appreciated the difficulty experienced and went 'over and above' to seek referral. I argue that this was completed because AUS *felt* obligated to reciprocate the gift (Testart, 1998). This was similar to what Bolton (2005) described as philanthropic *EM* as AUS wished to give this work, as a reciprocation of the gift of BD, to the families.

Despite the efforts made by AUS to refer a body, the family had an overriding influence.

[...] of course it all depends on the family, if the family at that point say well it's [this unit] or it's nothing then it's finished you know, we can't do anything, but most families do want to carry out their wishes and will accept any schools really.

(Sean, unit 16)

AUS explained that there were multiple reasons for families declining the referral option, such as having the donor in close proximity to the family, having an affiliation to a particular university, or wanting to give back to a particular university hospital because of the treatment they received during their life.

The extra cost of transportation may also influence the family's decision to refer. This was sometimes incurred if the body was transferred outside of the catchment area for which the AU paid. This was informed by the HTA's AU catchment areas for donation, which depended on the AU's location. Dawn explained:

We pay for the first 40 miles of any round trip for collection and anything over that is charged to the family, and that's £1.45 per

mile at the moment, so it's not excessive, we bear the brunt of it really.

(Dawn, unit 10)

The extra cost was covered by the family or donor's estate. I argue that this extra cost should have been outlined to families up front, as Ben expressed.

[...] we make all this apparent to the next-of-kin [...] we say "well you need to understand that there are set medical institutions that if we do successfully refer them, they may expect the family or the estate of the donor to pick up the costs", and we can give them outline costs at that point [...]

(Ben, unit 18)

The distance that the AU was willing to accept bodies from was decided by the AUS at that AU. Ian described that they often accepted referrals at unit three; however, the only case he has known where families paid for the extra cost of transportation was when they were transported a great distance due to their wish to donate to the university they attended as a student. This was the donor's/family's decision; thus, the donor/family incurred the extra cost. Steve explained that unit three avoided charging some families for transportation as their catchment area was large enough to cover certain referrals. Thus, the geographical location of the AU and its catchment area affected the cost incurred for the donor's estate or families, and in turn influenced the family's decision to refer. Next, the regional alliances, exchange relationships and geographical priorities that also affected referrals are deliberated.

4.4.2.1 Regional Alliances, Exchange Relationships and Geographical Priorities

Regional alliances, exchange relationships and geographical priorities formed around referring bodies. First, it was apparent that AUs referred to geographically proximal units. Sean maintained:

[...] we try and do close schools. The usual suspects when it comes to passing on.

(Sean, unit 16)

This was because of the time it took to transport a body and the extra costs involved in the relocation. The figure below illustrates the geographical movement of bodies that were mentioned in the interviews and ethnographic case study. The regional alliances and exchange relationships between geographically proximal units are indicated by the coloured groupings.



Figure 6: The geographical movements of bodies mentioned in the interviews and ethnographic case study – coloured groupings indicate regional alliances and exchange relationships between geographically proximal AUs (Image adapted from Pathiraja et al. (2014) by adding coloured lines)

Regardless of the efforts made by AUS some AUs were isolated which affected their ability to refer. Alice described:

Yeah because of where we are in the [country] [...] we don't tend to go to the others further afield because then there's delay in getting the body there and transit times, so we try to keep within the sort of the most, nearest area.

(Alice, unit 9)

There were restricted options then for unit nine due to time constraints. Alice also explained avoiding referral to a particular AU as they rarely

accepted. Furthermore, Sheila described the impact that the relationships between AUs had on the ability to refer.

[...] usually when we get to the summer, we reach our capacity [...] and we're turning down for non-medical reasons, umm but I feel like we have got quite a close relationship, particularly with X and X [...] they pass on donations, then we do.

(Sheila, unit 17)

This demonstrated the exchange relationships that formed. This required regional teamwork where AUS worked together to facilitate donation. However, this regional teamwork may, in fact, have the unintended yet negative impact of paradoxically restricting referral to other regional AUs. Sheila highlighted that there were seasonal fluctuations where the academic year and courses offered further influenced the exchange relationships and number of referrals.

It was also clear that geographical priorities affected the acceptance of referral offers.

[...] we can't offer to anybody else because everybody else is not taking out of that area because they're almost full and they want to keep it for people within their area [...] everybody puts the brakes on [...]

(Dawn, unit 10)

This was influenced, as I discussed in section 4.1, by the increasing donor population.

This section highlighted that there were several ways in which refusals could be avoided before and at the phone call stage. This was extremely important to reduce the amount of refusal FL work, which was mainly negative. This was also in the AUS's personal interests as

I demonstrated in section 4.3 that refusals also had a negative impact for some AUS.

4.5 CHAPTER CONCLUSION

In this chapter I have revealed for the first time the large extent of refusals in the BD process. Addressing research questions one (what FL work) and three (when does FL occur), I showed that a large amount of FL work was completed at this early stage in the process which was not expected. This ascertains, addressing research question three, that AUS did FL outside of accepting bodies, giving monuments (Bolt, 2012) and thanksgiving services (Strkalj and Pather, 2017). Addressing research question two (who completes FL work), I have shown that it was BSs, MMs and DIs who dealt with these contacts; especially MMs and DIs who became involved because of their authoritative position. I demonstrated that the nature of this FL was negative due to the detrimental effect that refusals had on the majority of families. I have revealed that there were several ways in which refusals could be avoided before and at the phone call stage. This was integral considering the negative impact of refusals for many families and some AUS. However, it was clear that although the AUS did their best to refer those that did not have conflicting morbidities, the large number of bodies offered meant that AUS could not refer all of these bodies, as many AUs were at capacity. It can be deduced that it was those absolute reasons for non-acceptance which made for the high number of refusals, despite other influencing factors and efforts to reduce refusals. Thus, there were practical restrictions to their completion of 'over and above' work. This laid the groundwork to recognise that AUS completed their *EM* not because they were prescribed to do it (disputing such work as *EL*), but because they felt it was necessary. It was also important to avoid bad publicity, because UK AUs rely on voluntary donation of bodies. This was especially evident in those cases where families threatened public authority, such

as the mayor, or legal involvement. In this chapter I have also ascertained that some of the AUS's FL work was hidden and unrecognised. The following chapter will continue to understand the extent that such work was completed and hidden after acceptance too.

CHAPTER 5: AFTER ACCEPTANCE: THE HIDDEN EXTRA WORK

In the previous chapter I focussed on the time around death, when the phone call was made (stage one), and the FL that AUS did at this time due to the refusal of bodies. In this chapter I consider the period following the acceptance of bodies and the FL that AUS undertook during this time. This was important because the literature suggested that such work did not take place. As Quigley (1996: 199) argued:

“The family members of a person whose body is donated to science are not surprisingly out of contact with the anatomy class from the time of the donation to the reclamation of the ashes or body after many months in the hands of medical students [...].”

However, in this chapter I reveal for the first time that in fact much hidden extra work took place after the body was accepted for medical education. I have called this work *hidden* because the extent of this work was not recognised by managers or the HTA or even by the AUS themselves. I explore this further in chapter six. I call this work ‘extra’ because much of this FL work was ‘over and above’ as AUS went out of their way to make the process positive for the families. Dawn exclaimed:

No one knows about our hidden work

(Dawn, unit 10)

In this chapter I address the first (what is the extent, nature and form of contact?), second (who has contact?) and third (when do such contacts occur?) research questions posed in chapter one. Theoretically, *EL* (Hochschild, 1983) and *EM* (Bolton, 2000) are again

applied. First, I set the hidden extra work in context. Second, I explore the families' continued contacts and sending in items. Third, I pay attention to the families' special requests. Fourth, the complexities around families changing their minds about contact options are deliberated. Fifth, I discuss those issues which required mediation. These sections address the families causing this extra work. Section 5.6 however focuses on the extra work that was caused by AUS after acceptance. In the final section I address research question five (how is FL brought to an end?) by uncovering those strategies used by AUS after acceptance to limit interaction and encourage closure which was a main way in which extra FL work was managed. Next, I turn my attention to the first of these six foci.

5.1 CONTEXTUALISING THE HIDDEN EXTRA WORK

It was useful first to lay out the 'normal' timeline of routine work after acceptance; Anthony describes this below, deeming it straightforward.

[...] the job on the surface would be, [...] get the bodies in, treat them, prepare them and use them, get rid of them at the end of the day.

(Anthony, unit 2)

However, in this chapter I clarify that this is not as unproblematic a process as Anthony first posited, as there were multiple disruptions to this 'normal' timeline caused by families and internal and external non-AU staff after acceptance. In this chapter I dig under the "surface" that Anthony initially described to excavate the hidden work. I thematically examine these points of disruption to problematise this seemingly straightforward process. These disruptions caused much hidden extra work as Anthony went on to highlight.

[...] over and above the job description it's just going into, it's delving into the personal interaction that is over and above what you would be expected to do- [...]. So, in a sense there's more a listening ear, a counsellor type role, which is definitely not something that is in our job descriptions at all.

(Anthony, unit 2)

This extra work and FL were not in their job descriptions, yet AUS chose to complete such work. This demonstrated that the AUS were aware that this work took place in response to some families in order to facilitate the process of BD and fulfil their duties of body procurement. However, some AUS were unaware of such work as when asked in the survey: "What kinds of involvement do Anatomy Unit staff have with families following BD and before disposal?", two units responded saying: "Generally none" (unit eighteen); and "No further contact once the paperwork has been completed" (unit eleven). Similarly, when I completed the unrecorded telephone interview with June, the BS at unit eight, she suggested that after the unit sent the letter thanking the family for completing the forms the unit would not normally have any further contact with them. However, in the same interview June described much FL work after acceptance. It may be that some AUS did not recognise such work as FL work. Thus, this work was even hidden to some AUS that completed it.

This work fell to the AUS, as they were deathworkers who completed "specialised work following death" (Walter, 2005: 383). This extra work however was not simply to facilitate body procurement; their sole duty as deathworkers, as some actions, such as returning a body to the family earlier than usual, contradicted this duty. It must then be comprehended why, to borrow Anthony's term, the AUS went "over and above" the work that was expected of them. Anthony asserted:

[...] I think that's the thing, you've got to be a (pause) a critical friend/counsellor/umm confidant/whatever. You're what you need to be when that phone call comes through.

(Anthony, unit 2)

Throughout this chapter I demonstrate a clear difference between waged and unwaged aspects of AUS's hidden extra work. McClure and Murphy (2007: 110) defined the "emotional work response behaviours" of nursing professionals "as a set of companionship, help and regulation behaviours, which are not always, and not only, performed because they are paid for in waged work environments, but are nonetheless, enacted for the purpose of improving social relationships and the emotional well-being of patients, clients and co-workers." The unwaged aspect of these behaviours were why they were referred to as work as opposed to labour (McClure and Murphy, 2007; Strazdins, 2002). These authors also recognised that such behaviours were partially work and non-work; thus, some of their behaviours were due to behaving professionally as well as those which they chose to give.

I argue that AUS were completing emotion work response behaviours which they chose to give, wanted to do and enjoyed doing (Bolton, 2000; Strazdins, 2002; Theodosius, 2006) as well as that which were performed professionally. As Bolton (2001: 89) theorised: "[...] they are able to carry out the performances required for an organizationally allocated role whilst also holding onto their own identities." Defining this in Hochschild's (1983) terms, this work had a use-value as opposed to an exchange value as this was more akin to what she called emotion work; however, AUS were performing this professionally thus challenging such work as *EL*.

I theorise that this extra work was completed due to a duty of care the AUS felt towards the donor and their family and the tacit social contract

that was created in the giving of the BD as a gift (Mauss, 1990). This gift relationship was due to the AUS's professional position. Mauss (1990) said that reciprocation was a key part of the gift relationship; therefore, it was understandable that the AUS did this extra work and FL out of a duty to reciprocate. This was similar to Bolt's (2012) hypothesis that body donor monuments were an act of reciprocation. Hochschild (1979: 257) does touch upon the concept of gift exchange describing that a "tribute" can be made as a way of "paying respect with feeling". Bolton (2000: 582), drawing upon Hochschild (1979), states that "it is a personal gift given freely, sometimes unconsciously, without the counting of costs." Chapter seven further explores the gift relationships apparent throughout the BD process and how this could explain the interactions seen in these data.

Drawing upon Hochschild (1983), I assert that the AUS used the means available to them on an *ad-hoc* basis to give these reciprocations. Hochschild (1983) argued, drawing from Goffman's (1961) dramaturgical metaphor, that "[t]he stage, the props, and the fellow members of the cast help us internally assemble the gifts that we freely exchange" (Hochschild, 1983: 85). Similarly, Bolton (2001: 89) recognised that "[...] people do not switch themselves on and off but glide from one performance of face-work to another [...]." The AUS were skilled performers. This performative aspect of their work was implicit in their role as "mediator deathworkers [who] gather information in private, edit a story, and then perform the story [...]" (Walter, 2005: 386). Now that I have set the context of the hidden extra work, I next move my attention to contextualising the main cause of hidden extra work; the disruptions to the 'normal' BD process caused by some donors' families.

5.1.1 Contextualising the Main Cause of the Hidden Extra Work

Neimeyer et al. (2010: 73) asserted that: “[a]lthough most people successfully navigate bereavement and retain or return to pre-loss levels of functioning, a significant proportion struggle with protracted grief, and are unable to find meaning in the wake of an unsought transition.” This assertion demonstrated that bereavement caused people to react in different ways. This may explain the spectrum of disruptions by families of donors, where it was the minority that caused these. I argue that disruptions, such as continued contacts, sending in items, special requests, and issues that required mediation, were a product of the families coping with bereavement. For example, I explore that these were ways in which families were *continuing bonds* (Klass, Silverman and Nickman, 1996); an arena in which *continuing bonds* has not yet been explored.

AUS expected a spectrum of responses from families after acceptance which ranged from no contact, which was the ‘norm’, to substantial contact, which caused extra FL work for the AUS day to day. Katie (unit four) interpreted this lack of contact, for some people, as being because they wished to ignore the realities of BD. This may be because some families found it hard to deal with their loved one donating their body or may not have agreed or even known that their loved one wanted to donate as discussed in chapter four. Next I focus on the first emergent aspect of the AUS’s hidden extra work after acceptance which was caused by families continued contacts and sending in items.

5.2 CONTINUED CONTACTS AND SENDING IN ITEMS

After acceptance the main cause of hidden extra work was the families' continued contacts and sending in items. I use *contacts* here to emphasise that there was a one-way interaction, where families contacted the AUS and AUS could choose whether to respond to these contacts and facilitate what has been asked for. It must be kept in mind throughout this section that it was a minority of families that continued contact and sent in items, meaning that the large amount of extra FL work was caused by a small number of families.

In this section I show that it was particularly BSs and MMs who had contact with families following acceptance due to continued contacts from families and their sending in of items. This occurred most frequently during the storage and use stage (stage three) while the body resided in the AU. According to the 'normal' timeline of routine work outlined in chapter one, this was deemed the stage in which the least FL work took place; however, this was not the case in practice. I argue that these continued contacts and sending in items were ways in which families were *continuing bonds* with their loved ones (Klass, Silverman and Nickman, 1996). The AU I argue was a new arena where *continuing bonds* were taking place. This happened while the body was in a betwixt and between state during the storage and use stage, where the individual was deceased but not yet disposed of (Turner, 1969; Van Gennep, 1960). Perhaps knowing the physical body of the donor was in the AU affected the way families were *continuing bonds*. This was likely why their *continuing bonds* were directed towards the AUS as they were the individuals caring for the donor. In this section I use empirical data from the interviews and ethnographic case study to explore the extent, nature and form of these contacts through the lens of *continuing bonds* (Klass, Silverman

and Nickman, 1996) and *meaning making* (Neimeyer, 1998), focussing on the continued contacts and the items that families sent in after acceptance.

However, parallels could also be made to the traditional stage theories outlined in chapter two. For example, the second stage yearning and searching described by Bowlby and Parkes (1970), where the family searched for their loved one to make sure that they were gone, could be seen in the families' continued contacts and sending in items while the body was within the storage and use stage. There was a paradox in the body still being present in the AU while being dead. This differed to the normal post-death process where the body would be disposed of at this time. Thus, BD may affect the way families were yearning and searching.

A comparison could also be drawn between Bowlby and Parkes (1970) and Neimeyer (1998, 1999, 2001) as families searched for meaning which could be seen in the actions of the families of donors outlined in this section. Similarly, it may be that while the body was within the AU (stage three), the families could not complete task three of Worden's four tasks (2009: 46): "[t]o adjust to a world without the deceased", or task four: "[t]o find an enduring connection with the deceased in the midst of embarking on a new life" (*ibid.*: 50). This was because the body was still present within the AU, therefore, the deceased may not be deemed missing. BD is thus a unique process which disrupts the traditional stages of dealing with grief (Bowlby and Parkes, 1970; Freud, 1917; Kübler-Ross, 2009; Worden, 2009). AUS interpreted the contacts as being made due to a lack of closure, because the body remained in the AU and had not yet been disposed of. Thus, the bereavement period continued, resulting in continued contacts and sending in items. However, this continued contact from some families may be a way of *continuing bonds*, transforming bonds or *meaning making* with the deceased, using the AUS as points of contact.

I consider that the AUS formed an integral part of what Klass, Silverman and Nickman (1996: 351) termed “social support networks”, as AUS facilitated the family’s *continuing bonds* and transforming bonds (Mathijssen, 2017a) with their deceased. However, there was an inherent contradiction emergent from the data where AUS facilitated *continuing bonds* while holding traditional views of the bereaved needing closure.

Again, I argue that the AUS gave this extra work as a reciprocation of the gift of BD given by families, as a duty of care and a rational and emotional appreciation of the families’ needs to continue contacts and send in items. AUS considered this to be part of their professional role although it was not explicitly part of their job descriptions. Next, I investigate the nature and form of continued contacts.

5.2.1 Nature and Form of Continued Contacts

This subsection explores the nature and form of continued contacts. First, I address continued contacts as a way of checking in.

5.2.1.1 Continued Contacts as A Way of Checking In

One family member used his contact with the AU to update the AUS about his endeavours, such as going on holiday. Other AUS described families checking in to update the AU that their loved one had become a Grandma, for example, with the arrival of a new baby in the family. I argue that this was a way “that the bereaved gradually transformed their bond with the deceased, to (re)negotiate his or her ‘absence-presence” (Mathijssen, 2017a: 2). Mathijssen (2017a) drew upon Maddrell’s (2013: 501) “more nuanced” concept of “absence-

presence” to show the interconnected nature of absence and presence within transforming bonds, which needed to be “dynamically negotiated” by the bereaved. I argue instead that the families of body donors were dynamically *renegotiating* the deceased within their life as a way of understanding their absence-presence.

These continued contacts were spontaneous; however, experience told AUS to expect such disruptions. It was the BSs that usually fielded these calls. They chose to put their other duties on hold on an *ad-hoc* basis. These other duties included answering phone calls regarding the death of other donors, responding to potential donors, or coordinating anatomy teaching and external short courses. AUS described that calls, where the families were contacting the AUs after acceptance, often took longer than other calls as the families liked to speak at length about their loved ones. The AUS were a “listening ear” as Anthony highlighted in section 5.1.

One such example of the type and content of some of these spontaneous checking in communications between the AUS and families was highlighted by Sheila.

We had a gentleman once whose wife died and he was obviously struggling, and he'd ring us quite often and just have a chat and he'd be saying “oh I'm going away this weekend and I've just loaded the caravan up and...” (laughs) [...] but he, that guy, kept ringing all the time.

(Sheila, unit 17)

This was indicative that much extra work was caused by only some families as some individuals, like the gentleman above, contacted the unit “all the time”. Of course, on some days there would be little or no contact and on other days this contact would take up the majority of their time. They provided a “therapeutic” service that was necessary, as Natalie highlighted.

I do get that impression for those people that do like to call and chat and, you know, and talk through it, yeah it does it feels like- I would like to think it's therapeutic yeah.

(Natalie, unit 4)

Its “therapeutic” nature indicated that the families were seeking more than a listening ear, they required a trained therapist/counsellor. This was ‘over and above’ the AUS’s training level. This type of communication, while potentially comforting or “therapeutic” for the family, was disruptive for the AUS. This again was an inherent contradiction as they facilitated the continuing contacts and provide a “listening ear” for example, but at the same time appreciated that this disrupted their everyday work. Given the benefits of such work for families, AUS justified its disruption. It was a practical and rational decision (as well as an emotional one) to complete such work which was given as a reciprocation. This communication, regardless of its disruptive nature, helped to build relationships and rapport between the AUS and the families, a potential benefit (Sque, 2007). I reason that AUS did this “therapeutic” work because their role had no defined boundaries. In chapter seven I suggest that there needed to be defined boundaries and resources that AUS can defer to, such as local counsellors.

This contact formed a key part of the hidden work that AUS did day to day. This hidden work or invisible work was important and relevant as it was implicated in a necessary task, yet was unrecognised in the AUS’s job description (Lee-Treweek, 2008). It was backstage work (Goffman, 1959). Daniels (1987: 403), coining the term “invisible work”, used this to describe women’s unpaid labour, in particular housework and volunteering which were devalued both culturally and economically. Hatton (2017: 336) developed this and presented a revised concept of invisible work where “cultural, legal and spatial mechanisms of invisibility” intersected. Drawing on the economic,

cultural and legal aspects of such work, I argue that the lack of economic incentive, recognition and regulation of this type of extra work that AUS chose to do rendered this invisible and hidden, 'over and above' what is expected, yet important and necessary. Such work was also spatially hidden as it occurred in the AU which was only accessible by AUS.

5.2.1.2 Continued Contacts as A Way of Meaning Making

During the storage and use stage, which can last up to three years after death, some families used continued contacts as ways of *meaning making* (Neimeyer, 1998, 1999, 2001) or meaning-reconstruction, which according to Holland, Currier and Neimeyer (2006) can happen during the early period of bereavement. These were efforts to: make sense of the loss; find a benefit or silver lining; or rearrange their own identity (Gillies and Neimeyer, 2006). Holland, Currier and Neimeyer (2006) made the distinction between the types of meaning reconstruction that happened throughout the first two years of bereavement. In the early period, sense-making was drawn most prominently upon, whereas benefit-finding occurred as time progressed (*ibid.*). Holland, Currier and Neimeyer (*ibid.*: 176) argue that: "Sense-making denotes the comprehensibility of the loss or the survivor's capacity to find some sort of benign explanation for the seemingly inexplicable experience [...]" or "the capacity to construct an understanding of the loss experience" (*ibid.*: 403). Whereas "[b]enefit-finding refers to the significance of the loss and entails the survivor's paradoxical ability to uncover a "silver-lining" [...]" (*ibid.*: 176). It was within the storage and use stage where sense-making and benefit-finding occurred. For example, one daughter asked after her dad: "can you tell us what you've been doing with him?" (Charlotte, unit eleven). I argue that this was a type of meaning reconstruction similar to sense-making as the daughter was attempting to make

sense of his usefulness in donation; trying to find the silver-lining. This was a common way of *meaning making*. Next, I focus in continued contacts as a way of *continuing bonds*.

5.2.1.3 Continued Contacts as A Way of Continuing Bonds

Instead of *meaning making*, I theorise that the gentleman's contact described below was an effort to continue bonds (Klass, Silverman and Nickman, 1996) and transform bonds (Mathijssen, 2017a). It seemed like an attempt at *meaning making* on the surface, but Katie evidently understood that this was not really his intention; he really wanted to build and maintain a connection with his loved one. Within these varied and often blurred attempts to continue bonds, AUS were faced with the decision of what to reveal and conceal to the families, as AUS were aware that families varied in the information that they wished to know. I use blurred here to highlight the nature of the calls, as families were not always transparent about what they wanted or may not have known what they wanted from the contact. In this case Katie gave a general statement which satisfied the family and created a feeling of connectedness.

I think with the Smiths it was building this connection and feeling as though they were still connected. They would say "oh what are you doing with her today" and I would say "the students are up there learning." He didn't really want to know but it was just, you know, just building a connection and still feeling connected because they hadn't had proper closure.

(Katie, unit 2)

Drawing upon Bolton and Boyd (2003: 289), it can be interpreted that Katie presented skilled *EM* as she was "able to juggle and synthesize different types of emotion work dependent on situational demands." Here Katie interpreted what information the family wanted to know and

controlled her emotional reaction to this. Katie was able to “resist and modify the demands” of the family member (Bolton and Boyd, 2003: 289). This contradicted Hochschild’s (1983) concept of the transmutation of feelings, where personal feelings were overruled by professional feelings which were controlled by managers. In this case Katie did indeed show agency by using her initiative to comprehend what he *really* wanted to hear from her. This would not be the case if these feelings were transmuted (Callaghan and Thompson, 2002; Paules, 1996). Katie was also agentic in giving *EM* philanthropically (Bolton, 2000) as Katie appreciated the family’s need to maintain a connection with the AU. This was something that AUS enjoyed and did out of choice (Theodosius, 2006), which again conflicted Hochschild’s premise of transmuted feelings. In the AU context, although AUS were required to do *EL* as part of their job, they still had ownership of their emotion which challenged the wider shift towards institutional management of emotions (Fineman, 2000).

The excerpt from Katie also highlighted the inherent contradiction in the AUS holding traditional views of closure and breaking bonds while facilitating *continuing bonds* and transforming bonds. In fact, the AUS’s mediation of *continuing bonds* was probably because private methods of *continuing bonds* had been redirected towards the AU, as this was where their loved one was located. The AU replaced the traditional resting place (for example, the cemetery) and the AUS were facilitators of these contacts as a way of *continuing bonds* as deathworkers that had a unique prolonged duty to care for the donor and their family because the BD process was extended. This was thus a new arena in which *continuing bonds* were taking place. In holding traditional views around closure this may have been a way in which AUS justified their extra work. AUS believed they had a duty to make up for the disruption caused by the BD to the tool of gaining closure (the funeral) which hindered the family’s ability to gain closure.

Finally, the space was important in the transforming and continuing bond. The space was that associated with the deceased and the physical place where the deceased was located. Tom discussed the connection that some families felt to the AU and university, especially if they were local. Thus, distance from the AU may affect the ways in which families continued bonds.

I've had a few people say to me that they always thought that say their Mum was still around because they knew where she was [...] especially if they lived in [the area] they always felt that there was some sort of connection to the medical school [...] until the day of the cremation of course [...] I think that people get a bit of comfort from that [...]

(Tom, unit 2)

This again was because the body was present in the AU and families could locate this which Tom noted ended abruptly at cremation when the body was no longer in the AU. Both Baker, Baker and Gentry (2016) and Valentine (2008) posited that the ability to locate the deceased was integral in *continuing bonds*. Next, I discuss sending in items.

5.2.2 Sending in Items

In addition to continued contacts, which were most frequently via telephone or sometimes via email, families also sent items and letters to be given to or held with the donor to the AUS that were caring for their loved one. Sometimes items would arrive with the body and be kept with the body in the same room, department or building. Items included cuddly toys, treasured items and keepsakes, photographs, items of clothing, items of religious importance, and items that had been made or brought at the time of death, such as photo albums, crocheted items or new clothing. AUS stored these in locked filing cabinets and cupboards in the BS's or MM's office, or in the dissection

room, labelled with the donor's anonymous number or code. The AUS made sure these items were kept safe and a note was written in the donor's file to ensure that these items were cremated or buried with the donor.

However, there was a distinction between jewellery and other items of less monetary value. AUS often pushed for high value items such as jewellery to be sent to the donor's family as they did not want the responsibility of keeping such items. Nonetheless, some families decided that the jewellery, especially wedding rings, should remain with the donor. Lynne described one such instance:

[K]nowing that they can send Mum- the wedding ring is a big one, "that was her wedding ring and I'm sure she'd want to keep it on" [...] whilst they're in the dissecting rooms they don't have any jewellery on, but they don't need to know that, [...] but having that personal touch of "of course you can" and then we come back and go [shrugs] well I don't know what we're going to do with that.

(Lynne, unit 4)

There was an interplay of emotional and rational management. The AUS carefully managed disclosing where the items were kept; AUS let families believe that they were on the donor's person in the case of wedding rings. They were not lying about the location of the items, simply allowing families to believe what they needed to make the process easier. This careful management of the family's emotions I argue was *EM* chosen to be given philanthropically (Bolton, 2000).

During my visit to unit four Lynne showed me a filing cabinet that was filled with items; each had their own story attached. One case, where the donor's family sent in slippers and a dressing gown, was explained by Lynne.

[...] Downstairs has a beautiful bath robe, purple bath robe downstairs, and a pair of slippers [...] they did say “oh Mum did love her dressing gown and slippers”, great (pause), if it's made you feel more comfortable about releasing [the body for donation].

(Lynne, unit 4)

Lynne justified accepting and storing the items, even though this caused practical implications.

Items could also come from people beyond the donor's family.

Jane: We had a school teacher once [...] and all her pupils had written a page and this book came in.

Alice: That's very emotive though because, you know, it does bring it back to you that this was a person with a life and not just a commodity to be used to teach with [...]

(Jane and Alice, unit 9)

Accepting such items had an effect on the AUS as this brought back the personhood to the cadaver; they must objectify the person back to cadaver in order to continue in their role in dealing with the storage and use of the bodies (Prentice, 2013). The AUS “tactically objectify” the body as a coping mechanism in order to deal with the body's ontological duality where they “objectify the body or call forth the person as needed.” (Prentice, 2013: 35). This also prompted them to perform *EM*, akin to philanthropic *EM* (Bolton, 2000), as they chose to complete such work for the families. This had a negative effect on the AUS. It could be appreciated from this that the situation in which the donated body was being discussed was contextual. It created different and opposing responses from AUS; sometimes rational and emotional selves emerged in the same sentence.

Written biographies were among the items the AUS received and they recognised the value of these. One unit encouraged families to write a biography for the students which they said was beneficial for the students, staff and families. Similarly, Lynne (unit four) highlighted that writing a biography was “therapeutic” for one donor’s daughter.

She said, “can I write a biography, so you can give it to the students” and I was thinking “yeah of course you can” [...]. She phoned the next week saying that she'd sent it and almost with a sigh of relief saying, “that was really therapeutic” [...].

(Lynne, unit 4)

Neimeyer (2007: 203) argued that “[n]arrative methods can play a role in restoring or re-storying a sense of autobiographical coherence that has been disrupted by loss.” The AUS were the recipients of these narrative methods as they were the deathworkers facilitating the process.

Sending in items and letters could be compared to the similar practices seen when mourners adorned the graves of their loved ones, where lack of visitation was symbolic of the deceased being forgotten (Davies, 2002). Adorning the grave was a way of *continuing bonds* (Klass, Silverman and Nickman, 1996) alongside memorialising (Mathijssen, 2017a) and caring for the deceased. Gibson (2004) argued that objects signified the presence of the deceased and mediated the attachment to material legacy. Thus, the connection to the place, continued contacts and sending in items and letters may have been ways of building memory. It was found, in a survey by Davies et al. (1990), that fifty-eight per cent of respondents found that physical objects and situations evoked memories of their loved one. I suggest that the AU replaced the grave in BD, as this was the place that the families felt closest to their loved one’s physical remains.

In this section I clarified that some of these families' continued contacts and sending in items was a way of *continuing bonds* (Klass, Silverman and Nickman, 1996) and *meaning making* (Neimeyer, 1999, 2001). AUS facilitated this out of a reciprocation of the gift of BD (similar to Bolt's (2012) study), out of a duty of care and by way of making up for the disruption to the normal post death process caused by BD. However, for some AUS this work in facilitating *continuing bonds* contradicted their traditional belief that closure was an end goal achieved through breaking bonds, as apparent in Katie's comment in the previous subsection. In section 5.7 I examine this further. Maintaining this theme of *continuing bonds* and *meaning making*, the next section discusses the special requests made by the families of donors and the extra work this caused for AUS.

5.3 SPECIAL REQUESTS

The second cause of hidden extra work by the families of donors was the special requests that families made after acceptance. Special requests were those that fell outside of what typically happened within the BD process, for example, if changes were made to the basic funeral plan offered by the AU. At the majority of AUs this included a basic coffin, transport to the crematorium/natural burial ground, a small chapel service and a polyurn for the cremated ashes. This was the norm, although at some AUs a floral tribute was offered too. The ashes were then collected, couriered or scattered at a university owned plot, or at a local crematorium/natural burial ground. This was free of charge.

I argue that the free funeral provided by the AU was a way of reciprocating the gift of BD; a reciprocation rather than a gift as Bolt (2012) proposed. This is in line with Titmuss (1971: 88) who would describe the free funeral as a "fringe benefit", thus disputing its nature as a true altruistic gift. Families did not know that they could make

special requests as this was not promoted by the AUS. Thus, these enquiries were made on an *ad-hoc* basis without the family knowing what the outcome could be. The AUS responded to these on an *ad-hoc* basis too, suggesting that there was a personal, emotional, moral or practical reason for making changes to the 'normal' BD process for certain families. These special requests typically happened during the disposal stage (stage four) and ashes stage (stage five), as these were the points at which families were invited to be involved in the BD process. In this section I will explore the special requests made during these two stages in turn. First, I examine those made at the disposal stage.

5.3.1 Special Requests during the Disposal Stage (Stage 4)

As previously described some families made amendments to the simple funeral plan offered; this caused extra work for the AUS. Charlotte highlighted one such case.

They can take what they want, if they want flowers, if they want a minister, you know, they can have a minister, but we would probably ask them to pay for that. [...] [One family] wanted a limousine, and it kind of became a proper funeral and he did say he was willing to contribute [...] I'm not too concerned about agreeing to it you know, I think it's the least we can do [...]

(Charlotte, unit 11)

I argue that these were ways of personalising the simple AU funeral package. In this, I assert, families were *continuing bonds* with the deceased (Klass, Silverman and Nickman, 1996) through a continued connection and continued care of their loved one. I also interpret these as opportunities for *meaning making* (Neimeyer, 1999, 2001) as families often used the committal service to comprehend their loved one's donation.

Furthermore, I assert that this may be a way of displaying family. Drawing upon Finch (2007), Bailey (2012: 85-6) established that “displaying family is: the process of individuals and groups indicating ‘family’ to others.” Drawing from this I argue that, in making special requests, families were not only *continuing bonds* and *meaning making* for themselves, they were displaying family to others; especially their BD family narrative. James and Curtis (2010: 1177) supported the need to display a “normal” and “proper” family. This was key “to convey[ing] the message ‘this is my family and it works’” (Finch, 2007: 70). In the case above, Charlotte proclaimed that from these special requests the funeral became like a “proper” funeral, suggesting that the funeral provided by the AU was not what the donor would have had if they had not donated. This inferred that the body donor funeral is *other* and without the kudos of a *Proper* funeral, as increasing the expense and personalisation of the funeral in turn amplified the perceived social importance of the deceased (Laqueur, 2015). In facilitating a proper funeral for those families that requested it, the AUS were making extra efforts to reciprocate the gift of BD in addition to the reciprocation of providing a simple AU funeral.

While families were often asked to cover the financial cost of these special requests, the extra work in facilitating these was given voluntarily by AUS as a reciprocation to the families and donors. AUS said they were happy to accommodate these requests as they wanted to make the process as positive for the families as possible and, as Charlotte declared above, they believed “it’s the least [they could] do”. However, these special requests were infrequent, so accommodating them was easier; it was only the financial element that could not be practically accommodated within the AU budget and families were asked to cover such costs.

Families or members of religious communities also made special requests. For example, Lynne described a request to add items such

as ghee and rice to the coffin for a Hindu donor. Similarly, Nikki demonstrated:

If somebody has said they have a particular religious affiliation then we will make sure we get a pastor, or a minister, or a priest, or whatever fits that religious affiliation.

(Nikki, unit 13)

The AUS felt a duty to comply with the religious requirements of the donor out of respect for the donor and their family. This non-discriminatory, flexible approach to disposal plans, where AUS allowed for alterations, did, however, require extra work in facilitating these changes. This extra work included liaising with families regarding changes to funerary items, music, casket and religious celebrant. The AUS would communicate with funeral directors and crematoriums to make sure these changes were possible, and report back to the families with the good or bad news. The AUS went 'over and above' to facilitate these wishes where possible. However, it was often the case that the families or religious organisations arranged and funded a private funeral for religious donors as some realised the funerals they required could not be facilitated by the AU, in which case the workload was delegated away from the AUS. In these circumstances, where extensive alterations were made, the AUS could have suggested that a private funeral took place. However, the AUS felt that it should be the families who decided to have a private funeral.

However, unit nine used a management strategy of not offering or allowing for changes to be made by the family which was beneficial for the AUS in reducing their workload at the disposal stage.

They don't have a choice in that, we pay for the cremation and we arrange it all so the first they see is when the coffin is brought out of the hearse at the crematorium [...]

(Alice, unit 9)

This contrasted to units eleven and thirteen quoted above and demonstrated the diversity in management strategies across AUs. At those AUs that did not allow changes, the family accepted this and appreciated that if any alterations were to be made then a private funeral, funded by the family/donor's estate would be the alternative option. It may have been that AUS at other AUs were giving the families too much choice and therefore allowing for extra work to be created by the family exerting their control over the disposal and ashes plans. Benefits however came from allowing the family to be involved; for example, the family members who had a positive experience may go on to donate their own bodies. This positive experience may be because of the ability to make meaning of the donation (Neimeyer, 1999, 2001) and display their family (Finch, 2007). Next, I focus on special requests during the ashes stage.

5.3.2 Special Requests during the Ashes Stage (Stage 5)

The majority of AUs offered a polyurn for the cremated ashes. The ashes were then collected, couriered or scattered at a university owned plot, or at a local crematorium/natural burial ground. This was the norm. However special requests, which disrupted this norm, were also evident during the ashes stage. I theorise that this was a way that the family displayed their continuing care for the donor. Such requests were infrequent but caused AUS extra work in facilitating them. In the case below extra work would involve gaining permission from the university and scattering the ashes themselves. This involved administrative work, physical work and extra time.

[W]e've had a few requests where the donor has been a graduate of the university [...] [and] the next-of-kin has come back to say that the donor wished for the ashes to be scattered within the university grounds. [...] We do try and facilitate that, but we do have to get permission [...]

(Bob, unit 7)

It was clear in this subsection that in making special requests the families were making the post-death arrangements personalised as a way of *continuing bonds* (Klass, Silverman and Nickman, 1996), *meaning making* (Neimeyer, 1999, 2001) and displaying family (Finch, 2007). Some AUS facilitated these wishes as an extension to the reciprocation of the gift of BD for those families that requested it, similar to what Bolt (2012) found. However, during the disposal stage some AUs employed a management strategy where they did not allow changes to be made to the funeral and the families accepted this, with those who wished to follow through on these changes arranging a private funeral at their own cost. But some AUS wanted to go 'over and above' as Charlotte (unit eleven) maintained "it's the least [they could] do." This was regardless of the management strategies they had in place, as unit eleven was the AU that relied most on management strategies. These were strategies developed and used by the AUS to manage and cope with their work. Next, I discuss the impact that changing minds had on AUS work.

5.4 CHANGING MINDS

There were also issues due to families changing their mind about the post-death contact options. Post-death contact options offered to families were contact by the AUS at the disposal, ashes and/or thanksgiving stage, where any combination of these options could be chosen. Alternatively, no further contact after acceptance could be chosen; the AUS assumed there would be no interaction with these families. However, no further contact does not always equal no further

work for the AUS as families could re-initiate contact. Within the document analysis these options were evident at all AUs; however, there were differences in when these decisions regarding contact were made. For some AUs this decision was made before death by the donor only. At other AUs the next-of-kin was able to make the decision on death regardless of what the donor selected prior to death; thus the donor lost their right to decide their post-death options in such cases. I assert that this may be because the funeral was for the living not the dead (Davies, 2002). This was complicated when potential donors did not discuss their wishes with their families as previously discussed in chapter four, especially for those AUs that went by the donor's pre-death wishes. These differences thus caused a plethora of things to happen across AUs. This was dependent on the families and could not be predicted. Consequently, there was not a direct causal relationship where confirming post-death options with the family led to more disruption. However, AUS remarked that allowing the family to confirm the donor's choices was beneficial in limiting the disruption caused by a subsequent change of mind after acceptance, as the families were thus aware of the options the donor had chosen.

I use an excerpt from an interview with Lynne below as an example of the practicalities involved in managing a situation where the family changed their mind about being informed of the post-death process. In this case the family originally chose no further contact but called the AU after the ashes had been scattered and Lynne was worried that the AUS had made a mistake. However, it was the case that the family had changed their mind to be informed after the ashes had been scattered. Lynne was then left to tell the family the bad news that they had rung too late.

[...] it's the gut-wrenching moment when you're going through the file thinking oh no, they weren't informed, and what's happened to the ashes. [...] not attending's one thing, but it's the ashes, that's the thing you think "oh flipping heck" and then

it's, turn it over and [gasps, outlets breath and puts hand to forehead]. So, I've got the relief, but I've then still got to speak to the family.

(Lynne, unit 4)

Lynne highlighted that these issues were due to the time frame of the BD process, which limited the time in which options could be altered. For example, if the call from relatives was received before disposal and cremation AUS were able to adjust post-death options for the family. However, if the call was made after the disposal and ashes stages it was too late and the family's wishes could not be facilitated. The latter scenario resulted in extra work for the AUS in managing negative family reactions. AUS at unit four alleviated this negative situation by offering a photo of the place where the ashes were scattered. I interpret this as the AUS being empathetic to the upset caused for the family. Again, I posit that these subsequent actions were given optionally by the AUS philanthropically (Bolton, 2000).

Some AUS suggested that families "tick everything". This reduced the upset for the families and thus the amount of extra work that AUS had to do at this stage.

Quite often, I suppose if they are unsure at the time, I always say just tick everything, just say you want the ashes back, you want to come to the memorial service [...]

(Charlotte, unit 11)

By pre-empting these changes that families often made, Charlotte was able to decrease the amount of work she had to do at the later stages in the process, although it was difficult for the AUS to intervene in this personal choice at a particularly emotive time for the family. However, I discuss in subsection 5.6.1 how contacting the family when they wished for no further contact caused extra issues. Next, I explore the AUS's role in mediating issues.

5.5 MEDIATING ISSUES

The final cause of hidden extra work by families of donors was by issues that arose after acceptance, such as family feuds and disputes, fraudulent activity, and altering information to ensure acceptance. Mediation was a way of “dealing with the highly emotional demands of [...] a sensitive subject” while permitting the “disputants to come together to find their own solution to the problem” (Josias, 2004: 1178). Extra work was created for the AUS, as they were used by the families as mediators to resolve family disputes after the body had been donated. Mediation was an *ad-hoc* approach taken by AUS in response to certain issues. Conway’s (2016) work, commenting on judicial dealings with family disputes over what happened to the dead, could be transferred to the BD context. For instance, Conway (2016) speculated that “there is scope for more widespread use of alternative dispute resolution (‘ADR’) techniques – especially mediation” (*ibid.*: 122). Mediation offered “more innovative and individualistic solutions” (*ibid.*: 122); this is evident in this subsection, where AUS responded to individual situations in a personalised way. Conway (2016: 90) remarked that “[w]here families are already divided and prone to conflict, death can resurrect old grievances.” The AUS were thus faced with issues that were amplified by the death of the body donor.

Some AUS, such as Charlotte (BS and MM at unit eleven), however, followed the premise that “[...] it’s nothing to do with us, you know, it’s not for us to pick a side and say who gets what”, thus aiming to reduce the mediation work she did. This acted as a management strategy, like the ones used to manage changes to funerals. However, Tom indicated:

It's the dispute ones that are the hard ones [...] because a lot of it is dealt with on the phone, you don't quite know who you're dealing with. [...] they do try and drag you into it. They try and get you to take sides, which you kinda do.

(Tom, unit 2)

Tom and Charlotte raised the issue of taking sides and being objective mediators. This was especially difficult as such work was completed via telephone which meant that *EM* needed to be completed solely through vocal cues which Jaarsveld and Poster (2013: 154) argued presented “unique challenges for performing emotional labour.” The dislike of family disputes that Tom described was also true for court judges. Conway (2016) elucidated that this was because the family were unlikely to reach a middle ground.

The AUS that relatives used as mediators emphasised the influence that families had on the AUS's work. Some AUS chose to do this work even though it was not explicitly outlined in their job descriptions. However, they did this to ensure the smooth running of the process for the families, thus fulfilling their duty in body procurement; this was similar to the work carried out by organ donation staff as described by Sharp (2006). Again, I theorise the reason for doing this work through the lens of Bolt (2012), as AUS felt a duty of care to reciprocate the gift of BD. By mediating these issues, AUS were giving back to the families for the disruption caused by BD and giving thanks for the gift. Mediating issues also involved philanthropic *EM* (Bolton, 2000). Most of this work was required of AUS during the storage and use stage (stage three) and the ashes stage (stage five). First, I discuss mediation work at the storage and use stage.

5.5.1 Mediating Issues during the Storage and Use Stage (Stage 3)

It was rare for AUS to return a body after acceptance; however, there were some legal cases where this decision had been made. These decisions were made on a strategic case-by-case basis where legal issues, such as fraudulent activity, were regarded as instances in which the body should undoubtedly be returned. However, in other situations that were ambiguous, AUS made the decision based on a subjective practical, moral or emotional basis.

At the very beginning of the storage and use stage AUS faced problems due to the family or executor altering details on the consent form to ensure the potential donor was accepted. These cases caused practical difficulties for AUS which they mediated. One example, where a donor was over the fifteen stone weight limit, was explained by Tom. This was an issue because the weight of a body increases significantly after preservation because of the embalming fluids.

I was assured that this guy was under 15 stone, and he come through and my god he was about 24 stone, and you're like well we've accepted him, we paid to get him here, so what do you do? And the family obviously don't want to know now. They've got rid of him; they're not having to pay for a funeral [...] you just have to do your best with what happens [...]

(Tom, unit 2)

In these situations, the AUS had to rely on the family giving the correct information. However, when this trust was broken AUS were put in the position where they must decide whether to keep the body, even though they were within their rights to return the body. In this case the AUS made a practical decision to keep the body; they had paid for the transportation and it was assumed that the family would not cooperate in the body's return. Here the practical decision overruled the legal

decision and there were moral undertones to this. Tom assumed the incentive of the deception to be financial; avoiding funeral costs. The AUS had accepted the gift, but the donor and family side of the gift relationship was intentionally sabotaged. This caused an imbalance and the AU was left short, evoking negative feelings in the service the AUS provided. On interacting with the family though the AUS had to manage their negative emotions.

Following on from altering details on or before the acceptance of the body, another similar situation that the AUS at unit two had to deal with was when a body had to be returned to the family because of the family's fraudulent activity. In this case a family member admitted to forging the donor's signature on the consent form in order to ensure acceptance. The body was returned to the family and the cost of embalming and transportation was billed to the family/donor's estate. This I argue was where the gift relationship between AUS and families ended; it was clear that AUS did not feel they owed anything to the family due to their fraudulent activity. The AUS decided to log this issue with the HTA as the family were threatening to involve the police. The AUS were abiding by their legal rights; however, they felt threatened, so they needed to ensure the HTA were aware. This again was a case where the family had deceived the AUS, and AUS had a management strategy in place to deal with the situation. This was a case where the legal decision overruled the moral, emotional and practical. When this legal case was compared to the previous practical case, it was the ambiguity that allowed for moral, emotional and practical considerations, whereas in legal cases the outcome was clear. There was a power imbalance; in legal cases AUS had the power over the family.

I now move on to consider situations where morality and emotions affected the outcome of the mediated situation. Tom commented that

AUS must be careful not to reveal information when families manipulated AUS into being mediators in family feuds.

And half the time there's a feud and they won't talk to each other; they expect to get the information off us. [...] It makes it really, really difficult for us.

(Tom, unit 2)

Lynne, the BS at unit four, explained one instance where a nephew of a current donor contacted the AU in a bid to find out where his cousin lived. However, the AUS could not disclose this information due to data protection. However, the nephew found out himself where his cousin lived through attaining a copy of the death certificate from the local registry office as these were public information in the UK. Therefore, even confirming the donor was deceased led to the nephew ascertaining the information.

Lynne also performed extra work in mediating the following situation due to her morality and emotions. A family feud resulted in one family member having the sole decision over the post-donation options in which they indicated no further contact. However, Lynne gave the second family member the option to complete the post-death options form to establish whether they differed from the next-of-kin's decisions. If they had differed, which they did not, Lynne would have mediated the situation. This was a moral and emotional decision over a legal or practical one. Drawing upon Lewis (2005: 565) I argue that AUS made choices akin to those decisions nurses made "when a nurse chooses to perform one form of emotion management over another (e.g. prescriptive over philanthropic)." In allowing the second family member to complete the forms, Lynne permitted them to be involved in the BD process, and thus lessen the family feud situation. This created a feeling that the family was continuing to care for the donor, similar to that discussed in section 5.3 where families made special requests.

AUS did this because they believed it was the right thing to do; they made assumptions about the influence on the family's wellbeing of being involved in the post-donation decisions.

Some families were aware of the possible difficult family situations that may arise and pre-empted these. One example was explained by Charlotte.

[...] we had this once where a lady said if anyone rings up I don't want you to give any information out whatsoever about my mother, I don't even want you to confirm that she is there, she actually put a password on her mother's file [...]

(Charlotte, unit 11)

This reduced the extra work AUS would have to do in these situations as AUS could give a definitive answer, as the decision was already made by the next-of-kin. Thus, the AUS did not have to make a moral decision around disclosing information. Next, I deliberate mediation work during the ashes stage.

5.5.2 Mediating Issues during the Ashes Stage (Stage 5)

The main issue that arose during the ashes stage was the control over what happened to the ashes by the next-of-kin, who had sole legal rights over such decisions in the BD context. This was different to the norm where there might be joint next-of-kin, for example two siblings of a deceased parent. Thus, I argue that who was named as the next-of-kin was something that potential donors should be aware of before death as this individual made the final decision on post-death options. Charlotte stressed:

[...] we will only give ashes back to the person that we originally dealt with, and that can cause problems. [...] if somebody else wants the ashes we have to get written permission from the original person. [...] that's our policy. That's who we deal with.

(Charlotte, unit 11)

This was a legal and practical management choice. Conway's (2016: 122) premise that mediation was a way of resolving family disputes can be adopted and applied in the BD context as it "[...] would shift the emphasis from a hierarchical to a consensus-based resolution, allowing the parties to negotiate a mutually acceptable outcome instead of being presented with a court ruling based on a mechanistic ordering of entitlement." But this was hard in the BD context as other family members had to agree or have a good relationship with the next-of-kin as the final decision rested with them. However, it is demonstrated in this section that when a consensus-based resolution was applied to the BD context with the AUS as mediators, it had positive results, such as the splitting of ashes. However, when AUS mediation failed, the mechanistic ordering of entitlement – where the next-of-kin had the final decision – prevailed.

The issues around AUS mediation concerning ashes arose when there was a family feud, when the family were no longer in contact, or when the family did not agree with the next-of-kin's decision. Conway (2016: 98) asserted that "[p]ost-cremation ashes can be divided to allow feuding relatives to inter, scatter or keep their portion as they see fit, and while a court can sanction such an agreement it cannot force a split if one person objects." The same rules applied in the BD context where family may agree in principle yet fail to follow through on the agreed splitting of ashes. However, the personalised mediation service that AUS provided helped towards ensuring that the promise of splitting ashes was followed through, as evident in the positive cases below. The first positive case was exemplified by Lynne where the AUS were able to mediate a resolution to the issue.

[...] that really got a bit sticky. That was another ashes problem. We were able to sort that. Half's going to Australia and half's staying here.

(Lynne, unit 4)

Lynne described a second positive case where the daughter of a current donor wished to know details of her mother's post-donation plans. However, her father was the next-of-kin and they were not on good terms. The AUS had to make the decision whether to disclose some information while adhering to data protection regulations – in this case Lynne did. AUS had agency in making these moral decisions where it was legally unclear; this could be problematic for the AUS. The personal moral decision here overwhelmed the legal/data protection position. In this situation the AUS liaised and mediated between the daughter and the father and successfully aided the father to first agree to split the ashes, then to allow the daughter to have all the ashes. Lynne justified:

It's going home at night and thinking have I done the best by my family without breaching any (pause) confidence or regulation, and knowing that the family can sit comfortably [...]

(Lynne, unit 4)

This was a personal decision that the AUS made in light of the information they had. Lynne defended her decision and reflected on her feelings about this decision. This again demonstrated that AUS were giving *EM* philanthropically (Bolton, 2000) in mediating the situation; they believed they owed it to the family and did what they believed was right. Even Conway (2016: 99), commenting on funeral disputes, posits that “[a]t a human level, judicial attitudes towards families fighting over their dead have ranged from expressive empathy to feelings of discomfort and embarrassment”, hence demonstrating the impact of emotions even in legal settings.

In these positive cases, the AUS successfully mediated the splitting of the ashes. Conway (2016: 98) asserted that “[f]amilies will invariably dredge up past histories, as the emotional ante of the conflict is upped significantly by the raw, consuming emotions of death. In these circumstances, a quick, pragmatic solution operates as a vital form of damage limitation.” In BD, it was the AUS as mediators that made these practical decisions within the highly emotional backdrop.

However, mediating issues at the ashes stage did not always work out well. Tom (unit two) explained a difficult case where a brother, who was no longer in contact with his sister, was preventing the sister from being involved in the post-death options for their mother. This issue came to fruition at the ashes stage and AUS became involved through the sister. Tom tried to mediate this situation at this stage, however this did not turn out positively. In this example the sister “threatened to kill herself” (Katie, unit two) as the brother would not allow her to be involved in the ashes arrangements or allow her to attend the cremation, even after the AUS’s mediation. Tom and Katie not only had to mediate the situation during, but after too, as the sister continued contact after the ashes had been collected. This posed difficulties in AUS closing the relationship with these families. Thus there was continued contacts in some situations that were not positively mediated. This supported the view that successful early mediation was a practical approach (Conway, 2016) which limited further extra work later in the BD process.

This family mediation process made clear that the AUS needed extra support, a clear procedure to follow, and to know to whom to refer individuals, for example counsellors, when such situations occurred. There was also a similar case at unit seven where a prospective donor informed an AUS member that she was suicidal. Lynne (unit four) also described “talking them off the ledge”. In these cases, the AUS were

pushed beyond their remit and were forced to deal with situations for which they were not trained.

Charlotte said that she tried to stay out of family issues and feuds. However, in the negative example below, it was evident that Charlotte did eventually attempt to mediate by phoning the brother regarding a letter received from the sister. However, when this mediation attempt was not successful, she reverted back to the original management strategy.

We rang him up and said we got this letter from your sister who wants the ashes, and he just said, “no she is not having them”, and “I’m not speaking to her” so (laughs). We just had to write back to her and say, you know, “we can’t be involved in communication between you two. We have to go with what he said. You’ll have to resolve it between yourselves.”

(Charlotte, unit 11)

In this instance Charlotte, who usually employed a management strategy to navigate situations, allowed her personal discretion to influence her work. The AUS were using “personal discretion in how they negotiate[d]” such cases (Bolton, 2000: 581). This mediation was a practical attempt to reduce the continued contacts from the sister.

I have made clear in this subsection that some family issues caused extra work for the AUS at different stages throughout the process. The family thus had an influence on the AUS’s work, except when the AUS had legal grounds to dispute the issue. It was clear that the gift relationship did not extend to legal issues, only those which were ambiguous and AUS had a subjective decision in mediating them. There was an evident difference between legal, practical, moral and emotional decisions. However, it was clear that some AUS, such as Charlotte, preferred to stay out of the situation and allow the family to resolve their issues. Yet even Charlotte mediated a situation, after a

failed attempt to employ her management strategy. In this case the initial management technique was overruled by a practical and moral decision to mediate. Next, I assess those situations where AUS caused extra work.

5.6 STAFF CAUSING EXTRA WORK

Extra work also arose from circumstances not caused by the family's continued contacts, special requests or issues, but by the staff themselves creating extra work. This came in two forms: unintentional and intentional. Unintentional reasons, caused by mistakes, practical and logistical reasons, were understandable. These were caused by both internal staff (AUS) and external staff (non-AUS, such as funeral directors). Yet it was less clear why AUS intentionally caused extra work. Again, I theorise that this was indirectly caused by a duty of care towards the donor and their family and a reciprocation of the gift of BD; similar to that which Bolt (2012) found in her study of anatomists giving monuments as a gift. There were several examples, outlined below, where the AUS went 'over and above' what was expected of them. This was detrimental as it caused extra work throughout the process and after the natural close of the process, but reaped positive outcomes, such as building rapport and making the BD process positive for the families of donors. In doing this the AUS also countered their efforts to limit interaction and encourage closure, described in the next section, by re-initiating contact in some cases. First, unintentional causes are examined.

5.6.1 Unintentional Causes of Extra Work by Internal and External Staff

In some cases, like the case described below by Lynne, the AUS (internal staff) caused extra work by using the donor quicker than the family expected.

They have ticked the box to say they want their own funeral [...] They're upset that he's been finished with too soon. They said, "we were expecting it next summer."

(Lynne, unit 4)

In this case the family refused to collect the body for the private funeral. This had practical implications for the AU as space in the cold store was taken up. Cases such as this required continued liaison, much like those cases where families did not collect ashes.

Contacting the family to inform them that the body was ready for disposal was a contentious action which caused family upset and extra work for the AUS in some cases. This upset was stimulated by AUS contact, which AUS interpreted was because it re-opened their grief.

There have been quite a few where we've made contact with family after we're done with the body, at the time of disposal, and they've probably just said, "well we don't want to know anything about it."

(Anthony, unit 2)

The family had the option of no further contact; however, for those that did not make this decision at the time of death but changed their mind later in the process without informing the AUS, this was a negative experience. This demonstrated that if AUS encouraged families to tick every box to avoid upset, as discussed previously, this too could have

negative outcomes if the family forgot to inform the AU of their change of mind.

Many issues around no further contact were caused when it was the donor that decided the family must not be contacted when they completed the forms before death, as previously discussed in sections 5.4 and 5.5. To counter this unit two sent a letter to the family at the point of donation to check that their wishes were in line with the donors.

[...] to be fair when we receive the body in the first place, I always send a letter and I put what it's said about the ashes on the consent form, so they could challenge it at the time [...]. That gives them the option, if it says to scatter and they say, "oh we want them back" and then we'll go along with their wishes [...]

(Katie, unit 2)

Sending a letter was a management strategy used by the AUS to counter potential extra work caused by family wishes if they differed from the deceased's wishes. This action demonstrated that the AUS were aware that the donor may not have discussed their post-death decisions with their family, as was outlined in chapter four. Katie stressed:

What the person consenting puts and what the family thinks are often two different things and that's where all the problems lie [...] we always say discuss it with your family, but it doesn't make a difference.

(Katie, unit 2)

However, this meant that it was the family who made the final decision regardless of whether this was in line with or in contradiction to their loved one's decision. There was an issue, however, in the timing of this letter to the families, as it was unlikely that the family knew how

they would feel about the same decision up to three years later due to their state of grief around the time of death.

However, even for those families who chose to have further contact at the time of donation, receiving the letter informing them of the disposal could be upsetting.

[...] we'd sent her a letter, even though on the letter it says, you know, you're not obliged to come but were doing it out of sort of a requirement to inform you and she felt that she needed to go and it upset her and she told us [...]

(Tom, unit 2)

Katie: Occasionally we have people say "oh you've brought it all back" when we've sent the letter of cremation, but that's the risk, you know, that you have to take. You're following instructions of the person and sometimes people aren't happy about it.

Tom: [...] we're just doing what we need to do and what we feel is the right thing to do. Like we also ask now "do you want any further contact?" [...]

(Katie and Tom, unit 2)

Here the AUS caused extra work for themselves in completing a routine task, which in other cases would not have caused extra work. The AUS subsequently employed a management strategy where the option was re-iterated verbally to families as well as in the letter on receipt of the donation.

The documentation that AUs sent to donors and their families was also influential in the families' comprehension of their ability to contact the AUs after the donation process should have ended. In some cases, the wording in information documents sent to potential donors and their families, such as "feel free to contact the anatomy unit if you have any questions", invited contact and thus caused extra work. This

countered their efforts to encourage the closing of the relationship which I discuss in section 5.7. This was illustrative of the contact with AUS throughout the process as families felt the AUS were there to speak to and answer any questions, and as AUS said they were “happy to listen”, or they “would never rush anyone off the phone”. This again, I assert, was because AUS felt a duty of care towards the families and a need to reciprocate the gift of BD (Bolt, 2012) and make up for the disruption the donation had caused.

There was an example at unit four where the funeral directors (external staff – non-AUS) had made mistakes and called families that wished for no further contact.

[...] we don't do the contacting, our funeral directors do, and recently they've made two mistakes [...] the funeral directors have contacted them and then the families have phoned us and said, “What the heck is going on, we asked you not to, and now you're telling us, and it's really upset my Mum”, [...] it is an error and we are the first to say, “I'm sorry we've mucked up and we are so sorry for the upset that it's caused, thank you for drawing it to our attention, and we are horrified [...]” We write to our funeral directors and say, “How could this have happened, they have ticked no.”

(Lynne, unit 4)

Thus, in delegating the FL around the funeral and ashes arrangements to the funeral directors, a task which usually reduced the work for AUS, extra work was created due to the funeral director's errors. It was the AUS who were left to amend the funeral director's mistakes in these cases. This upset for the families caused could be explained drawing upon traditional stage theories of grief (Bowlby and Parkes, 1970; Kübler-Ross, 2009; Worden, 2009) as contact may have disrupted their dealing with their bereavement by bringing it back up when the family may have gained closure or families may have been *continuing bonds* elsewhere. This was evident for those families who had a service at the time of death and did not attend the services provided

by the university for this reason. Next, I focus on those intentional causes.

5.6.2 Intentional Causes of Extra Work by Internal Staff

Those unintentional causes of extra work were understandable. However, there must have been something else at play regarding those intentional actions/decisions that caused extra work. In previous sections I asserted that AUS responded to these issues caused by families out of a duty of care, a reciprocation of the gift of donation (Bolt, 2012), and to make up for the disruption caused by BD. I argue that this may explain those intentional causes of extra work too. The mixing of the AUS's personal, moral and emotional views with their work can be compared to Goffman's (1961: 152) ideas around the division of "the individual into a profane and sacred part." Goffman (*ibid.*) maintained: "The profane part is attributed to the obligatory work of social roles; it is formal, stiff, and dead; it is enacted by society. The sacred part has to do with 'personal' matters and 'personal' relationships – with what an individual is 'really' like underneath it all when he relaxes [...] one shifts it from the sacred category to the profane [...]." I reason that this shift was what made AUS act in personalised ways in a professional context. Drawing upon Goffman, Bolton (2001: 89) ascertained that "at all times an element of self is present." This element of self I argue caused AUS to go 'over and above' and cause themselves extra work. These subjective, emotional, and moral decisions often overruled practical reasoning which caused extra work. AUS spoke warmly of "their families" (Lynne, unit four) and felt they needed to do as much as they could for them.

However, even though philanthropic *EM*, such as compassion and empathy, were given authentically (Bolton, 2005) by the AUS, Brook

(2009: 539) argued that “employers understand that the final service product, whether planned, enhanced or sabotaged, is their ‘property’; a view shared by recipients, as those unhappy with their service experience will invariably seek redress from managers rather than the front-line culprits.” Thus, in this light all AUS work, regardless of its origin, were commodified service acts because they were exchanged for a wage; this was in line with Hochschild’s (1983) original premise. Therefore, I argue that the *EM AU* performed was a result of professionalism.

The examples of AUS intentionally causing extra work through this duty of care/reciprocation and element of self emergent from the data included: making sure donors have a *Proper* funeral (Laqueur, 2015); AUS attending cremations; AUS delivering ashes; combining cremations (where two or more donors were cremated close together so the ashes could be collected at the same time); AUS building relationships (and rapport) with families; sharing information with families; catering to specific family needs; contacting families around the services of thanksgiving; and AUS always being available. I focus on two key examples of these intentional causes of extra work that happened at the disposal (stage four) and ashes (stage five) stages in this subsection. First, AUS attending cremations will be discussed.

5.6.2.1 AUS Attending Cremations

Some AUS attended some cremations as they felt it was the right thing to do; this was an emotional and moral decision. This attendance was extra work that the AUS were not expected to do. Lynne and Natalie (unit four) did not usually attend cremations; however, they attended one cremation that they were invited to by one family with whom they had built a relationship through telephone conversations and email contact. This was also due to a professional need to see a cremation.

[...] I've only ever been to one cremation. Natalie and I said that we needed to go to one, we decided to go to that one because we'd had long conversations and I felt like we'd really got to know the family, and I hadn't told them we were attending just in case anything had happened in the office and I didn't want them to feel like we'd let them down.

(Lynne, unit 4)

Lynne felt that she would have let the family down by not attending if she had said she was going to. However, it was not their duty to attend. In this example, interim contact with a particular family led to extra interaction later in the BD process as they had built a relationship and emotional attachment. Likewise, Sheila and a colleague attended a funeral at unit seventeen because of the relationship they had built with the family. As with unit four, AUS at unit seventeen did not usually attend funerals. Sheila commented that it was the emotion of attending that made it difficult for her to attend.

[...] I'd rung him about the funeral date and made sure everything was ok and I said "[my colleague] and I will be thinking about you on Monday", and he said, "will you not be there?", and I said, "oh we don't normally attend, would you like us to attend?", and he said, "I'd be honoured if you attended." (Gasps), and that's the only funeral we ever attended [...] It were too emotional though I couldn't do it regularly (laughs).

(Sheila, unit 17)

I argue that Sheila's attendance and putting her own emotions to one side acted as a "tribute" to the family (Hochschild, 1979: 257). The AUS at unit two also did not attend committal services; however, they attended one to oversee and be better informed of the process (as did unit four). AUS at unit two said they were careful not to be seen by the family as it was the family's service and it was the family's decision whether they wanted AUS to attend; the AUS assumed their presence would be an intrusion. However, if invited, the AUS felt obligated at other AUs. The AUS's covert attendance was due to them taking pride

in making sure the process was run to a high standard. Families evidently influenced AUS behaviour in these cases.

The AUS at unit eleven also did not attend cremations and Charlotte remarked that this would be desirable; however, due to the size of the AU, and thus the number of cremations they completed, it would not be feasible for the AUS (and in this case the families) to attend.

I suppose some of the smaller medical schools will have attended funerals, where families and staff will go to them. I think that's a really good idea, and I think that that would be lovely, but it's just not practical for us.

(Charlotte, unit 11)

This extra work was demanding of the AUS's time and Charlotte did not deem this to be necessary, again employing a management strategy to reduce workload. The extra work involved also meant that AUS could not attend private thanksgiving services at the time of death that they were invited to by the families.

His son told us he was having a service of thanksgiving for Dad, we couldn't make it, we had too much going on in here, we can't just leave it [...]

(Lynne, unit 4)

Building relationships thus caused extra demands which could not be fulfilled; it may be best practice not to continue relationships to avoid extra work later in the process. However, as previously discussed, building relationships was key in making the process positive for these families. These examples contrast to practice at unit nine and unit three where AUS chose to attend all funerals, which was demanding of their time and was extra work that was not necessary. These AUS felt a duty of care to attend, even when families did not attend, thus

creating a theatre of presence (Laqueur, 2015). This again was a moral and emotional decision. Next, I explore AUS delivering ashes.

5.6.2.2 AUS Delivering Ashes

Some AUS, such as Charlotte and Tom, have personally delivered ashes to families' houses. Again, this was a subjective emotional decision, which they justified as a practical decision, to help those that could not come to the AU or those that lived close to the AUS. This, however, overruled the practical option to courier the ashes. This further demonstrated how the relationships developed with some families could lead to extra work later in the BD process. These relationships could affect the amount and type of work that AUS did, as these AUS went above their remit to fulfil these tasks. Even Charlotte, who usually used a management strategy to inform her FL work, went 'over and above' because she enjoyed this part of her work and had made a particular connection to one individual.

One lady whose husband came to us, she struggled with it quite a bit and I spoke to her quite regularly, and then when he was cremated and his ashes came back to us, she lives in [local area] which is where I live [...] so I took them back to her and that was nice, so I got to meet her and she showed me some pictures of him and we had a little natter [...] It is nice, I like dealing with the relatives, I do enjoy that side of it.

(Charlotte, unit 11)

Similarly, Tom justified:

I've taken ashes round to people's houses [...] the ones that get me, and this is the same as when I was funeral directing, is the little old guy that's just lost his wife, [...] and he is absolutely lost and he doesn't know what to do. They're the ones that you really put yourself out for because it's upsetting.

(Tom, unit 2)

Again, I argue that the AUS were going 'over and above' as a "tribute" (Hochschild, 1979: 257), as a way of "paying respect with feeling" (Hochschild, 1983: 76), giving philanthropic *EM* as agents (Bolton, 2000). Charlotte demonstrated that the effort in building a relationship with the family was a desirable part of her role because it resulted in job satisfaction (Bolton, 2000; Strazdins, 2002; Theodosius, 2006). Similarly, Tom highlighted that for some individuals he would carry out extra work because he had an emotional reaction to the individual and their situation.

In this section it was evident that AUS were making decisions to do 'over and above' work for the families and the donors. It was clear that subjective, personal, emotional and moral decisions overruled the practical decisions in these cases. I theorised that this was again implicated by the gift relationship (Bolt, 2012). In addition, I found that previous jobs and the culture of the individual AUs affected these decisions too. For example, at unit three there were several ex-police workers, which was likely to have influenced their working on Christmas day. However, boundaries needed to be set as it was clear that families influenced the AUS's work and would take advantage of such situations. There needed to be distinct boundaries between the AUS's job role and that of a counsellor, courier, and friend et cetera, although this work reaped positive benefits for the AUS (Bolton, 2000; Strazdins, 2002; Theodosius, 2006). Now, I turn my attention to those strategies used to limit interactions and encourage closure.

5.7 STRATEGIES TO LIMIT INTERACTION AND ENCOURAGE CLOSURE

There are two main foci of this section that are interlinked. First, addressing research question five, I examine how FL work was brought to an end, if at all. This was imperative given the large amount of FL work that AUS completed after acceptance. It became evident that the AUS found it difficult to close the relationship with some families, and thus were unable to reach stage seven 'closure' (the end of the BD process). The second main focus is *closure*. In this section I adopt the definition of closure that AUS used as the end of the bereavement process and something towards which to aim. This could be interpreted in two ways. First, as adopted from traditional stage theories of bereavement (Bowlby and Parkes, 1970; Kübler-Ross, 2009; Worden, 2009) where closure was the end goal. However, this runs in contrast to their facilitation of *continuing bonds* (Klass, Silverman and Nickman, 1996) and *meaning making* (Neimeyer, 1999, 2001), as discussed in the first section of this chapter. AUS interpreted that for some families the contact continued because the goal of closure was not achieved. However, the second way this could be interpreted was that the AUS were aiming to re-direct the families' *continuing bonds* and continued contact away from the AU. This would end the family AUS relationship, but bonds may still continue elsewhere.

In this section I explore the multiple strategies used by AUS to limit interaction with families, to encourage the closing of the BD relationship, and to encourage *closure*, thus preventing further contact. I address this first in the storage and use stage, then in the disposal and ashes stages. I then outline those strategies used in the

thanksgiving stage, which was the main stage in which AUS aimed to limit interaction and encourage the closing of the relationship with the families. These strategies aimed to prevent further AUS extra work beyond these stages. Again, the strategies were used on an *ad-hoc* basis and differed between units; AUS adopted the attitude of: “you’re what you need to be when that phone call comes through” (Anthony, unit two). In this, morality or a duty of care, for example, overrode AUS management strategies and caused extra work, similar to when AUS mediated issues. There was some sharing of strategies (discussed in chapter six); however, most were kept within the individual AUs. I recommend some of these strategies as best practice in chapter seven. First, strategies used during stage three are addressed.

5.7.1 Strategies to Limit Interaction and Encourage Closure during the Storage and Use Stage (Stage 3)

There were several examples of the AUS making the donor’s length of stay shorter. This was a strategy to limit interaction and encourage closure during the storage and use stage as the AUS were aware that some families were not comfortable with the donation or could not cope with the length of time donors were within the AU (up to three years). This strategy was put in place when there was continued family contact with the AUS, or where the family member(s) had specifically voiced their discomfort, or this had become apparent to the AUS through their interpretation of the situation. Two cases at unit two were highlighted.

[...] we might have somebody down as indefinite and somebody will ring up and say oh, I need closure, so we'll immediately arrange a cremation [...] legally we don't have to, but we always would, we would never leave somebody hanging on like that.

(Katie, unit 2)

Tom: [...] at the time they were quite distraught, they didn't even know that she wanted to donate her body but they went along with it and we had her about a year and they were always on the phone really upset [...] so we said, "well if we reduce the time for you" [...] we kept her another, about twelve months [...] it was too much for them and I said, "look let's just organise a cremation [...] you've got closure then."

Katie: Where possible we will go along with what the family want.

(Tom and Katie, unit 2)

In these cases, it was clear that the only way to stop the continued contact during the storage and use stage was to reduce the duration of the stage for families who found this difficult. The AUS interpreted this as a need for families to gain closure. There was an interplay of encouraging closure and limiting interaction benefitting both the AUS and the families. However, this was financially detrimental to the AU as they were not using the bodies to their full potential. There was extra practical work involved in removing the body as a teaching source, finding a suitable replacement body in a short time frame, arranging the disposal of the body and the distribution of ashes. However, the extra work completed at this stage in shortening the donation process was likely to have reduced the extra work at later stages; this was a practical approach to managing AUS work. AUS also wanted to make the experience positive for the family. The families influenced the AUS's work as AUS gave *EM* philanthropically (Bolton, 2000) as they felt they owed it to the family as the distress was caused by the BD process.

It was also clear from these excerpts that AUS used the concept of closure as an end goal, something the families needed and sought. In the strategy used here the AUS were facilitating closure by shortening the BD period. It could be deduced that some AUS believed that, for some families, closure was not reached while the body was in the AU. However, AUS also facilitated *continuing bonds*, evident in sections 5.2 and 5.3, which demonstrated that AUS were also aware that some families did not need *closure* in the way that other families, such as those above, did. Or indeed it could be that these families wished to transfer the site of their *continuing bonds* as they did not feel comfortable with their loved one being in the AU. I discuss strategies used during stage four next.

5.7.2 Strategies to Limit Interaction and Encourage Closure during the Disposal Stage (Stage 4)

There were differences between AUs around the family attending the committal service which affected the AUSs' ability to limit interaction and encourage closure at this stage. June revealed that not many families wished to attend the cremation at unit eight. Non-attendance at committal services or no further contact was decided before death by the donor in some cases, or at the time of donation by the families confirming or changing the donor's selections. This was likely due to it being an emotive and difficult time. In the majority of cases this no further contact decision reduced the extra work that AUS completed at later stages in the process, although for those families that changed their minds later in the process, this caused extra work as previously discussed. The opposite was true at unit seven where the majority chose to attend the committal service.

[...] probably about 80% of those next-of-kin do wish to attend the cremation or burial and see the whole process through as the cremation is the very final, end of the process.

(Bob, unit 7)

Issues arose for those families that did not attend the final event (the cremation/burial in this case) as it was problematic for AUS to close the relationships with families that did not have that final point of contact with the AU. However, this was adequate for the majority of families that wished for no further contact. The AUS theorised this using the traditional stage theory approach, interpreting that these families had wished to have closure around the time of death. This worked in those instances where the family did not re-initiate contact, as demonstrated in section 5.4. It was only those that continued contact after this point that caused extra work, because the AUS did not have a final point or tool to close the relationship with these families. However, units ten and eleven did not invite the family to the committal service. This was a successful way of limiting interaction at this stage but could cause extra work at later stages. Next, strategies used during stage five are focussed on.

5.7.3 Strategies to Limit Interaction and Encourage Closure during the Ashes Stage (Stage 5)

The AUS interpreted the collection of ashes and memorialisation through cremated remains as a way in which some families gained closure and coped with their grief (Heessels, Poots and Venbrux, 2012; Mathijssen, 2017b). This was an opportunity for families to speak to the AUS and find out more information about the use of the donation.

I find it's when they come in, for closure I suppose, at the time they are picking up ashes that they then want to know, you know, was this useful. [...] it's definitely closure, [...] it's part of their grieving [...] they're looking for something that gives them comfort that that sacrifice that they made, and the donor made, was actually worthwhile. [...] I think in the sense of coping with grief, yes, and I don't know whether it's coping with the long-term grief between the time they lost the donor and that time of closure [...] but they receive the ashes and quite often they are in tears and so on, so the grief's come back, however well they've coped with it.

(Anthony, unit 2)

The collection of the ashes from the AU was important as the families had an opportunity to speak to the AUS face-to-face and make meaning of the donation (Neimeyer, 1999, 2001). This opportunity was lost for those that collected ashes from the funeral director or had them couriered. This was important for the family, but caused extra work for the AUS. Furthermore, this face-to-face contact could work two ways: by encouraging closure and limiting interactions; or by building relationships between the AUS and families, eliciting further contact and thus extra AUS work. Anthony also understood it to be the case that the families experienced “long-term grief” due to the time-lag in BD (up to three years) between death and collecting ashes. This reiterated the AUS’s belief that some chose no further contact to gain closure earlier. AUS made it clear, across the AUs that allowed families to collect ashes from the AU, that this was a positive experience for the majority of families and the AUS. Therefore, those AUs who delegated the collecting of ashes may have experienced unexpected further contact after this stage if families wished to gain the information that they did not have the opportunity to at the ashes stage.

Additionally, family feuds at stage five resulted in AUS not being able to close the relationship with some families. For example, a family at unit two refused to collect the ashes. This was an unresolved situation;

the ashes remained in the AU and contact continued. In these circumstances AUS used the strategy of continued liaison to try to mediate the situation, encourage the family to come to an agreement, collect the ashes, and close the relationship. However, in doing this there was much extra work for the AUS. Families had a great influence over the continuation of contact. Next, I address those strategies employed during stage six.

5.7.4 Strategies to Limit Interaction and Encourage Closure during the Thanksgiving Stage (Stage 6)

The thanksgiving stage was the stage in which most of the FL work was expected to take place. However, in this thesis I have demonstrated that such contacts occurred throughout the BD process. On top of this expected FL work there were multiple disruptions at this stage, caused by families, AUS, and the logistics of arranging and getting families to the event. This was the stage which most prominently acted to encourage the closing of the relationship between families and AUS, and thus reduce the amount of work AUS did with families after this stage. The thanksgiving stage included the thanksgiving service, held in thirteen of fifteen AUs (including one AU that did not invite families), and physical memorials such as a plaque, bench or book of remembrance that six of eleven AUs had. The numbers represent the number of AUs that responded to these questions in the survey. There had been a recent growth in the number of schools that held a thanksgiving service and had a physical memorial, and those that did not discussed their intention to do so in the interviews. I argue that this was because the AUS felt a duty of care and a need to reciprocate the original gift of BD, as suggested by Bolt (2012) in her study of physical monuments, as these too were

derived from anatomy professionals feeling they owed the families and donors. First, thanksgiving services are addressed.

5.7.4.1 Limiting Interaction and Encouraging Closure at Thanksgiving Services

Anthony (unit two) described the thanksgiving services as a way of “bringing closure to the grieving process and wrapping up the gift.” By “gift” Anthony was referring to the gift of the BD and the gift relationship it evoked. Most thanksgiving services had a dual role as they acted as a way to say thank you to the donor and their family, and to explain what the donor had been used for; a way of *meaning making* (Neimeyer, 1999, 2001). They were also a key event and strategy to limit interaction and encourage closure, thus preventing further contact and unexpected extra work. However, some families chose not to attend because they had a private service at the time of death, as previously discussed. The closure in these cases had already been achieved without AUS facilitation.

[...] sometimes when we've invited them to the memorial service and they're ringing up to say that they're not coming, then they will quite often say “we had a service for her when she died, and you know we are happy for that to be it.” You know, “it's three years ago, we don't really feel that we want to bring it up again.”

(Charlotte, unit 11)

It was common for families not to attend the thanksgiving service because of the delay in time due to the BD process. Further to this the frequency of the services depended upon the AU. For example, some AUs held a service every five years, whereas other AUs held an annual service. This further influenced family attendance.

AUS made allowances for some families that wanted to attend a thanksgiving service that was closer to the time of their loved one's death, as some families found the extended length of time the body was within the AU difficult to cope with. By allowing the families to come to an earlier service, the AUS were limiting the interaction that may have occurred later in the BD process. They were pre-empting in the storage and use stage the possible extra liaison work that they may have needed to do in later stages. This was a tactical management strategy because they were aware that the sooner the families had closure, the less interaction the AUS had with the families after this stage. Closure in this context was achieved by the thanksgiving service acting as their final event; this played a similar role to the family having a private service at the time of death.

However, if families were invited to a service closer to the donor's time of death/donation it was likely that their name would not have been in the order or service.

[...] we have the memorial book so the names of the donors that have been accepted for that past year go into the memorial book and that's displayed at the service. So, for instance if we accepted someone a week before the service it's too late for them to go in the book but we do say to the families we're having this memorial service, you're welcome to come, the name won't be in the book until next year, but if you feel like you want to be there this time because it's so close.

(Sheila, unit 17)

Much of the face-to-face interaction between AUS and families happened during and after the service. All of the services I attended, apart from unit four's, had refreshments either before or after the service which provided an opportunity for AUS and students to speak to the families. Unit six had refreshments before, and a walk to the site where ashes were scattered after the service, where families could speak to the students. AUS spoke positively of this experience for both

themselves and the families. It was apparent that the AUS appreciated the uniqueness of the BD process in contrast to the 'normal' post-death process where they argued "traditional closure" was achieved earlier. This again emphasised that the AUS used traditional stage models of grief to comprehend the distinctiveness of the BD situation. For example, AUS recognised the need to attend a service close to the time of death as a means of establishing "traditional closure". However, as I discussed in chapter two, the funeral/memorial event was also key in *continuing bonds*, so I argue the AUS may have misinterpreted the families' needs. For example, the need "to talk about that person to somebody" could be a way the families attempted to continue bonds, meaning make or display family (Finch, 2007; Klass, Silverman and Nickman, 1996; Neimeyer, 1998, 1999, 2001). Nevertheless, this appreciation of the disruption caused by BD was a justification for why they did this extra work.

[...] for some of them it is their only sort of funeral service, so they do want to talk about that person to somebody [...] a lot of the staff stay behind because it is important that they get that opportunity to talk if they want to. It's such a unique thing ain't it, I always feel for the families [...] not only are you having to deal with their death, but then you don't have that funeral, so you don't have that traditional closure [...]

(Sheila, unit 17)

This time built into the event for the FL interaction meant that families were likely to leave the service happy and not continue contact afterwards. However, in some cases the positive interaction promoted continued contact for some families, which was detrimental in causing extra work for the AUS. For example, a family member at unit seventeen asked whether she could attend multiple services.

[...] we had one lady she came for three years on the trot (laughs). We even got to the point where we were hugging and kissing when she came through the door.

(Sheila, unit 17)

In allowing this individual to attend multiple services AUS facilitated *continuing bonds* which ran in contrast to the closure that was sought after. This happened at multiple AUs. However, this called into question how the AUS closed this relationship that the family wished to continue. For instance, it was clear that Sheila and the lady had developed a close relationship. These continued relationships were detrimental in the AUS closing the relationship with the families and were the cause of extra work. This was also true for those individuals that had multiple family members that had donated as they attended multiple services and they too developed relationships with the AUS. Some family or friends of donors also went on to donate their own body, which began a new relationship. Next, I turn my focus to physical memorials.

5.7.4.2 Limiting Interaction and Encouraging Closure with Physical Memorials

Physical memorials were another key way in which the AUS aimed to limit interaction and encourage closure. Lynne and Anthony highlighted the importance of physical memorials which supported Bolt (2012).

[...] the gentleman said, "I come up twice a year" and he goes to the stone. [...] I think it was his Father [who] donated twenty odd years ago and he's still visiting. You see it's what people need.

(Lynne, unit 4)

[...] on occasion we find flowers on the bench, usually around say Mother's Day and Father's Day [...] I know it's been used by people who come to collect the ashes [...] that's part of why we wanted it out there because we didn't want people to be tied down to our opening hours, you know, if were not open at Christmas it doesn't mean that someone can't come in and do what they need to do.

(Anthony, unit 2)

By “do what they need to do”, I understood that Anthony was referring to memorialisation. Having the bench in a public area on the university grounds (an external physical memorial) meant that families did not need to contact the AUS when they visited the monument, thus reducing contact. This contrasted to those internal physical memorials, such as the memorial book at unit eleven, where a member of AUS needed to facilitate the visit. This often led to further contact.

In this section I revealed the multiple strategies that AUS used to limit interaction and encourage closure which were based upon a complex mix of practical, emotional and moral decisions. It was clear that the thanksgiving stage was the main strategy that was used to limit interaction and encourage closure. However, these efforts may also have the opposite effect, as some families continued relationships with AUS and wished to attend multiple services for example. Reducing the time that the body was within the AU and interaction at the time of ashes collection were also ways in which AUS aimed to achieve this sought-after closure. I present some of these strategies as best practice in chapter seven. However, despite these efforts, it was clear that some families successfully resisted them and could re-initiate the relationship at any point. It then must be questioned when closure occurred in these circumstances and how far the gift relationship should go. Again, the reciprocation of the gift (Bolt, 2012) was implicated in this and could explain why AUS did extra work beyond the natural point of closure. AUS felt they owed it to the families and had a duty of care.

5.8 CHAPTER CONCLUSION

In this chapter I have exposed, for first time, the work that AUS did with families of donors after acceptance in addition to that during the thanksgiving stage. This chapter has used multiple theoretical lenses to examine the empirical data collected with the aim of answering four of the five research questions posed in chapter one (questions one (what is the extent, nature and form of contact?), two (who has contact?), three (when do such contacts occur?) and five (how is FL work brought to an end?)). I have evidenced that these contacts happened from the storage and use stage to the thanksgiving stage and beyond, when contact was not closed, and were facilitated mainly by the BS and MM. I have shown that the form of contact was via telephone, email, sending in items, and face-to-face at thanksgiving services and when families visited physical memorials. The nature of these family contacts I argue was *continuing bonds*, transforming bonds, *meaning making*, displaying family and the mediation of issues. These contacts all caused extra work for the AUS, much of which was 'over and above'. It was apparent that the majority of these contacts were initiated by the families of donors, although only a minority of families. However, I demonstrated that the AUS also initiated contact with families and caused themselves extra work. This was confusing as I assumed that AUS would want to limit the contact that caused them extra work. I then sought to comprehend why they caused themselves extra work and why they did this extra work. The nature of this AUS contact I argue was:

- a) because the AUS wanted to make the process positive for the families to fulfil their overall aim of successful body procurement (and keeping the bodies for the length of time needed) and;
- b) out of reciprocation of the BD.

I will now discuss these two reasons for AUS contact in turn. First, I argue that AUS did all they could to fulfil their goal of making the BD process positive for the families of donors, to the extent that they sacrificed their own workload and contradicted their own beliefs. The AUS put the family's positive experience first, even if it went against their overall aim of procuring bodies and keeping them for the length of time required. This was apparent in the AUS contradicting their traditional views of closure and breaking bonds to accommodate the family's needs in *continuing bonds* (Klass, Silverman and Nickman, 1996). This was also demonstrated in the act of shortening the length of time the donor was within the AU because the family were struggling with the donor being in the AU. In such cases AUS put the families first and aimed to make the BD process positive which defeated their overall aim to procure and keep donors. Putting the family's positive experience first was also evidenced in section 5.7 where I demonstrated that AUS even prohibited the closing of the relationship between AUS and families and overlooked strategies to limit interactions (detrimental to their overall aim of closure) by acting on an *ad-hoc* basis in response to the family's needs. AUS were intuitive and used their initiative which often caused the contact to continue and thus extra work for the AUS. The AUS felt they had a duty of care for the families and felt they owed it to the family remarking that "it's the least [they could] do." (Charlotte, unit eleven). For example, even Charlotte, the AUS member that most used management strategies to try and limit extra work, completed 'over and above' work in order to make the BD process positive for families.

Second, building upon the premise of owing it to the families, mentioned above, and drawing upon gift relationships (Mauss, 1990), I argue that the second reason for this 'over and above' work was due to a reciprocation of the gift of BD. This supported Bolt's (2012) findings in her analysis of body donor monuments. However, I have developed reciprocation beyond the gifting of body donor monuments

(*ibid.*) to include the multiple iterations of extra work after acceptance evident throughout this chapter. This was in addition to that extra work completed for similar reasons around refusals discussed in chapter four. I argue that AUS did this extra work as they were giving *EM* philanthropically (Bolton, 2000) in reciprocation for the BD. This was 'over and above' their job descriptions and they chose to do this. However, I recognise that this was still completed as part of their professional role. I place this 'over and above' work after acceptance, along with the implications caused by refusals, in the overall gift relationships in BD in chapter seven.

I argue that this extra work was also completed because there was a lack of guidance and because the limits to the role were not prescribed. I explore this further in the next chapter when I address the recognition, support and training AUS received for their work. In chapter seven I outline best practice recommendations (BPRs) as guidance for AUS to manage their work, especially that which was 'over and above'. I advise on how to set boundaries in AUS work, as striking a balance between creating and maintaining positive BD experience for families and managing AUS workload was evidently needed.

CHAPTER 6: RECOGNITION, SUPPORT AND TRAINING

In chapters four and five I have examined the disruptions that were made to the 'normal' timeline, at the point of non-acceptance and after acceptance, and the extra work involved as a result of these disruptions for the AUS. In chapter four, I revealed that these disruptions took the form of refusals and I highlighted the extra work involved in navigating the refusal of bodies. Although non-acceptance was expected, it was the volume of non-acceptances and the intensity of some cases that caused for extra work. In chapter five, I evidenced that unexpected and unplanned family contacts disrupted the 'normal' timeline, meaning that AUS completed extra work that was 'over and above'. As I established in chapters four and five this *routine work* and *extra work* could be both practical and FL work, although I have shown in this thesis that FL work in particular was extensive at the point of acceptance/refusal and after acceptance.

I established that the majority of this work required *EM*, including that which was determined by the job, that which was performed due to social rules, and that which was given philanthropically; respectively prescriptive, presentational and philanthropic in Bolton's (2000) typology. I have made a case for the lack of pecuniary type *EM* (Bolton, 2000) due to the gift relationships within BD and the indirect effect procurement had on commercial gain for the AUs. Also included in their work was the emotion work (Hochschild, 1983) that AUS did on themselves as a result of their jobs. In this chapter I address research question four by examining the extent of the recognition, support and training AUS received in order to do their work (both practical and FL work, including their 'normal' everyday work, as well as the extra work that was 'over and above') as there was no literature around this. However, before addressing the recognition, support and training, I

first outline the background and professional experience of individuals entering into the role of AUS, including BS, MM, DI and technical staff who performed FL work as part of their role.

6.1 AUS BACKGROUND AND PROFESSIONAL EXPERIENCE

The individuals taking these roles came from a number of different professions, such as bank clerk, administrative work, funeral directing, police family liaison work, paramedic, retail and customer service, and other administrative or technical jobs within the university. These staff were hired for the transferable skills that they had gained from professions which required similar interpersonal skills to those needed of AUS. Recruiters also described getting a feeling about a candidate – whether they were empathetic, good communicators and would fit in with the team.

This was similar to the recruitment process for other deathworkers, for example Walter (2005), when describing civil funeral directing trainees, explained that many of them were previously probation officers or police officers which equipped them with many of the skills required to deliver a funeral tribute. Walter (2005: 408), however, questioned whether deathworkers were “taught to be passive receptors” and asserted that there was a need to teach the relationship present in mediator deathwork, similar to the training that doctors received regarding the patient-doctor relationship. Walter (2005) concluded that deathwork was a particular type of work which needed to be recognised, understood and trained for. In this chapter I explore the extent of recognition, support and training for AUS.

As I demonstrated in chapters four and five, it was often the case that the job advertised was different to the job in practice, as much work

that was 'over and above' the 'normal' timeline of routine work was completed. Anthony, the DI at unit two, said that it was extremely difficult to advertise for the roles and provide an accurate job description. For instance, the BS role was often advertised as administrative without full explanation and recognition of the FL that they would do. Anthony asserted that it was also difficult to describe the job in interviews.

I mean, if you can't put it in words in the job description you can't [...] clearly give it to an interviewee in a way that they will actually understand how vast the experience is going to be [...]

(Anthony, unit 2)

This was similar in other professions too. For example, O'Donohoe and Turley (2006) described that newspaper In Memoriam (IM) writers often came into their roles as newspaper staff but were asked to complete IM duties. Such duties were different to other aspects of their role, as this particular service encounter included FL and *EM*. It was problematic that staff were expected to do work that they were not explicitly aware of in the recruitment process as this was difficult *EM* that they were not prepared for and they may not have applied for the role if they had known. It was common that such work was overlooked; however, I argue in this thesis that such work needs to be recognised as difficult, integral and productive, which supported literature around *EM* in organisations that has made this case (Dent, Buke and Green, 1991; Hochschild, 1979, 1983; James, 1989, 1992; Smith, 1988, 1992; Taylor, 1998). For example, Anthony (unit two) went on to stress:

[...] it's those things that you don't actually write in to, say job descriptions and so on, so it's expected that you will speak to family and expectant you will interact with them and deal with them somehow, but there is no hard and fast way of doing it you know.

(Anthony, unit 2)

However, I argue that it was possible to make FL and *EM* duties explicit in the recruitment process even if there was no one way of doing it, for example, case studies could be used. I assert that such work needed to be explicit, as many AUS remarked, especially BSs and those completing FL duties as opposed to practical duties, that they did not know what their role would entail until doing the job. This was why individuals were recruited internally wherever possible so that they knew the university or departmental procedures; however, even internally recruited staff did not have a full sense of what the job entailed. In contrast, there were external temporary staff at unit four that had to adjust to the job quickly without prior knowledge of the university or department.

With a combination of new employees having non-job-specific transferable skills and a recruitment process that left the employee unaware of what the job entailed, it was the task of the AUS to provide job-specific training, support and recognition. I explore in this chapter the extent to which this occurred and the way in which recognition, training and support was provided for AUS in UK AUs. Next, in section 6.2, I address the recognition that AUS received, followed by a consideration of their support needs in section 6.3, and support networks in section 6.4, the coping strategies used in order to deal with their work in section 6.5, and training needs and how they are addressed, if at all, in section 6.6. Finally, in section 6.7, I offer insight into the reasons AUS did their FL work. Next, I address the first of these six foci.

6.2 RECOGNITION OF AUS FAMILY LIAISON WORK

I demonstrated in chapters four and five that AUS undertook a substantial amount of FL work both in avoiding and dealing with

refusals and after acceptance. However, in this section I expose that there was very little formal and informal recognition for this type of work. First, formal recognition is addressed.

6.2.1 Formal Recognition

I define the *formal recognition* of AUS FL work as that provided by the HTA, the Institute of Anatomical Sciences (IAS) and by their own AU. Addressing the HTA's recognition first, it was clear that only one of the twenty-one AU inspection reports available at the time of this research (2017) recognised the AUS's FL work in the additional comments section, although this was because these reports were conducted by the HTA routinely to examine the practical processes of procuring, storing, using, displaying and disposing of human tissue at UK AUs. Thus, FL work was not the HTA's primary concern and was overlooked in many AUs. However, Anthony said that the HTA were aware of this "background" FL work and would say if it's not being completed well enough, even though it was not formally recognised in most cases. This was problematic as there was no explicit expectation or recognition of FL work in most cases, as was highlighted by Anthony in section 6.1, yet it was essential to the role. Anthony, the DI at unit two, commented on the recognition of FL work in HTA AU inspection reports.

I don't think it's included at all because they come in to check in four regulatory areas; [...] consent; storage; disposal; and [...] governance. [...] That's what they're primarily focused on [...]. I've never actually been asked directly about family liaison because it doesn't fall under the regulatory agreements, [...] but they're quite often aware that there's stuff going on in the background, so they will highlight that usually in the added information, best practice type of thing [...] if you're not doing it well enough they will say. So that's usually an afterthought if you like, outside of the regulatory framework.

(Anthony, unit 2)

O'Donohoe and Turley (2006: 1442) highlighted that it was also true for newspaper IM workers that their managers, as with the HTA, were "[...] failing to appreciate this aspect of their work [...]." AUS FL work, including associated *EM*, was thus hidden and underappreciated yet was essential to the role; this was problematic as AUS were left feeling confused about their duties and underprepared for them. Research across multiple occupations has also shown that a lack of recognition had a negative impact on workers as recognition and appreciation were key motivational factors which led to job satisfaction (Goetz et al., 2017; Graham and Messner, 1998; Knoop, 1994; Marmo and Berkman, 2018; Tietjen and Myers, 1998; Willis-Shattuck et al., 2008). Furthermore, research has shown, across multiple occupations, that recognition was important to the general well-being of staff (Gilbert and Kelloway, 2018). In particular Honneth (1995, 2010) and Dejours (2007) demonstrated "how (in)adequate acknowledgement of workers' contributions can significantly affect their well-being at the level of self-conception" (Tweedie et al., 2019: 1). In this thesis I recognise this work. This would be recognition from an external third-party that had observed the need to recognise such work without agenda. This recognition was expected to have a positive effect on AUS's motivation, job satisfaction and well-being.

The IAS provided the second means of formal recognition, where a Certificate in Anatomical Bequeathal Services was offered. However, in the eighteen months that it had been available at the time of submitting this thesis no AUS had taken this up. The third means of formal recognition (that provided by the AU) was not noted by AUS in any of the data collection methods.

I have shown that the HTA and the AUs offered minimal formal recognition and that which was offered by the IAS was not taken up by AUS; thus, this was a multifaceted issue. Further research was needed to explore why AUS did not take up such formal recognition.

On the basis of these data I ascertain, in line with Bolton (2000), that it would appear that there was minimal organisational understanding of the nature and ramifications of such work. Bolton (2000: 156) argued that it was the lack of conceptual clarity around emotion in organisations that meant that “[...] the employee, as a multi-skilled emotion manager, remains unrewarded for their efforts at this particular type of labour [...]” Bolton (*ibid.*) asserted that “[w]ithout identifying the emotion management which can be classified as being an essential element of paid work, organisational emotionality will continue to be relegated to the “private sphere”.” This was associated with women’s work, which was natural and not productive even though it was essential work (Maddock and Parkin, 1993). In this thesis I have recognised and presented the AUS’s *EM* at work as important, hard and productive work that was integral to the facilitation of the BD process in UK AUs. In this recognition I hope that such organisational emotionality will be formally recognised, in turn offering positive benefits such as motivation, job satisfaction, support and training.

6.2.2 Informal Recognition

Despite the minimal formal recognition, the AUS did however receive some informal recognition. I define *informal recognition* as that which came from the families of donors or from colleagues. For example, Charlotte, the BS and MM at unit eleven, received a bouquet of flowers from the daughter of two donors to thank her for the FL work she had done in facilitating the combined collection of her mum and dad’s cremated remains who both donated their bodies to unit eleven. Charlotte explained:

[...] she came in and we had a cup of tea and she brought me some flowers in, and she took the ashes away with her. [...] It is nice yeah when they come in and say you were really helpful and really kept us informed, that kind of thing.

(Charlotte, unit 11)

I argue that this was an act of reciprocation, where the daughter reciprocated Charlotte's reciprocation of 'over and above' FL work with a bouquet of flowers. Charlotte's work was an example of philanthropic *EM* (Bolton, 2000) where Charlotte actively wanted to give this extra work (Theodosius, 2006) to make the process positive for the family. The giving of the bouquet was a further act of reciprocation that will be positioned within the overall gift relationships in BD in chapter seven.

Families also gave informal verbal recognition of the AUS's FL work when they met them as Charlotte described. However, this type of informal recognition was rare, as routine FL and acts of going 'over and above' were not often recognised by families. This was likely to be due to the family not distinguishing such work from that 'routine' work or finding the means to acknowledge this work. The thanksgiving services often brought to light the AUS's FL work for the families as I witnessed, during my participant observations at these services, that families subsequently thanked the AUS. Therefore, the thanksgiving service (the final event at most AUs) was the main way this informal recognition from families came to fruition.

Although the senior members of AUS, such as the DI, were informed of positive situations, it was often the case that the everyday occurrences were not discussed with the DI. This was mainly due to time restrictions. It was only the "exceptional" cases (both positive and negative) that were raised. Anthony, the DI at unit two, said:

I don't get the day-to-day [...]. When there is something exceptional, so if there was a case that they couldn't quite

resolve or they felt unsure about, say consent, or they had a particularly bad interaction that they thought might have repercussions, or anything out of the norm would then come to me – I might hear of something once a week maybe and it's not necessarily bad, it's even the good stuff, so if something's really worked well, if someone wrote a letter of thanks, or if someone says something really kind on the phone I'm going to hear about that, but the mundane no.

(Anthony, unit 2)

This meant that AUS were not receiving even internal informal recognition for their day-to-day work (which included much FL work not expected of them or made explicit in their job descriptions); it was only in exceptional cases that the DI would be informed to then offer recognition of their work. Again, this related to O'Donohoe and Turley's (2006: 1442) comment, highlighted earlier in this section, that it was simply a "failing to appreciate this type of work." Consequently, as exemplified previously, this FL work and associated *EM* was not even informally recognised as hard or productive work as it was being demoted as mundane and everyday work. This was problematic. In this thesis, however, I recognise such work. In this PhD thesis I have shown that AUS completed much FL and *EM* in their duties to procure, store, use and dispose of body donors and I made a case that this work should be recognised as hard and productive work which was essential and central in the AUS's role. This also had benefits for AUS's well-being as highlighted in the previous subsection. Next, I turn my attention to the support needs identified by AUS.

6.3 SUPPORT NEEDS IDENTIFIED BY AUS

In the previous section I highlighted the paucity of formal and informal recognition that AUS received for their everyday and 'over and above' work. It is important now to consider the key emergent support needs

identified by the AUS during semi-structured interviews. The support needs identified were emotional, AUS being used in lieu of a bereavement counsellor, and the need for extra staff to support the existing AUS. Each are discussed in order. This section is theoretically supported by considerations of the support needs of workers in other contexts, such as police workers, teachers, and funeral directors, which were applicable to those of the AUS. First, emotional support needs are addressed.

6.3.1 Emotional

I found multiple examples of the AUS's emotional involvement in their work. This happened throughout the process as the AUS were dealing with the dying and the bereaved and this was cause for upset. The first major point of emotional support needs arising was at the time of refusing donors; a task which evoked an emotional response for many AUS. Alice disclosed:

[...] there are times that I've been quite upset, moved by it, umm. I found it very difficult when we have to decline, and the family are upset. That always bothers me.

(Alice, unit 9)

This was something that continued to cause emotional distress for AUS. Other workers, such as medical professionals, also reported that breaking bad news caused emotional distress which "may lead physicians to emotionally disengage from patients" in order to protect themselves from emotional attachment (Vandekieft, 2001: 1975). Thus, it was problematic that patients valued "frank and empathetic disclosure" which required medical professionals to empathise and emotionally engage with the case (*ibid.*). The patients that Vandekieft (2001) described had taken the breaking of bad news well; however,

Charlotte explained that AUS experienced negative emotions if the families took the refusal badly.

[...] some people it leaves me with this bad feeling, umm, if you had to turn one down and they took it badly [...]

(Charlotte, unit 11)

Charlotte demonstrated how the AUS's emotion could be influenced by the families of donors. These AUS had not been able to emotionally disengage like those medical professionals in Vandekieft's (2001) study. AUS were compassionate and empathetic which was crucial to their role. Kanov et al. (2004: 808) described "[...] compassion as a dynamic, interactive process comprising three sequential subprocesses: noticing, feeling and responding to the pain of others." In this practice of compassion, the AUS's emotions were inextricably linked with the families'; AUS were feeling and responding to the families' emotional cues. This was a similar phenomenon to the influence that families had over the work AUS did, which was explored in chapter five. It was the negative nature of the interaction that caused emotional distress for Charlotte due to her emotional engagement with the family, though the emotional disengagement described by Vandekieft (2001) would not be feasible for all AUS and may have negative consequences for the families of donors. Additionally, the AUS did not have the training around emotional detachment that the doctors in Vandekieft's (2001) study received.

Now I move on to consider the AUS's emotional support needs after the body was accepted. Sheila highlighted that AUS's emotions were influenced by the families of donors after acceptance too.

I think if they're dealing with it [the death of a loved one and body donation] matter-of-factly, it's easier for you to deal with it matter-of-factly, but when they're getting upset, it is hard to not let it affect you, but obviously you have to stay professional-

usually I put the phone down then I have a bit of a cry (laughs) then I'm alright again.

(Sheila, unit 17)

Similarly, Carrie, the senior technician at unit seventeen who completed FL work, remarked that she found it unprofessional to show emotion as she felt it hindered her ability to do her procurement and FL work as she believed it rendered her unprofessional in the view of the family.

[...] sometimes it's awful but you've got a job to do and you know you can't afford to break down in tears or not be able to speak, or not make them feel confident that you know what you're doing. You can't afford that.

(Carrie, unit 17)

Sheila managed the family's emotions by controlling her own emotions and dealing with them after the interaction with the family member in order to remain "professional". In contrast Katie (unit two) allowed herself to be emotional around families; Katie described "crying with them" which she did not try to hide from the families. While Sheila's and Carrie's management of their emotions could be considered surface acting (Hochschild, 1983), where they suppressed their naturally felt emotions to preserve their perceived professionalism and present the desired face. Katie's reaction could be deemed deep acting (Hochschild, 1983) as she genuinely felt the emotions that she exhibited. This may come with the benefits of deep acting such as feeling fulfilment and job satisfaction (Hwa, 2012; Kinman, Wray and Strange, 2011; Kim, 2008; Lee, Ok and Hwang, 2016; Rogers, Creed and Searle, 2014; Van Gelderen, Konijn and Bakker, 2017), although I argue that Katie's reaction was not an example of Hochschild's (1983) deep acting, as Katie was not informed or encouraged by managers to perform this. In fact, many AUS tried to avoid having such emotional reactions in front of families as this was not considered

“professional”. Thus, I argue that Katie may have acted out of naturally felt emotions which were authentic and did not require regulation (Diefendorff et al., 2005; Randolph and Dahling, 2013), further disputing this as deep acting (Hochschild, 1983). Naturally felt emotions also had positive benefits for AUS such as job satisfaction (Cheung and Tang, 2010; Mesmer-Magnus, DeChurch and Wax, 2012).

Reconsidering Sheila’s and Carrie’s management I assert that these were rather examples of multifaceted *EM* as their performance was also not prescribed by managers. For example, it was Sheila who created the concept of “professional” not her managers. This was a similar view to that of other professions, such as medicine, where “[t]he expression of emotions in medical practice is perceived as unprofessional and many doctors learn to suppress and ignore their feelings” (Kerasidou and Horn, 2016: 1). This was embedded in the work culture, but I argue, for AUS, that this was due to general social rules rather than those prescribed by managers, thus supporting the case against the type of *EM* that AUS were completing as prescribed (Bolton, 2000) or *EL* (Hochschild, 1983). Practice also evidently differed across AUs and even between AUS at the same AU, as exemplified in the discussion between Tom and Katie below, which further corroborated this theorisation. The type of *EM* that Sheila and Carrie performed may be closer to presentational *EM* (Bolton, 2000) as they were influenced by social rules; they had learned that professionals did not show personal emotions in front of their customers/clients. Furthermore, Sheila’s personal emotional reaction after the interaction with the family was not for the benefit of the family, informed by managers or productive, as her crying was hidden from the family. I therefore argue that this reaction was also a result of naturally felt emotions (Randolph and Dahling, 2013). However, this was still completed as part of her professional role.

This separation of personal emotional responses from the work interaction, due to AUS's concept of professionalism, supported emotion work (that which is completed on oneself) as private emotion management (Hochschild, 1990). Although, most AUS considered that these emotional support needs were part of their professional duties and must be addressed in the work environment, thus disputing Hochschild's (1990) emotion work as this, I argue, was not completed in the private sphere for most AUS. This allowed AUS to separate work from home life, which would prevent AUS from drawing upon family and friends as a support network, as I discuss in section 6.4. However, I discuss in subsection 6.3.3 that some AUS took their work home as a further layer of separation which may be akin to Hochschild's (1990) emotion work taken into the private sphere.

The individual differences between AUS's emotional reactions was also evident, which exemplified different emotional support needs even between AUS at the same AU when dealing with the same instances. This demonstrated that the conceptualisation and dealing with emotional responses to work was not a result of the work culture but due to individual differences. This was evidenced in the discussion between Katie and Tom at unit two below.

I struggle with that side of it more than you do, you're better at dealing with that. If somebody is crying on the phone to me, I join in, or if they come and pick the ashes up and they're crying I can feel myself going still, even after all this time, whereas you're much more able to deal with that. [...] If I get someone emotional on the phone I just [mimes crying] (laughs).

(Katie, unit 2)

Katie used negative language such as "struggle" to denote that this was something that she found difficult, hard and effortful and with which she could not cope. This true empathetic reaction was key to performing *EM* well (Kerasidou and Horn, 2016). Katie was probably

hired for her empathetic nature. Katie aspired to cope with her emotion response as Tom did, as she described him as “better” or “more able”. Tom, as an ex funeral director, was probably employing coping mechanisms from his previous role as he described his desensitisation to the work and was thus able to suppress his emotional reaction, whereas Katie had not had such prior experience in her customer service and admin roles. This demonstrated the individual differences in emotional reactions to FL work and the influence that previous experience had on ability to cope.

It was also evident that some AUS did not initially even consider themselves to be emotionally involved however, following prompting, they re-assessed this.

Lynne: [...] she's able to say that to me because I'm not emotionally involved.

Natalie: We are emotionally involved.

Lynne: Yeah, we are (Natalie and Lynne laugh), far too emotionally involved but we're not in the same way [...]

(Lynne and Natalie, unit 4)

This initial lack of recognition of emotional involvement was telling that emotional involvement was not prescribed by managers. In Bolton's (2000) typology, it was rather presentational or philanthropic because AUS were acting out of empathy, which appealed to their good human nature and wider social values. This emotional involvement I argue was also a result of their empathetic nature which was a trait for which AUS were hired (Anthony, unit two). Lynne described that the AUS were emotionally involved in a different way to the families as they had no personal or kinship connection to the family however, through their empathetic and compassionate nature they become emotionally involved but not to the extent that it prevents them from completing

their duties. Thus, although this emotional involvement was integral to AUS work in allowing them to be empathetic, this should not hinder their ability to fulfil their duties. This was similar to how O'Donohoe and Turley (2006) described newspaper IM writers, as their empathy allowed them to do their job well but did not hinder their ability to do the work.

There was evident variation in the AUS's emotional support needs as some, such as Charlotte, did not consider emotional support to be an important need for herself. When comparing her current role to her previous role as a funeral director, Charlotte said that she did not feel as emotional. I argue that she was probably using coping strategies from her previous role to cope with her current role. Similar to the police workers that Mitchell (1996: 141-142) described, Charlotte became "habituated and immune", where exposure led to emotional "hardiness". This was problematic as AUS, like Charlotte, were not accessing the appropriate support as they did not consider that they needed it. However, these AUS may have overlooked their emotional support needs as it was apparent that Charlotte did have an emotional response when the family reacted badly to the refusal, as evidenced in a quote from Charlotte earlier in this subsection.

I don't find it very difficult, I mean, you know, I've been doing this for 20 odd years now, umm, and obviously in the funeral business you are dealing with people who have lost babies, who have lost children, or have lost multiple family members [...] whereas our donors that come to us they are usually elderly, they are usually already aware that they want to do this so it's not kind of such a- as distressing. Obviously, it is distressing but not as distressing as other situations might be.

(Charlotte, unit 11)

There were many studies that have found that individual differences influenced support needs which were also affected by previous roles, context and coping mechanisms. For example, Collins (2008: 1776)

asserted that “individual differences such as self-esteem, resilience, hardiness and personal control, along with generally well-known physiological release mechanisms such as exercise [...]” can all affect the support needs of workers.

Nevertheless, emotion and empathy were crucial and unavoidable. Kerasidou and Horn (2016) said that this repression and non-acknowledging of personal emotions could have negative consequences for the doctor. Kerasidou and Horn (2016: 1) said: “When facing stressful situations, these physicians are more likely to suffer from depression and burnout than those who engage with and reflect on their feelings.” Therefore, Kerasidou and Horn (*ibid.*) suggested that “[p]hysicians should be supported in their emotional work, which will help them develop empathy.” Developing empathy was key to performing *EM*. Therefore empathetic personal responses should not be viewed as negative and unprofessional but should be encouraged as an integral part of their work and used as a tool. Kerasidou and Horn (2016) stated that empathy should be central to doctors’ medical practice in order to support them in performing *EL*. Kerasidou and Horn (2016: 1) said: “Empathy should not only be expected from doctors but should be actively promoted, assisted and cultivated in the medical profession.” It can thus be said that both Katie and Sheila’s dealing with their emotions at work and completing emotional work (Hochschild, 1983) on themselves was positive.

Alice supported the importance of empathy within the AUS’s roles.

[...] you'd have to have a heart of stone to not feel anything, and I think when you get to that point you shouldn't be doing the job, because you've got to have empathy with the people you're dealing with, and I think if you haven't got that you shouldn't be doing it. So, it's right that I do feel something.

(Alice, unit 9)

Alice justified her emotional responses. She described them as normal, essential and indicative of the type of individuals that are employed as AUS. It was evident that empathy was a beneficial personality trait for AUS to have, as with other workers (Kerasidou and Horn, 2016; O'Brien and Linehan, 2018). Accordingly, complete emotional detachment was not productive for AUS.

I have established in this section that emotions are present and affect the AUS's ability to do their work, but that emotions are crucial and unavoidable. Thus, this is a support need that must be addressed in order to manage the AUS's emotions and allow them to address their own emotions, so that they do not hinder their work. Next, I explore the completion of bereavement counselling work.

6.3.2 Completing Bereavement Counselling Work

The second support need arose from the work AUS completed that was akin to that of bereavement counsellors. AUS did this work because they observed that the families required this and responded directly to the families' requests and needs. However, this was extra work, 'over and above' what was expected by the HTA or their AU, and AUS did not have the training to do this work. Thus, it was dangerous, for both AUS and families, for AUS to complete such work, as a bereavement counsellor is a trained individual who specifically addresses the needs of bereaved individuals. A bereavement counsellor has specific training around grief and how to address needs in an appropriate way (Humphrey and Zimpfer, 2007). This requirement was a common theme across AUs, and AUS expressed their discomfort in this expectation from some families. In section 6.5 it can be seen that some AUS took bereavement counsellor training courses which was indicative of their 'over and above' work if this was

able to be put into practice. As this work was falling to the AUS there can be two approaches to addressing this support need: first, by providing appropriate training and support for this work and making it explicit in their job descriptions; or, second, by providing support for AUS in ways to avoid and refer this type of work.

As with the extra work outlined in chapter five, it was clear that the AUS were doing extra work because of the families' influence. AUS did not feel that they could say no. However, they should have been able to. This was similar to funeral directors who had ambitions to be "a co-ordinator and a counsellor" (Bremborg, 2006: 276). Both funeral directors and AUS were similar in taking on extra work and both felt that they could not say no to families' demands. This led both to take on work that was akin to bereavement counsellors that was 'over and above' their job roles. However, as Bailey (2009, 2012) highlighted for funeral directors, which was applicable to AUS too, this continuation of care seemed incompatible with their mission to provide a funeral for a family which was a short interaction. For AUS, their mission to procure bodies, use and dispose of bodies in a three-year timeframe was incompatible with going 'over and above' and continuing care beyond that which was required and particularly when this relationship extended beyond the donation period.

Bailey (2010: 205) also found that "philanthropic emotion management predominates among funeral arrangers." I argue that this was also the type that most closely resembled the *EM* AUS completed. This challenged "the assumption that funeral directors' motivations are primarily commercial" and showed "that they exercise care directly of the client rather than through caring for the deceased person" (Bailey, 2010: 205). The relationship between AUS and families was also a philanthropic one not solely a commercial one, as BD relied on people gifting their bodies and AUS receive but do not force receipt. There was no direct financial benefit, in that AUS were paid regardless of the

number of bodies they procured; hence they were not incentivised to procure bodies. There were also no pressures of needing bodies as the shortfall was very low ($n = 6$) over all AUs as presented in chapter four.

Some AUS felt that they were able to manage the conversation in a way that allowed them to stop the conversation when it got to a point that they were not qualified to address however, not all AUS felt that they could do this or, as was clear from Sheila's comment, did not realise the cut-off point.

[...] we've had this discussion before with the bequeathal officers the fact that we're not counsellors, we don't offer a counselling service and obviously if families are struggling we can sit on the end of the phone and listen but we're not qualified really to give them professional advice [...] I'm more than happy to sit and listen to somebody while they want to talk about their relative [...] but I think if it got to a point where I thought it was going beyond that I think I would have to refer them to someone else.

(Sheila, unit 17)

Although some AUS recognised that there were some conversations that could go 'over and above' their job role, many AUS, like Sheila, still completed 'over and above' work in being a listening ear. Sheila, without realising, completed 'over and above' work; demonstrating that determining this point and managing this situation in practice was very difficult, which led AUS to do work that they were not qualified to do. I argue that AUS completed 'over and above' work to reciprocate the gift of BD through philanthropic *EM* where AUS were compassionate and empathetic and wanted to help the family. AUS started off as a listening ear but eventually found themselves in a bereavement counselling role. At the beginning of this subsection I defined a bereavement counsellor as a trained individual who counsils individuals in their grief, and who has specific knowledge of grief theory

and its manifestations (Humphrey and Zimpfer, 2007). AUS, however, were not trained professionals, did not have this specific knowledge, and therefore should not be taking on these tasks. AUS needed guidance around establishing, understanding and maintaining the boundary around their duties in order to help them distinguish their duties from that of a bereavement counsellor.

One tool that some AUS used to manage this boundary was by suggesting that the family attend the thanksgiving service; this deflected the need to complete 'over and above' work that required a bereavement counsellor.

[...] I always say, "well if it helps, we have a memorial service at the university" and some of them will say ooh that's a good idea.

(Sheila, unit 17)

Some AUS were able to use the mechanisms available, on a case-by-case basis, to counter the need for extra work in taking on counselling type duties. The thanksgiving stage (stage six) was a particularly good tool in countering some emotional needs that families raised through continued contact during the storage and use stage (stage three) in particular, as I revealed in chapter five, which would require the expertise of a bereavement counsellor. This aimed to reduce the number of interactions while the body was in the storage and use stage (up to three years) by giving the families an event to which to look forward. However, as I have demonstrated, for some families this did not result in a three-year interaction as some families continued to contact the AUS outside of the BD time frame. It may then be that AUS could refer these individuals who continued to contact to alternative bereavement counselling services and retract the continuation of care that was 'over and above' their remit and training level. However, I exemplify in subsection 6.4.2 that only some AUS knew of local

bereavement counsellors to whom to delegate this aspect of their 'over and above' work. Next, I examine the third key emergent support need.

6.3.3 Need for extra AUS

There were several single points of failure that were difficult to mitigate against because only one member of AUS was able to complete this specialised work in many AUs. However, it was clear that some AUs overcame these single points of failure by having extra AUS. I argue that extra AUS could help to support and alleviate these points of failure in AUs that did not already have this safety net. For example, Carrie explained the difficulties they had with a reduced number of AUS in comparison to when they had enough AUS.

[...] there used to be three of us in here. To run it properly we really need three of us. We've got a bit of help part-time [...]

(Carrie, unit 17)

The AUS were unable to complete all of their duties to the standard required when they did not have enough AUS. This was somewhat remedied at unit seventeen by arranging for part-time AUS to fill in the gaps. However, many AUS were used to working in full-time teams with little turnover so this may not fit with many AU's work culture.

Sheila (unit seventeen) described her anxiety of being the only BS after her job-share colleague had retired. She asserted that the job-share of the BS role worked well for them as they got on well and had similar ways of working. It was apparent that the positive working relationship between job-share colleagues was important. Although job sharing the BS role, I argue, was not ideal because there were tasks that were hard to hand over to another colleague, for instance, mediation FL work, where an intricate understanding of the case was required. My theorisation was supported by Charlotte:

I know a lot of people do job share in other universities but I think it's so much better if one person does it because it's just one person following the whole thing through [...] It's bad in another way because it means if I get knocked down by a bus tomorrow nobody really knows what they're doing, I mean we have standard operating procedures in place but there's a difference between reading a script of how to do something and actually doing it, but I much prefer to do this on my own I don't think I'd like to- it's not in my vision that [the new mortuary technician] will ever do this bit [(the family liaison work)] although I think maybe [they] would be shown the basics of it just in case I'm ever off [...]

(Charlotte, unit 11)

Furthermore, Charlotte reasoned that she did not feel the need for extra AUS as she believed she could complete the tasks alone due to her length of time at the AU and her experience from her previous role as a funeral director. This highlighted that there were individual differences in perceived support needs and showed that previous roles and experience affected perceptions of capability. However, Charlotte acknowledged this single point of failure, as the AUS were irreplaceable in such circumstances where only one individual comprehended how to complete the specific and specialised role that relied upon nuanced information that was not always recorded and was hard to hand over. Unit nine mitigated against this by training extra staff to take over the BS duties if the full-time BS took a holiday, needed a break from the work, or was to leave the role.

Charlotte did acknowledge that having a new member of the technical team to take on practical and technical work allowed her to focus on her FL duties which addressed her unidentified support need, making clear that she did need extra AUS. However, there was a need for extra AUS to take over BS duties when the BS was absent. Extra AUS could mitigate against the detrimental effects the lack of AUS had on the BD process, such as increased refusals. This was evident in chapter four, where unfilled posts resulted in non-acceptance in some

cases. Such support would also allow AUS to take holidays without feeling guilty that they had left their duties unattended.

I thus suggest, in line with the AUS, that AUS would benefit from having AUS that can provide short-term and long-term cover. This was beneficial across other work groups too; for example, for newspaper IM writers (O'Donohoe and Turley, 2006), for nurses (O'Brien and Linehan, 2018), and for organ procurement operators (OPOs) (Sharp, 2006). This will be discussed further in subsection 6.4.2 as allowing for time out and having colleagues to take over was a key part of the *ad-hoc* support network to address this support need. Sharp (2006: 52) assessed this for OPOs; she explained: "Sometimes one person performs all the necessary tasks; in larger OPOs the duties may be split between two people, in part because the work at either end is exhausting, especially when a case extends over the course of several days. As one OPO staff member explained, it can be an emotionally trying experience for the same individual to tend to the clinical needs of a depersonalized body while also trying to comfort a family in the throes of grief." Due to the multiple aspects of OPOs' roles, as with those of AUS, it was useful to separate and delegate tasks in order to cope with their work demands. Having multiple individuals that could perform the tasks was ideal. This would mitigate against these single points of failure when only one individual could complete the tasks. This was especially true for AUS too when the case was extended over multiple days. The "situational factors", such as the "impact of situation, the duration, the variety and frequency of felt emotions, may draw on energy resources even further" (Van Gelderen, Konijn and Bakker, 2017: 870). It was clear that having extra staff could reduce exhaustion, emotion fatigue, sympathy burnout (Sharp, 2006) and burnout. Burnout syndrome, determined using the Maslach Burnout Inventory, can be broken down into three categories of depersonalisation, emotional exhaustion, and personal accomplishment (Maslach and Jackson, 1981).

When Sharp (2006: 52) was referring to “work at either end” she meant *EM* or *EL* and administrative work. It was acknowledged in the literature that *EL* was hard and exhausting work (Dent, Buke and Green, 1991; Hochschild, 1979, 1983; James, 1989, 1992; Smith, 1988, 1992; Taylor, 1998). Surface acting was where naturally felt emotions were suppressed and organisational or fake emotions overruled these to present the desired face (Hochschild, 1983). Many studies across a range of jobs supported that surface acting led to emotional exhaustion/burnout. For example, Näring, Briët and Brouwers’s (2006: 303) study aimed “[...] to show that emotional labour has a unique relationship with burnout that is separate from its relationship with the variables of the Demand Control Support (DCS) model.” The DCS model, developed by Karasek and Theorell (1990), included work that was of high demand, with low worker decision making and low support, which decreased health and well-being. Näring, Briët and Brouwers (2006: 303) unveiled that “job characteristics were found to be specifically related to emotional exhaustion. Surface acting was significantly related to depersonalization, and emotional consonance (the absence of emotional labour) was related to personal accomplishment.” Therefore, AUS completing *EM* with a high level of emotional consonance may have gained personal accomplishment.

In contrast to surface acting, deep acting was where the emotions needed to present a desired face were felt by the worker, thus there were fewer negative effects of deep acting. For example, Rogers, Creed and Searle (2014: 234) revealed that “surface acting and training stress were associated positively with work-related burnout, where deep acting was associated negatively with work-related burnout, where work-related burnout was associated positively with depressive symptoms. The results suggest that assisting junior doctors to manage workload demands and patient contact will have beneficial effects on their work enthusiasm and mental health.”

Similarly, Van Gelderen, Konijn, and Bakker (2017) illustrated differing relationships between strain, surface acting and deep acting among police officers. This solidifies, supported by the data from AUS's work, that *EM* was a special type of work that was difficult and exhausting and there was a difference in how staff were personally affected by deep acting, when they felt and experienced a personal emotional reaction to the situation, versus surface acting, when they faked an emotional response.

Overall, I clarified in this section that there was a need for:

- a) emotional support for some AUS, as this was the main support need and could affect the AUS's ability to complete their work,
- b) the AUS to be able to re-direct some work that they were not trained or supported to do, and
- c) extra AUS to support the current AUS.

These will help manage their work and its pressures. In the next section I address those support networks that the AUS drew upon to support their personal and professional needs.

6.4 SUPPORT NETWORKS

In the previous section I discussed the key emergent support needs identified by AUS. I now explore those support networks that AUS drew upon to address their support needs in both practical and emotional elements of their work. I draw upon the support mechanisms used by other workers in order to understand and critique the support networks that were available and used by AUS. There were three main support networks that emerged from the data; *formal*, *ad-hoc*, and *family and friends*. It is useful to define what I mean by these support networks first. By *formal* I have deemed this as support from the HTA, normally upon AUS contacting the HTA or by them offering support

guidelines, and institutional formal support within their university, such as scheduled meetings, pre-arranged procedures and university counselling services. By *ad-hoc* I mean those which were established on a case-by-case basis when they were needed. These were often internal, between colleagues or close external staff, such as funeral directors or bereavement counsellors. Although these could also take the form of inter-unit meetings, normally arranged by the BSs. Both of these took place within a work context. By *family and friends*, I refer to those personal relations of the AUS, drawn upon in private outside of the work context. In this section I explore these three key support networks in turn beginning with formal support networks.

6.4.1 Formal Support Networks

Two formal support networks were identified by the AUS; the HTA and institutional formal support. There was also some external formal support that the AUS did not seem to be aware of or did not take up which will be highlighted. First, the HTA as a formal support network will be discussed and critiqued.

6.4.1.1 The HTA

Much of the communication with the HTA occurred between the DIs and the HTA. There were also differences evident between AUs in their relationship with the HTA, which affected their perceived ability to contact the HTA for support. For example, the DI at unit nine felt that she had “quite a good relationship with them.” As she “kn[e]w a couple of them very well so [...] [she] can just phone them up and ask” (Jane, unit nine). The BS agreed:

I phoned them just last week about a Will [...] they are very helpful [...]

(Alice, unit 9)

At this AU the previous network between the DI and the HTA staff meant that a relationship was formed, however this was not the case for all AUs, especially where the DI was not a member of the AUS team that dealt with FL. For example, at unit eleven, the DI was the director of the medical school and did not complete FL work. The DI was also removed spatially as their office was in a different part of the building. This was also true for Sheila at unit seventeen; she said: “I couldn't tell you anybody's name from the HTA. I don't know anybody's name. It's just this body ain't it, governing.” It was also an issue for temporary administration staff, who were employed to take on BS duties at unit four, that they were not able to build networks with the HTA as they were only in their role temporarily with no prior experience in the field. Most AUS were detached from the HTA as there was a difference between knowing one individual (as previously in the case of the Inspector of Anatomy under the Anatomy Act (1832-2004)) and knowing a large group of anonymous people from whom AUS received automated emails in response to their initial enquiry (at the HTA). As an urgent response was required in some cases it was understandable why AUS or DI made their own decisions around practice.

Although official support was not offered, it was clear from Alice's comment above that this was provided on an *ad-hoc* basis for some AUS. However, Sheila criticised that the HTA often referred the issue back to the DI. Many AUS described a similar issue.

[...] because the HTA, it's not that I would say it's that they're not supportive, but they do tend to refer things back to the DI. So, if you do have a question and you raise the question with them, they'll say well it's at the DI's discretion [...] [that's okay] if your DI's okay, but if you've got a corrupt DI (laughs) what do you do then?

(Sheila, unit 17)

Sheila made the point that if the AUS did not have a good working relationship with the DI this could cause further issues in not being able to gain support from the HTA. This was also an issue in those AUs where the DI was distanced from the FL team as described previously. Sheila continued to consider that “luckily” she was in a position where she could speak to the DI at her AU and she felt that she could question the DI’s opinion if she did not agree. The ability for AUS to be able to input their ideas and have control over their work was extremely important. Agency was also integral in other professions, especially those which involved *EL* such as nursing (Huynh, Alderson and Thompson, 2008).

There was confusion around the HTA’s support role as the AUS were seeking advice from the HTA, only to have their support request deflected back to the DI. Under the Human Tissue Act (2004-present) there was a feedback loop which usually ended with the individual AU’s DI making the final decision. This contributed to the differences in practice seen between AUs. I argue that best practice should be shared across UK AUs which would build towards positive change in practice over all AUs; suggestions follow in chapter seven. The HTA’s provision of support differed to that under the previous Anatomy Act (1832-2004) where the Inspector of Anatomy, one man, made the final decision on all of the queries directed to him. Sheila highlighted this difference and said that she felt formally supported under the Anatomy Act (1832-2004).

[...] before the Human Tissue Authority took over, we were governed by Her Majesty’s Inspector of Anatomy, so if we had any query, we’d pick the phone up and he’d be on the end of the phone and your answer would be instant. Whereas now you email the HTA and you get an email back saying, “we’ll deal with your enquiry within 28 days” and it’s not, you can’t have that sort of support in this procedure, it does need to be instant [...]

(Sheila, unit 17)

The automated message that AUS received in response to their query, the delay in time, along with the aforementioned re-direction of the query back to the AU's DI, all contributed to the AUS feeling that there was a lack of formal support from the HTA. This led to many AUS seeking internal support in lieu. However, this was understandable as the HTA's role was concerned only with the governance of the procurement, storage, use, display and disposal of human remains. The support that was previously provided by the Inspector of Anatomy under the Anatomy Act (1832-2004) was now delegated to the AU's DI as it was not the HTA's duty to address these issues. However, as I established in chapter five, the HTA would say if FL work was not completed to a high standard, thus deeming FL as integral. The AUS must then seek this support through other means, explored below in subsections 6.4.2 and 6.4.3. I argue that the HTA were viewed as OFSTED was among school educators in the UK (Gallagher and Smith, 2018); the HTA was to be feared rather than offering a supportive network for the AUS.

The change in management and procedures left the AUS feeling "scared" and confused as Sheila went on to criticise.

Yeah it was a real culture shock when [the HTA] took over yeah. Yeah it felt a bit, well from my point of view, I felt very scared about doing anything wrong, but didn't feel that there was a comprehensive set of rules to abide by, it was sort of a bit like, you know, just a bit unsure, but you can only do what you feel is right in line with the DI can't you really.

(Sheila, unit 17)

There was pressure from the HTA to do things right, but the AUS were left feeling unsure as there was not a "comprehensive set of rules". This put the AUS in a conflicted position where they felt confused and unsupported. It seemed that providing clear and comprehensive guidelines and support for the AUS was needed, but this was not likely

to come from the HTA. I suggest that the HTA needed to be explicit in their role, what they would support and what fell outside of their remit, to counter the confusion that AUS felt. As Sheila explained, AUS were used to one set of rules, overseen by one man, the Inspector of Anatomy, who was immediately contactable giving direct guidance of best practice. Thus, AUS believed the HTA would provide a similar service. Although, Sheila stressed that AUS could not challenge the Inspector of Anatomy's opinion as his way was the only way.

[...] you wouldn't have questioned his judgement, but sometimes that's not a bad thing. I think if you've got somebody, you know, that everything is black and white, you know, there's no grey area [...]

(Sheila, unit 17)

The AUS described that under the HTA there were fewer hard-set rules and AUS relied on gut feelings of what was right and expected of them by their DI. Thus, AUS felt that governance under the HTA was more flexible, which I argue resulted in differences in practice between AUs. However, because of the lack of communication between individual AUs there became disparity in practice. As a result of this thesis, I bring together best practice at each AU, in the hope that it will:

- a) lessen the gap between practice at individual AUs,
- b) encourage communication, and
- c) the sharing of best practice.

The guidelines offer examples that otherwise would not have been shared across AUs. These guidelines may become a reference bank of information to support the AUS throughout the BD process, including their important and integral FL work. These may also be a useful tool in training the AUS. Next, I address the second emergent formal support network.

6.4.1.2 Institutional Formal Support

Despite the minimal formal support obtained from the HTA, formal support was offered by the institution through scheduled meetings or pre-arranged procedures at the individual AUs. For some AUS this was through weekly meetings with the whole team (Alice, unit nine) or an annual review meeting after the thanksgiving service (Sheila, unit seventeen). These were important ways that AUS could share and review best practice internally. However, not all AUs had this internal formal support and relied solely on *ad-hoc* support, as I discuss in subsection 6.4.2.

Furthermore, it was apparent that AUS were aware of wider university services, such as counselling, that were available.

The university has counselling services, so if something did get, you know, to that point, there are other steps you can take to talk things through [...]

(Alice, unit 9)

It was clear that AUS felt that these services could only be drawn upon as a last resort, in those extreme cases where all other support mechanisms had been sought. For example, many AUS drew upon their *ad-hoc* and family and friends support networks before they considered formal internal support, such as counselling. However, formal internal support should not be seen as a last resort but something that was appropriate to use throughout the process to address support needs. This was similar to police culture, which was “masculine”, “aggressive” and “tough” (Brown, 1994: 151), where police were hardened to the emotional effects of their work and went by the rule of “chin up and bear it.” Stratton (1984: 281) asserted that police had a “macho image, [with a] need for non-emotional responses.”

There was also an issue that these services were not specific to the AUS role as they were for university staff in general. However, the AUS did not seek private services either. They mostly used their colleagues as an internal *ad-hoc* support network, as they were the only people who truly comprehended the unique nature of the work that they were doing; they were insiders. Furthermore, the lack of institutional understanding and recognition of AUS work, as I discussed in section 6.2, affected the AUS's take up of institutional support. For example, it was apparent in the ethnographic case study that the managers of the AUS, such as the Head of Anatomy or the Dean of the Medical School were seen as outsiders, as they were disconnected from the practices and procedures of the procurement and disposal of bodies, in particular the FL work that was involved.

It was also useful for AUS to know that their colleagues could step in and support them if they needed to take a break from their work. This was a pre-emptive internal formal support mechanism. The ability to step back when necessary, with no severe consequences, was a useful and valued support tool for some. However, there was a lack of this form of support at some AU's due to a lack of AUS, as I previously discussed in section 6.3, where others were not trained to take over or offer time out which was beneficial (O'Brien and Linehan, 2018; O'Donohoe and Turley, 2006). Alice explained the fortunate situation at unit nine:

[...] we've also got enough people on the team that if you we're feeling too stressed to do it on a given day somebody else could take over, and you could do something else, and I think that's important to be able to step away as well. So, we have got back up for one another, which I think is very important, those are the safety nets really aren't they? [...] we've introduced that over the last few years [...] [previously] it's been a sole person doing it, and that's too much.

(Alice, unit 9)

Alice described the ability for colleagues to take over, along with university counselling services, as the “safety nets”, indicating that these were put in place to allow for a safe supported work environment for the AUS. Taking time out and the need for extra AUS to cover was justified because FL work was seen among the most difficult types of work (Dent, Buke and Green, 1991; Hochschild, 1979, 1983; James, 1989, 1992; Smith, 1988, 1992; Taylor, 1998). Thus, AUS would often fulfil other duties, such as administration work, for example, replying to emails or filing, as these were deemed less stressful aspects of their role. I address this further in subsection 6.4.2 as this internal support was conducted on an *ad-hoc* basis.

Jane highlighted the importance of having adequately trained individuals to be able to step in.

It's really tricky because you need someone with a level of knowledge to come in and take it, but that's why we've trained a lot of people in the office around Alice, so she can have holidays and go away [...] they are trained up and they'll step into the role should Alice decide to go.

(Jane, unit 9)

These mechanisms allowed AUS to have holidays where they were not worried about the AU in their absence, though, I argue that there were particular tasks that institutional outsiders could help with. For example, it was clear in the ethnographic case study that the institution's communications team aided the AUS in planning and facilitating the thanksgiving service. This relieved the AUS of some of the practical tasks in preparing for this important event. Next, I explore formal support that was not recognised by AUS.

6.4.1.3 Formal Support Not Recognised by AUS

There were also associations such as the Association of Anatomical Pathology Technology (AAPT) that offered events, such as the Mortuary Managers Study Day, which may be a way in which MMs could be supported formally. This was an annual event which allowed MMs and senior Anatomy Pathology Technologists “the opportunity to discuss and obtain support on non-technical management-related issues.” (AAPT, 2018). The AAPT maintained that: “These roles can feel isolated, with little training available, and we recognise the importance of peer support” (*ibid.*). Thus, the AAPT appreciated the nature of the roles and how this resulted in AUS feeling unsupported. However, when discussing support networks with the AUS, they did not seem to be aware of or take up these events offered externally.

In this subsection I have shown that there were minimal formal support networks for AUS FL work, which was an integral and difficult part of the AUS’s roles. The major shortfall in this minimal formal support seemed to be due to the governing body, the HTA, not being in charge of this aspect of their work. I presented a case for the HTA’s role to be made explicit, to lessen confusion for AUS and help them better address their support needs. I demonstrated that AUS drew upon their internal formal support network where this was in place however, it was not available for all AUS. Furthermore, it was clear that AUS did not recognise or take up the external formal support that was available to them. Moreover, in lieu of formal support, AUS were mainly seeking support from their *ad-hoc* support network and the support of family and friends which I discuss in the following sections.

6.4.2 Ad-Hoc Support Networks

In contrast to the formal support network described above, the *ad-hoc* support network were those internal colleagues, inter-unit contact,

contact between AU DIs, and external colleagues, such as funeral directors and bereavement counsellors. These were drawn upon on an *ad-hoc* basis. Each will be discussed in turn in this section.

6.4.2.1 Internal *Ad-Hoc* Support Network

Many of the AUS drew upon their internal *ad-hoc* support network for multiple reasons. One such reason, described previously in subsection 6.4.1, was the lack of formal support for the majority of AUS. Another reason was because the internal *ad-hoc* support network was most beneficial and convenient which was due to the AUS's status, spatial dynamics, and nature of AUS support needs. Their status as dirty workers, as they worked with the polluting dead (Douglas, 1966; Howarth, 1996), meant that they were separate from society, as were other dirty workers, such as funeral directors, whose work was perceived as degrading and disgusting (Ashforth and Kreiner, 1999). AUS were also deathworkers, like funeral directors, who possess "an "outsider" status in society" (Howarth, 1996: 4). AUS also resided in a space separate from the rest of the department/university. The AU was regarded as a safe space, a closed, heterotopic (Foucault, 1967) and liminal space (Turner, 1969; Van Gennep, 1960) that was other. The spatial dynamics and nature of their work meant that individuals outside the AU were not drawn upon as they did not comprehend and were removed from the AUS's dirty work. This explained why AUS used the internal *ad-hoc* support group most prominently. AUS were thus separated from external sources of support as only internal AUS appreciated the unique nature of their work and that support was needed on an *ad-hoc* basis. It was also frowned upon, as I demonstrate in section 6.4.3, to take work outside of the AU, due to confidential information and the idea that work should be dealt with at work.

The AUS were able to be open within the space yet when leaving the AU, the conversations changed. This was apparent when I visited the AUs, during interviews and most evident within the ethnographic case study. For example, Tom said that he did not talk about what he really did outside of the AU; he stressed, “we cannot discuss what we do in here outside of the anatomy unit.” Tom often remarked upon the AU being a hidden place with nobody being aware of its inner workings. On one occasion Tom wanted to go to the medical school café to get lunch however, he asked another colleague to get his lunch as he did not want to leave the AU in his scrubs. This was because wearing scrubs would provoke questions, as they were deemed out of place at the university and it would be unhygienic to wear them outside of the AU. His uniform thus positioned him as an outsider. This supported Ashforth and Kreiner (1999) and Hochschild (1983) as they proposed that shielding their status or identity helped those doing dirty work to lessen the stigmatisation. Accordingly, there was a prevailing premise that those outside the AU did not know what went on inside, and it should stay that way. This could be conceptualised by applying Goffman’s (1959) analogy of the front stage/back stage dynamic where the AUS were separating the back stage from the front stage in keeping it hidden. They were using “[...] stratagems for averting or masking its hostile destructive force [...]” (Duvignaud, 1973: 86). This front stage/back stage divide could also be seen in the way the bodies were collected when being taken for disposal as they were taken in an unmarked private ambulance out the back entrance of the AU, which could not be seen by other university members.

In fact, AUS across all AUs noted that the AUS team were separate from the wider medical school and university as nobody knew about the hidden work (physically and in content) that they did. AUS worked behind the scenes (Goffman, 1959). Charlotte supported this:

I think compared to other medical schools we are quite a small team, I think we're like our own little unit, and we don't have much interference from the rest of the medical school, we kind of just do what we do and we're left alone. Which is good.

(Charlotte, unit 11)

This left AUS feeling secluded from the wider university, which was detrimental to their ability to use external and formal support networks, or even *ad-hoc* inter-unit support networks; they were more likely to use their internal *ad-hoc* support networks, although it was evident that the AUS liked to be left alone to complete their work. It must be questioned then whether the AUS would want formal support and may explain why the external formal support available was not accessed as I highlighted in the previous subsection.

Due to the spatial dynamics and close-knit nature of the AUS groups many said, echoing Carrie, that “everything” should be discussed with internal colleagues.

There shouldn't be any secrets in a place like this. It is the kind of place that you should discuss everything.

(Carrie, unit 17)

Indeed, I witnessed that many matters, topics and issues, both professional and personal, and practical and emotional, from the mundane to the important, were discussed. The AU was a place in which things were shared and dealt with collectively. AUS formed small close-knit groups of individuals who often remained in their roles for a long period of time; therefore, close work and personal relationships formed between them. AUS often had one or two close colleagues that they frequently spoke to about their work.

I have a lot of conversations with Jane (laughs), she's my ear (laughs), and that always helps when you've got someone to

talk it through with and just have a moan about it. I think it helps doesn't it, puts the day at rest in a way. [...] I always feel that there is an ear there if I've got a problem, there's always someone to turn to and I think that's the most important thing.

(Alice, unit 9)

The knowledge that a supportive colleague was there for whatever reason, big or small, was highly regarded by AUS. The previous excerpt came from a group interview with Jane and Alice; the light-hearted and easy way Alice spoke about drawing on Jane for support demonstrated the truthfulness of this comment. Alice also argued that the support of her colleague “puts the day at rest”, meaning that she did not take her work home and draw upon her family and friends as a support network, which I discuss in subsection 6.4.3. AUS felt it was extremely important to be able to leave work at work, in part because their family and friends often did not understand their work as well as their colleagues, as they were ‘outsiders’, but also because it was important to have a work-life divide, especially with a role that was so emotionally demanding. Katz (1996: 136) supported the importance of dividing work issues from nurse’s private lives, stating that “[...] nurses suggested that they compartmentalised work issues, separating them from their private lives.” Rest, separation and detachment from work at the end of the day was integral for AUS to continue work the following day. However, as evident in this section, this was not always possible for AUS to do.

Some BSs shared roles with colleagues on a part-time basis or some AUs had more than one member of AUS sharing the duties. The latter addressed the support need presented in section 6.3 as AUS were able to share their work (particularly their emotional duties) on an *ad-hoc* basis. It was helpful to have a colleague that comprehended exactly the role they were doing. Sheila, the BS at unit seventeen, had a part-time job share of the BS role with her colleague Pat where they

overlapped for one day a week and shared the BS duties. She explained her position after Pat's retirement.

It's scary for me though, I've always had Pat there with me and now I'm all on my own (laughs) [...] she's only on the end of the phone [...] it is strange not having someone to bounce ideas off of, although [the MMs] there, I know she is, and I could talk to her about it, but it is weird not having somebody around.

(Sheila, unit 17)

When the team changed, or a colleague was absent, AUS said they felt unsupported and some drew upon alternative support networks, for example in the absence of her colleague, Sheila was more likely to draw upon her family and friends for support as discussed in the following subsection (6.4.3). The lack of uptake of the support from the MM was likely due to the physical separation in space, as the MM's office was based in the DR, which was in a different part of the building to Sheila's office. Therefore, she had to pass through several thresholds and exit the space before she could arrive at the MM's office. For example, there were doors that required key codes or key passes; there was also a walkway between the separate parts of the building. This made it a physical effort to make the journey. It was also a ritual effort for Sheila as it meant exiting the space of her office and passing through the thresholds into the liminal space (Turner, 1969; Van Gennep, 1960) of the dissection room (DR) where the MM's office was located. She experienced *separation* (first stage) (*ibid.*) from the outside (the university) upon entering the liminal space of the DR. It was also significant that Sheila did not like seeing the cadavers; she actively avoided entering the DR which was a coping mechanism that prevented her from accessing the internal *ad-hoc* support available.

Furthermore, Sheila viewed the AU as a strange, off-centre and atypical space where the body was dealt with; constituting a heterotopic space similar to the cemetery in Foucault's (1967)

analogy. Sheila felt that her office was a safe space and her work, solely FL work, was contained within this space. Therefore, it was often only a one-way commute as the MM often made the journey to the BS to deliver consent forms for example. However, she often saved these up as to only make one trip as this was more time efficient. Thus, spatial dynamics and use of coping mechanisms affected how the BS did her job. It was difficult for Sheila to communicate with the MM, compared to her job-share colleague with whom she previously shared an office.

However, for some AUS, like Charlotte, who was the only person doing her role, they felt that they did not need the support of colleagues. I assert that this was due to these AUS making the assumption that other AUS did not appreciate the unique nature of the FL work they did. It was clear that Charlotte viewed her internal colleagues as outsiders. It was evident then that some AUS did not draw on formal or even *ad-hoc* support mechanisms.

I mean nobody really does this apart from me, umm, so I guess in that way I don't really have anybody to talk to, but then I don't really feel that I need to, you know, if I don't know the answer there's nobody else that's going to know the answer, so it's just a matter of asking advice on maybe how you should approach something [...] or [the DI], he's always very helpful if it's a HTA thing, he's much better at the legalities than I am, so if I'm struggling with something like that then I'll go to him.

(Charlotte, unit 11)

It was problematic that AUS did not feel they could use any support networks. This may be because these were not available, or AUS did not realise they were using them. For example, Charlotte did not consider that she used her internal *ad-hoc* support network however, I argue that she was, as she drew upon her colleagues and DI. It was also apparent, when I visited for interview, that Charlotte discussed seemingly menial issues with colleagues over coffee for example.

Charlotte compartmentalised the support she received. For example, colleagues only gave general advice and the DI only gave legal support regarding the HTA, as this was his area of expertise. Thus, Charlotte drew upon the DI (internal *ad-hoc*) rather than the HTA (formal) for such support.

I observed that there was a hierarchy within the internal *ad-hoc* support network. In the first instance it was provided by the BS, MM, or member of the technical team, then by the DI, and then by the deputy or head of anatomy. For example, June, the BS at unit eight, reflected, “I think coping with it is talking to [the DI] afterwards and talking to [the deputy of anatomy] on a difficult day.” Which member of the internal *ad-hoc* support network was consulted depended on the severity, content and context of the issue. The hierarchies within individual AUs and the spatial relationships between the AUS’s offices/working areas also influenced the uptake of this support network. However, most AUS said that they had never gone beyond internal *ad-hoc* support as Anthony, the DI at unit two, explained.

[Support] is in the first instance provided by myself [the DI], but there are obviously avenues where staff will get pastoral type support and counselling and so on. It's never gotten to the point where we need it. A lot of what we will do is support each other in the team [...] it's a bit of group therapy [...] Generally, we seem to kind of cope as a group. So, it's finding like minds and just chatting about it.

(Anthony, unit 2)

It was evident that AUS did not take up university pastoral support. There was a consensus that issues could and should be first and foremost addressed by the AUS internally. Anthony described this internal *ad-hoc* support at unit two as “group therapy” in which the AUS took on extra work in providing themselves with support. Anthony continued:

[...] if [the mortuary manager] found something that was a challenge we would help him deal with it in terms of maybe the paperwork, the procedures and so on, take some of the load, obviously we couldn't take the emotional thing directly but it's just taking some of the administrative and procedural work does help to lighten things, so if there was a difficult conversation to be had and maybe a letter to be sent out I might write a letter instead because I'm viewing it as kind of an outsider, I can do it in a less involved fashion.

(Anthony, unit 2)

Included in this “group therapy” was another AUS member taking on the physical aspects of the role, such as administrative work, as previously discussed in subsection 6.4.1. This took the burden off the colleague that required support and allowed them to do their more difficult FL work and deal with the emotional burden involved. It was thus clear that *EM* was valued as hard and productive work by Anthony and AUS at unit two. This supported the aim for this work to be conceptualised as such (Dent, Buke and Green, 1991; Hochschild, 1979, 1983; James, 1989, 1992; Smith, 1988, 1992; Taylor, 1998). It was recognised that the emotional burden could not be relieved in the same way but taking on other tasks could help. As previously highlighted, this was similar to OPOs who shared the work at “either end” as performing both (physical and emotional) could be “exhausting” (Sharp, 2006: 52). Thus, this “group therapy” addressed the support need for extra staff to take on duties to cover AUS raised in section 6.3. Next, I move on to consider the inter-unit *ad-hoc* support network.

6.4.2.2 Inter-Unit *Ad-Hoc* Support Network

AUS, usually BSs, also arranged meetings on an *ad-hoc* basis where they would meet at one AU to discuss best practice. I call this the inter-unit *ad-hoc* support network. Sheila commented that the inter-unit *ad-*

hoc support network was particularly useful in readdressing practice and discovering best practice.

Yeah like we all do the same process, but we all do it slightly different. So like in the past - we had a meeting here and bequeathal officers came here, er and we like exchanged information that we sent out [...] I think sometimes as well because you do something for so long, not that you get blasé about it, but you're doing it because it works, and then when you meet the other people involved in it and they say oh we do this, and you think that's a really good idea, I've not thought about that before. So, like I say I would really like us to get together again, I find it really useful.

(Sheila, unit 17)

The AUS were aware of the differences between AU practice and took the initiative to arrange meetings on an *ad-hoc* basis. There was a call for inter-unit best practice sharing. I argue that this was a way in which AUS were making up for the lack of formal best practice recommendations and support. The AUS were resorting to other support networks to fulfil their support needs.

However, Sheila was particularly active in her engagement with the inter-unit *ad-hoc* support network, whereas other AUS noted that they did not find this useful, but that having the support options available was valued. Sheila described multiple regional and multi-regional meetings that she had attended and also mentioned that the Institute of Anatomical Sciences Meeting was a good way of engaging with the inter-unit *ad-hoc* support group as BSs and other AUS often attended. This was a bi-annual two-day meeting which brought together anatomical professionals to share research and network. Sheila also stressed that it was useful to keep up to date with changes with regard to AUs to whom they could refer potential donors; as I described in chapter four, some AUs accept certain medical conditions that others would not, and this changed depending on the programme of teaching.

This saved the AUS from completing unnecessary extra work around the referral of bodies.

The inter-unit *ad-hoc* support network also manifested through telephone and email contact as Alice at unit nine and Sheila at unit seventeen highlighted.

We've got good relationships with them all and we all email, you know somebody has a query they'll email round to everybody [...] it's really good. That's a nice support back up as well.

(Alice, unit 9)

We are quite a close community and I always feel that I could just ask, I could just email any of them at any time and you know they'd all come back with their thoughts or advice.

(Sheila, unit 17)

It was again apparent that talking to other AUs was only possible due to the good relationships between external colleagues. Some AUS noted that attending face-to-face meetings helped facilitate these good relationships. This posed a problem for AUS that did not attend such meetings or had not developed good relationships with peers at other AUs. These AUS may then be forced to draw upon alternative support mechanisms.

It was also clear that regional inter-unit support groups formed where geographically proximal AUs would support each other. This was similar to the geographical alliances and exchange relationships discussed in chapter four regarding the referral of bodies. AUS also attended thanksgiving services at geographically proximal AUs as a way of gaining best practice recommendations in the way that other AUs ran their services. Sheila explained:

So, we've been to one at [a geographically proximal unit] and I'd quite like to go to someone else's you know just to see how someone else does it.

(Sheila, unit 17)

It was often the case that AUS did not feel that they could attend other AU's services that were out of their region, perhaps because good relationships had not been formed with these AUs. It was apparent then that these regional alliances were not just generated due to practical issues, such as the referral of bodies, but because of procedural and FL best practice sharing.

In one interview with a BS from a southern UK university it was clear that she wanted to meet up with peers at a different AU but was not informed of the meet ups or felt that she could afford the travel time. The fact that AUS were very busy made it understandable why they formed regional alliances, as this was what was practical to reduce the extra time in travelling to meetings. This also explained why most of the inter-unit *ad-hoc* support manifested itself through emails and telephone calls as this was more time efficient. Thus, the support networks used were also a result of the practicalities of their role. This may be why some AUS drew only upon their internal *ad-hoc* support network as this was the most convenient. Next, I explore the third emergent *ad-hoc* support network which was also informed by regional alliances.

6.4.2.3 DI-to-DI Support Network

In a similar light, DIs, again usually from regionally proximal AUs, or those that had connections through networking or previous working relationships, sometimes supported each other and shared best practice. The DI-to-DI support mainly manifested itself through annual site visits, which were mechanisms put in place by DIs to share best

practice in preparation for the official HTA inspection visits. Anthony explained:

Well the communication we tend to have is between DIs usually, because we tend to do site visit type inspections annually. So, I'll go over to a facility to do a site visit, make some comments and I'll make some suggestions, I'll share the best practice there, but it's usually DI-to-DI [...] but we don't formally share. [...] if I go over to do a site visit and there's something particular that they're doing that I think is nice, then I'll come back and you know suggest we do it [...] I think that's partly because the DI is the decision maker, as it were, as to how the policies and procedures run so it's important to have that communication. [...] it's been advised from the HTA, but also something we've just done routinely. Partly to make sure that institutions are prepared for the next HTA site visit [...]

(Anthony, unit 2)

Anthony asserted that because the DIs were the ones who have the influence in how policies and changes were implemented, then it was them who sought and shared best practice with their own team. However, this best practice was not formally shared across all AUs. This meant that best practice remained within a small group of people, often between two regionally proximal AUs. Each new visit resulted in a closed model of best practice sharing. This was likely because there was no incentive or means to share this best practice among the whole group, no formal way of recording this, and because support was often only provided in response to a request. Thus, I argue that the opportunity for wider support and development was lost. This might have been because AUs, although adhering to the same flexible HTA guidelines, had a competitive nature. Thus, these closed modules of best practice sharing may only work because practice recommendations were exchanged. This inter-unit competition may be inherent within the AU working culture as the AU, operating within a university, were competing for the best applicants and for their institution to be deemed in a positive light. This was apparent when I visited the AUs and during interviews; AUs were proud of the work

that they did and often, if there was a particularly innovative or novel thing they were doing in FL, they kept this within their AU or geographical area where regional alliances had formed. Next, I turn my attention to the final emergent *ad-hoc* support network.

6.4.2.4 External Ad-Hoc Support Network

AUS also sought support from external colleagues, such as funeral directors, as they worked in similar FL roles.

[...] I did spend a lot of time on the phone to the crematorium manager because obviously he's experienced in this sort of thing as well – in family disputes [...] he's been there 12 years and we've got quite a good relationship with him [...] he'd tell me how we stood from his point of view [...] having him on the end of the phone was a real bonus.

(Sheila, unit 17)

This demonstrated that it was not just AUS peers that could empathise with and thus provide support for AUS, especially in their FL work. By having a similar point of view in a different context, funeral directors proved a helpful support resource for both practical and emotional issues. Although, again, having a good relationship with the AU's associated funeral director over a long period of time was integral to the support provided. It was important that AUS remained in their roles for a long period of time to be able to develop these long-standing relationships with external colleagues. This could prove difficult for those AUs with temporary staff; however, for the AU that had a temporary staff member at the time of interview it seemed that they had fitted in well and got on with the funeral directors, even though they had only been there for a short amount of time.

It was also useful for AUS to draw upon local bereavement counsellors that worked at hospitals from which many of the donors were patients;

however, this was rare as many AUS were not aware of such individuals and did not have contact with them. Carrie described delegating work to local bereavement counsellors when families asked for her to do the work of a bereavement counsellor that was 'over and above' as discussed in section 6.3.

I try and leave that to the bereavement officers [...] the circle bereavement officers we've got at the moment are incredibly helpful [...]

(Carrie, unit 17)

It was very useful for AUS to have the appropriate contacts to delegate 'over and above' work to which relieved them of tasks which they were not trained or contracted to do thus addressing their support needs. I investigate the final emergent support network in the next subsection.

6.4.3 Family and Friends as a Support Network

Family and friends were also used as a support network, albeit much less than the *ad-hoc* support network, but considerably more than the formal support network. This was often used if the necessary support could not be gained from the internal colleagues within the AU. However, AUS did emphasise that they tried, where possible, not to take their support needs home, especially for emotional and confidential issues. It was clear that taking things home was seen as negative and a last resort for particularly difficult cases among AUS. In fact, ability to detach from work was encouraged across all professions (Smit, 2015: 493) as it "[...] is an important prerequisite to effective daily recovery and psychological well-being." However, Gallie et al. (1998) found that seventy-two per cent of workers reported worrying about their job after work and twenty-two per cent said they worried regularly. In addition, those cases that spanned over multiple

days or re-occurred also counteracted the necessity to detach from work that Smit (2015) described.

It needs to be discussed and resolved in the office and part of the role is learning that you have to leave work at work, those aspects of work at least. Umm sometimes, depending on the issue, you may have to carry it on because it's a big far-reaching type event, and the tendency is to try and dissociate yourself from things at work, and deal with them as best as possible at work, so you can go off and, you know, so you don't have that emotional baggage.

(Anthony, unit 2)

By “those aspects of work” Anthony was referring to the confidential and emotional aspects of the work associated with FL. It was evident that these aspects were viewed and dealt with differently and should remain in work where possible; AUS should avoid drawing upon their family and friends network to deal with them. Anthony also emphasised the ability to “dissociate” as a key skill that AUS must learn in order to cope with their role. I argue that these key skills were actually coping mechanisms that AUS employed in order to deal with their work and avoid drawing upon friends and family as a support network. Additional coping strategies are discussed in the next section (6.5).

For some AUS however, avoiding taking issues home and drawing upon their friends and family proved difficult; for example, June, the BS at unit eight, said that she thought about people and conversations afterwards which often extended into her personal life. June said that she tried to deal with the things that were bothering her with her colleagues whilst at the AU but said that they sometimes stayed in her head on the way home. June had to make a conscious effort to switch off from these things, but it was not always possible (June, unit eight, non-recorded interview notes). This was likely because the journey home, whether walking, by train or by car, was the space in which the

day's events were contemplated after exiting the liminal space (Turner, 1969; Van Gennep, 1960) of the AU. The journey home from the AU was a transitional space. The individual reintegrated into society after exiting the situation and they considered what they had experienced in the liminal space (*ibid.*).

Often families and friends would ask about their day and it was difficult for AUS not to talk about the people and conversations that remained in their head. For most AUS it was the difficult cases that stuck with them.

There are days when I take things home with me if there's been a difficult conversation or something then yeah you do take it home.

(Alice, unit 9)

AUS also found that speaking to outsiders could lead them to consider the strangeness of their job as Carrie explained below. AUS recognised themselves as deathworkers doing dirty work, a job which was viewed as other by society (Douglas, 1966; Howarth, 1996).

[...] yes I can go home and leave the bodies and things here and occasionally I say to a friend of mine we got the bodies out today [...] I say "I walked past 26 tables with dead bodies on and didn't bat an eyelid you know, what is the matter with me?"

(Carrie, unit 17)

Speaking to friends and family could have a negative effect and AUS were often reluctant to use their family and friends as a support network as the latter were outsiders. It was the similarity in role and ability to empathise that were the appeals of using the *ad-hoc* support networks. There was also a data protection and confidentiality aspect of drawing upon family and friends which was not present with *ad-hoc* support networks, as the information regarding the potential donors,

donors and their families was confidential and should not be discussed with family and friends.

Having assessed the three main support networks that AUS used it was clear that the main support network that AUS drew upon was the *ad-hoc* support network where internal colleagues, inter-unit support, and DI-to-DI support (usually between geographically proximal units), or close external staff were drawn upon. However, the internal *ad-hoc* support network was most frequently used and was utilised in the first instance. Most support was drawn upon on an *ad-hoc* basis where problems were solved as they arose. Thus, *ad-hoc* support best suited these requirements. Drawing upon internal colleagues was also suitable as they were insiders who comprehended and could emphasise with the issues, especially those emotional and FL issues. It was encouraging that such work was viewed as hard and productive and recognised as a unique aspect of the AUS role. It was apparent that AUS used *ad-hoc* support because they felt that formal support was not sufficient or available. However, it was also evident that not all issues were resolved at work and some were taken home as AUS drew upon their family and friends as a support network in some cases. Next, I explore the coping strategies AUS used in addition to their support networks.

6.5 COPING STRATEGIES

It's my job and I deal with it because it's my job

(Carrie, unit 17)

As I established in chapters four and five, and throughout this chapter, the AUS role came with many physical and emotional challenges that were not always recognised and supported. Bolton (2001: 96) described the use of coping strategies for nursing professionals

positing that, “[d]ue to the nature of much of their work, nurses create their own coping mechanisms, their own methods of letting off steam and their own ways of presenting the ‘correct face’.” I argue that this was also true for AUS, where they were inventive in their methods of coping in order to do their work. The most prominently used coping strategy was dark and gallows humour. This will be focussed on and explored further in this section as an example. The other three emergent coping strategies were dehumanising tactics, detachment and avoidance behaviours, and justifying the donation. These strategies were used by AUS to separate the practical side of their role from the FL work, to make it possible for them to complete their FL duties. The four emergent coping strategies were evident during the interviews, participant observations during visits to the AUs, and the ethnographic case study. These were used on an *ad-hoc* basis in everyday work and were employed immediately to address issues as they arose. I argue that most of these coping strategies were emotion work; that which AUS completed on themselves that was not dictated by the organisational feeling rules (Hochschild, 1990). In her earlier work Hochschild (1979: 266) asserted: ““emotion work” refers more broadly to the act of evoking or shaping, as well as supressing, feeling in oneself.” Later Hochschild (1990: 118) clarified: “[...] by “emotion work” I refer to the emotion management we do in private life; by “emotional labor” I refer to the emotion management we do for a wage.” However, I agree with Bolton (2000) that the public/private dichotomy was drawn upon too heavily as I have shown that in fact AUS were completing emotion work in the workplace; in the public space. AUS emotion work was not directly or knowingly exchanged for a wage but must be viewed as a component of AUS work and therefore dealt with in the workplace, especially, as discussed in section 6.4, because it was preferred that work was kept at work; this included personal emotions. I argue that personal emotions were therefore not always carried out in the private sphere as Hochschild (1979, 1983, 1990) claimed. I now focus on dark and gallows humour.

6.5.1 Dark and Gallows Humour

Dark and gallows humour was the most prominent coping strategy used by individual AUS and by groups of AUS. It was used in multiple ways, for example to deal with their dual role in practically dealing with the bodies and liaising with family members, similar to medical educators (Prentice, 2013) and OPOs (Sharp, 2006). AUS thus offered humour as a type of philanthropic *EM*. Humour was a break from other types of *EM* too, such as the smiley face or professional face (Bolton, 2001). AUS also discussed issues between colleagues under the guise of humour. Humour was also used as a form of emotion work to deal with their personal emotional responses to situations – for example laughing at one’s self crying. I have also indicated throughout this thesis that AUS often laughed in interviews at presumably serious issues and circumstances they were describing. Finally, humour was used as a group coping strategy where AUS enjoyed down time in off-stage areas (Goffman, 1959).

Dark humour was used generally within the office with reference to the AUS and their roles in general however, AUS also applied dark humour to specific cases and scenarios in order to cope with what they were doing. For example, on embalming a body, a practical rather than FL task, Annie used dark humour which changed the mood of the situation.

[...] you can be feeling quite sad like that when the person you’re embalming suddenly does a big poo on the table and you have to laugh, and it sort of changes the mood.

(Annie, unit 17)

This can be described as pure humour (Fox, 1990); the genuine pleasure from their interaction with bodies. As evidenced later in this subsection AUS also gained this ‘pure’ humour through their

interactions with each other and the families of donors in some cases. This was similar to that which nurses got from each other and from their patients (Sumners, 1990). Humour was often the initial reaction to tasks that could be unusual and upsetting, like embalming, dissecting or creating prosections (where an experienced anatomist dissected parts of a cadaver to demonstrate anatomical structures to students). Annie described the “unspeakable brutality” involved in her role:

I feel like I inhabit different worlds, I feel like I inhabit a world of of sort of gallows humour and (laughs) of effectively unspeakable brutality, of the type that wouldn't happen anywhere other than here, “oh I'm just going to hack this leg off this person because we don't need it anymore.” I inhabit that world, but I also inhabit a world where I'm dealing with traumatised people who've just lost somebody [...] it's quite varied.

(Annie, unit 17)

Here Annie used the term “gallows humour”, which was “sinister and ironic humour” in hopeless or desperate situations (Collins Dictionary, 2018), to refer to the practical side of her role. There were multiple and intersecting aspects of the AUS role, one of a practical nature in dealing with the bodies, which could be brutal, and the other in dealing with the families, which could be emotional. Most AUS (with the exception of those like Sheila who actively avoided the cadavers) were Janus faced as they occupied two positionalities within their role; that of facing the family and potential donors and that of dealing with the cadavers which they had to switch between. AUS also “walk a tightrope between respecting the emotional fragility of kin and remaining true to the ideological premises that drive their work” (Sharp, 2006: 75). They must attend to comforting kin as well as supporting their professional duties (i.e. body procurement).

Carrie described that the bodies were in the AU as anatomical learning aids which meant that there was no reason why there could not be a light-hearted atmosphere.

[...] it's not a funeral parlour, so people don't come in here because they've got a relative that's just died, people come in here to learn anatomy from dead people. There is no reason why it shouldn't be fun.

(Carrie, unit 17)

Carrie explained that there was a fine line between allowing the DR to have a light-hearted, fun and humorous atmosphere and the humour being used disrespectfully. The AUS explained to the students at the beginning of their time in the DR that “being respectful doesn't mean you can't have fun.” (Carrie, unit seventeen). Carrie elaborated:

[...] the distinction I suppose is that you don't have fun at the expense of these people you know, the fun is around and about the place, it's not about these people you know, and that's the difference. [...] carry on being respectful and treat these people with the dignity that they deserve, but you can still have fun.

(Carrie, unit 17)

It was clear across all AUs that bodies were treated with utmost respect and their dignity was preserved, even with the much-needed use of the humour coping mechanism, as the humour was never directly related to the body donors; it came from the AU or dissection room environment.

Humour was also used between colleagues in relation to their roles.

I have no plans on leaving anyway (laughs). [The DI] always says to me you can't get pregnant, and I will say I'm a bit old for that now (laughs), but when I was younger that was his main concern.

(Charlotte, unit 11)

This was just one example of how issues were discussed under the guise of humour to avoid difficult issues in some cases, although through using coping strategies, such as dark humour, it was evident that AUS sometimes did not feel that they could delve into the sensitivities of certain issues – they often brushed things off, downplayed them or made light of the issue with humour. This was very similar in police work cultures (Joyce, 1989; Mitchell, 1996).

AUS felt that they needed to have a serious work-self/humorous work-self divide for several reasons. First, because it was an important way of coping and for AUS to take a break from their hard and emotionally exhaustive FL work. This was down-time between colleagues where they could “play” as Anthony portrayed.

[...] [when] we're on the phone with somebody, a family member and so on, we've got to be serious, we've got to be engaged and so on and you're taking all of this in, sometimes it's an emotional drain [...] you want to make an emotional link and that's giving, giving, giving, umm so when we are off that there is a lot of: let's play together, let's cope with this sort of thing, let's keep these things light. Yes, things are serious out there, but we don't have to be serious all the time.

(Anthony, unit 2)

The FL work was emotionally draining for AUS and the families were taking from the AUS; the AUS were giving but not receiving respite. Again, it was the *EM* that was regarded as difficult work for AUS. They needed lightness and humour in their down time to cope with the seriousness of their FL work. It was in these off-stage areas (Goffman, 1959), in the bounded liminal and heterotopic space of the AU away

from families (Foucault, 1967; Turner, 1969; Van Gennep, 1960), that this humorous behaviour could be exhibited (Ackroyd and Thompson, 1999; Bolton, 2001).

Second, because AUS felt they could not use humour when on the phone with families, or physically around families (when they occasionally entered the space to collect ashes for example, or at thanksgiving services), even though this was in the space of the AU. Although the spatial dynamics allowed humour to be used, it was the individuals within the space that deemed whether humour could be used. This was for similar reasons to that which were discussed in section 6.3, where AUS actively hid their personal emotional response in order to remain professional. AUS could use humour around colleagues in the AU but not around families. In the ethnographic case study I observed that the AUS's behaviour would change if a family member entered the AU to collect ashes for example. It was sometimes the case that humour could be carried out with some potential donors and families, but only if the families initiated it. Again, the boundary was set by the families and it was families who influenced the way the AUS completed their work.

[...] I had a man who rang up and he was just cracking jokes all the time [...] he was laughing all the time, he thought it was hilarious, [...] I have had two or three of those.

(Carrie, unit 17)

Carrie was using her humorous face (Bolton, 2001) in liaising with this gentleman as this was what she interpreted that he required from her when calling the AU. Carrie was giving humour philanthropically to this gentleman as she perceived he wanted to conceptualise his potential BD in this light. Bolton (2001: 95) asserted that “[t]he humorous face can signify many things and nurses use it to create and maintain familial bonds, to relieve anger and anxiety, to register their resistance

to demands made of them by management and to take time to offer extra emotion work as a 'gift' to colleagues or patients." As with the nurses that Bolton (2001) studied, dark humour was used as a tool by AUS to offer extra philanthropic *EM*; AUS would offer humour as they knew this would be beneficial for the families or colleagues.

Some AUS used humour as a way of coping with the emotional reaction evoked while performing their FL duties. Katie divulged:

If I get someone emotional on the phone I just [actions crying] (laughs).

(Katie, unit 2)

Interestingly Katie laughed after she described crying in response to an emotional family member; she was using humour to cope with her own emotional reaction. Kahn (1989: 57) stated that humour was a mechanism by which individuals became "detached from threatening aspects of the situation they f[ou]nd themselves in." Yet, this laughter may be because she was embarrassed about her emotional reaction; as previously mentioned in section 6.3, some AUS viewed personal emotional reactions as negative.

It was because of the type of work that AUS did that they used humour as a coping mechanism. Humour was used as a distancing tool (Kahn, 1989; Mitchell, 1996; O'Donohoe and Turley, 2006). It seemed that there was an AU culture where humour was expected. This was true in police culture too as Joyce (1989: 380) explained that "recruits to the [police] service, witnessing the emotionless, light hearted way in which colleagues confront deaths and other tragic events, quickly learn how to adopt similar disguises." They must cope well together, and humour was a common coping strategy. However, as I have demonstrated in this chapter, most AUS were more open about the

emotional effects of their work than police officers and also made time to address these.

[...] because the kind of conditions and the events that we are dealing with are challenging there is a lot of need for us to cope together and so we will make jokes about things which are not necessarily, you know, joke material it's just, you know, we make light of things like death and – between ourselves obviously not with other people – death and procedures, embalming and plastinating [...] I think that's more a coping mechanism which helps us kind of distance ourselves from what we actually do, which I suppose in a social sense would be taboo dealing with dead bodies all of the time.

(Anthony, unit 2)

There was a recognition that the dark humour must stay within the team; AUS could not make these jokes with outsiders as they would not appreciate the nature of their humour. AUS were aware that humour could be misconstrued by outsiders and AUS were careful in their use of humour outside of the AU. This was similar to the phenomenon of not discussing AUS work outside of the AU as I discussed in section 6.4. Kahn (1989: 59) similarly separated outsiders from insiders stating that humour was used by emergency service workers “in a way that appears to outsiders to be callous, but which in reality allows them to cope with things that are happening.” In this sense, lay people (outsiders) may interpret humour negatively even though this was an integral coping mechanism. Likewise, Williams (1987: 269) argued that “[o]utsiders to the law enforcement culture frequently deplore police officers’ seemingly indifferent or irresponsible behaviour, but they don’t understand how important it is for self-preservation [...] gallows humour is common to those dangerous occupations; it reflects a need to distance oneself from the emotional intensity of experiences.” Conversely, Mitchell (1996) raised the point that there was no harm in using gallows humour because it was not seen frequently by the public.

Overall, it was essential for the AUS to use coping strategies in order to complete their duties in body procurement. However, it was vital that they were aware of their environment and the individuals around them when doing so. In the next section I focus on those training needs that AUS identified and how these needs were addressed, if at all.

6.6 TRAINING NEEDS

In this chapter I have already unveiled that AUS received little recognition for their work, and that AUS had various support needs that were most frequently addressed, if at all, using the internal *ad-hoc* support network. I also revealed that AUS used various coping strategies in order to complete their work. In this section I explore the AUS's training needs and how these needs were addressed, if at all. I begin by discussing the lack of formal training available for AUS. I then explore the training that was available and discuss why there was no uptake in some cases. Finally, I outline the main form of training, in-house informal training. The first of these three foci is examined next.

6.6.1 Job-Specific Formal Training

It was clear that the only formal training that was offered by the HTA had been removed in 2014 and not replaced, which left AUS questioning how they could fulfil their training needs. There was a lack of communication between the HTA and the AUS about the removal of this training and the AUS did not know whether it would be replaced. This previous "official" training took the form of an e-learning course provided via the HTA staff platform. Jane, the DI, and Alice, the BS, at unit nine discussed this:

Alice: Well the HTA took away the person's designate course didn't it? [...] So, we do sort of in-house training now. It would be quite good if there was something else perhaps.

Jane: Something official [...] because at the moment I create the kind of in-house training and that's just me doing it it's not official.

Alice: Yeah so I think it would be quite good if we had something official again, and everyone knew that they we're signing up to something that was official and I think it, umm, it sort of rubber stamps the importance of what you're doing and the severity of it as well doesn't it really, because it is, you know, it's a highly regulated area and it has to be.

(Alice and Jane, unit 9)

AUS liked having formal and “official” training that instilled the “importance” of their work. AUS questioned why no “official” training was provided as it was a “highly regulated” area of work. It was considered by the HTA that in-house training would be provided by the DIs at the individual AUs in lieu of this formal training. However, this change in training was not made explicit to the AUS and it was often the case that DIs were already overstretched in their workload and did not have the capacity to fulfil these training needs. This change demonstrated the integral role of the DI in training and informing practice. It was understandable then why practice differed between AUs.

Anthony, the DI at unit two, however, remarked that the formal DI training that he took when he first started the role (which was subsequently removed as outlined above) was focussed on the legalities specific to the DI role. As previously discussed, the HTA were concerned only with the legalities and practicalities of receiving, using, displaying, storing and disposing human remains.

[...] my job came with online training. You had to do it to be a DI until a few years ago and that's been scrapped [...] but it was really knowing about the legal obligations, there was no training provided in the way we deal with people and families, so that's not been dealt with at all, and for that one I'm just drawing back on my own clinical experience from way back, you know, just

how to deal with patients basically. [...] The rest of it had just been a case-by-case thing, just take it slow, deal with what comes, whatever it is, learn from it and be better prepared for it, so it's more experiential.

(Anthony, unit 2)

As no training was available around FL, which was understandable because this was not a concern for the HTA, Anthony described, like many other colleagues, how he drew upon transferable knowledge and previous case-by-case and *ad-hoc* experience. However, Anthony was unique in being able to draw on clinical experience. It was often the case that AUS coming from funeral directing, police family liaison work or medical backgrounds were assumed to have this previous training and experience. This was why such individuals were recruited for the roles. The problem then arose for those novel issues that AUS dealt with on an experiential basis as they had no specific guidance on how to address these. It must also be considered why training for FL work was not offered by the HTA when FL was deemed integral and recognised as best practice at some AUs in the HTA AU inspection reports, as I discussed in section 6.2.

It was often the case that universities would not provide FL training either, as there were only a small number of AUS that completed such work at the university.

[...] it will be very difficult for a university to say we're going to provide specialist support for this particular person. In the same way, it would be difficult to say we're going to tailor a training programme for this person because it's a very niche role, but having said that it would be good to have something. I would say it would have to be national, a national forum of sorts, a national training thing of sorts, so there's some sort of like-mindedness and you know when you get a bequeathal secretary, you get a trained bequeathal secretary, you get a trained mortuary manager and so on.

(Anthony, unit 2)

It was a “niche role” and it was hard to justify spending time and money on training within an institution, but Anthony suggested that a national training/forum may be feasible. I argue that this could take the form of case study and best practice sharing to create more uniform practice; I discuss this further in chapter seven. This would provide the “official” training called for by some AUS and could take away the burden of training from the DIs. If such training was available for new recruits this could lead to Anthony’s idea of recruiting a trained BS or MM. Next, non-job-specific formal training and its uptake are deliberated.

6.6.2 Non-Job-Specific Formal Training and Uptake

In lieu of job-specific formal training, some non-job-specific formal training was available from the universities or external organisations. In this subsection I highlight this training that AUS described and consider the various reasons that affected the uptake of such training. Most of the non-job-specific training that was offered and taken up was aimed at bereavement counsellors. For example, Sheila said that she benefitted from the bereavement counsellor training that she attended.

We did one umm course with Cruse [Bereavement Care] er a bereavement [course] which was quite useful, and I think I would quite like to go on a few more of those, umm, it's just handy understanding the bereavement process and what people are going through.

(Sheila, unit 17)

As no specific AUS training was available it was sometimes the case that similar training was shoehorned in to provide some related training. However, this could lead to role confusion where those individuals that attended bereavement counsellor training may then put this training into practice and go ‘over and above’ what they were

expected to do as was evident in chapter five. This was problematic because these AUS were completing work that they were not contracted to do which took away from their other duties and could lead to overworked staff, exhaustion and burnout which had negative consequences for the organisation (Martinez-Iñigo et al., 2007; Mesmer-Magnus, DeChurch and Wax, 2012; Rogers, Creed and Searle, 2014). It was clear that AUS were faced with issues that were 'over and above' their remit if they are able to put training for bereavement counsellors into practice. This resulted in the key emergent support need that I raised in section 6.3. However, as Sheila highlighted it was useful for AUS to comprehend the context of their role, for example the bereavement process, drawing upon key bereavement theories such as stage theories (Bowlby and Parkes, 1970; Kübler-Ross, 2009; Worden, 2009) and *continuing bonds* (Klass, Silverman and Nickman, 1996).

Charlotte attempted the bereavement counsellor training she was offered, but found this non-applicable.

I did get offered to go on some bereavement counselling but I didn't really, I kind of initially went and didn't really think it was appropriate for my role you know, I'm not a counsellor that's not what I'm here for, although obviously if families do want to talk I'm happy to do that, but I'm you know counselling is not part of my job.

(Charlotte, unit 11)

Training that was non-specific to the role was off-putting for some AUS as they did not feel their needs were addressed effectively in these courses. It was apparent that Charlotte initially attended the course in the hope that her training needs would be met, which evidenced her need for training, even though Charlotte said she did not have any training needs. While Charlotte did not find this non-specific training useful as she was not completing the duties of a bereavement

counsellor, it was clear that she did “talk” to families if they wanted or needed to. Thus, I argue that she was completing work akin to that of a bereavement counsellor in talking to families however, she was unaware of the ‘over and above’ work she had completed.

Some AUS were also offered non-specific training by their universities.

[...] the university, they'll offer course on Microsoft Word or Excel or anything but not really job specific.

(Sheila, unit 17)

I argue that AUS FL training needs were as important, if not more so, than their IT training needs, and this should be supported. It should be that all training needs were addressed, not just practical or administrative ones.

There was also training available from external bodies such as the Association of Anatomical Pathology Technology (AAPT) which addressed the practical aspects of the role but also touched upon the FL work needed to complete these. For example, the Consent Training Day. This training event was run in liaison with the HTA and offered training on HTA consent processes and the facilitation and consent process between the next-of-kin and clinician (again, not specific for AUS). There was a fee for this training day which was reduced for AAPT members (AAPT, 2018). However, it was evident during interviews, participant observations and ethnographic case study that there was a lack of uptake of this training as AUS were not aware of this; the same reason that external formal support was not accessed as I discussed in section 6.4. Similarly, Carrie said that AUS were not aware of training and did not actively seek this out.

[...] there probably are [training courses] but I've never heard of one to be honest [...] Somewhere there will be a course that teaches ya – but you see, whether it's a course that teaches

you to be as specific as we are, you know we're not bereavement officers [...]

(Carrie, unit 17)

Again, Carrie raised the point that training needed to be specific to the niche AUS roles. The issue with the training available was that most of the training was for bereavement officers, which could offer some transferable training but did not address the specific training needs of the AUS.

Another reason for a lack of uptake of training was that some AUS felt that they did not need training because they already had training in their previous roles and could draw upon their specific and transferable skills. AUS were often hired for these skills and it was expected that AUS would not need additional training other than in-house learning on-the-job on an *ad-hoc* basis, which I describe further in the next subsection (6.6.3). Previous roles included police family liaison officer, medical professional and funeral director. These roles provided specific experience in dealing with death, the dead and FL. For example, the MM at unit two and the BS/MM at unit eleven were both ex-funeral directors, which provided them with these transferable skills. Charlotte commented:

[...] I never really felt that I needed any extra training and apparently neither did anybody else (laughs). I must've been doing something right [...]. I've never really felt the need for any additional training. I kind of think coming from a funeral background is pretty much the perfect training really.

(Charlotte, unit 11)

Charlotte was able to succeed in her role by applying her transferable and specific skills from her previous job. However, it was problematic that the lack of training offered was interpreted as doing the job right. Charlotte's experience as a funeral director also provided her with

practical skills, as well as the communication skills specific to FL, required for her dual role as BS and MM.

I used to be a funeral director [...] I qualified to be an embalmer and then I trained to be a funeral director and I did that for seven years and then I got offered the job here. [...] When I first came I was just responsible for the running of the dissecting rooms and somebody else did the bequest side, so when she retired I was more than happy to take over that side of it because I quite like the involvement with the families and you know dealing with the relatives. [...] I did that as a funeral director, so it's kind of a natural progression for me to do it rather than for someone else to train up and do it. And I really enjoy kind of the dual side of my job, so you know the office side of it and the technical side of it [...]

(Charlotte, unit 11)

Charlotte could draw upon her transferable skills from her role as funeral director as a way of career progression. Charlotte's skills were taken advantage of rather than employing and training another individual to complete the BS role.

However, not all AUS had the ability to draw upon transferable skills from previous jobs. The MM at unit seventeen said that she had "no formal training of any sort for anything, ever" (Annie, unit seventeen). This situation for AUS like Annie, who had many transferable skills and had previous teaching duties in the department but had no experience in FL or preservation techniques, proved very difficult because they had unmet training needs. AUS were left feeling confused about how to address their training needs, even if AUS had transferable skills and had been working in the medical school. Similarly, other roles, such as administrative roles, provided some key skills but lacked others. For example, Alice reflected:

I guess I've always had people facing jobs, so I think I've got reasonably good communication skills which definitely helps

with it yeah. So, I think that's probably the strongest thing for me.

(Alice, unit 9)

The ability to communicate well with families was a crucial part of the BS role, which was a key transferable skill that came from jobs such as customer services. This was also true for Katie, the BS at unit eleven, as Anthony described:

Katie would have come in as an administrator without any particular training. Now there's not any training that I know of that prepares people to be bequeathal secretaries or you know the front desk people. I think they just have to build on whatever customer relationship type skills they have and kind of take that further. It's I think a role that just requires, or their roles just require empathy. Umm and it's just drawing on that and drawing on a vast array of other experiences to just make them work.

(Anthony, unit 2)

It was the case that most AUS were hired because they were deemed to have the right personality to do the job. As Anthony described, AUS were empathetic, good communicators and good with people. Although some of these skills could be gained from customer service roles, it was often just a feeling that the recruiters got about a person. It was also the case that the recruiter judged whether a person fitted in well with the team. This was true for permanent contracts and temporary AUS. Supporting this postulation, Charlotte argued:

I think it's very difficult to train people to do this, I think you either can speak to people in that situation or you can't, you've either got empathy for them or you haven't.

(Charlotte, unit 11)

Many AUS had also worked in the university before working in the AU as jobs were usually offered internally. This reduced AUS training

needs as they were already familiar with the AU or medical school procedures. For example, the DI at unit nine had been working at the AU for sixteen and a half years; Jane “started as a junior technician and just worked [her] way up” (Jane, unit nine). This meant that these AUS knew the role before coming into the job full-time.

[...] it was what I expected because I'd been covering from the previous post holder when she retired [...]

(Alice, unit 9)

Alice, the BS at unit nine, had been “with the university since 1999 [...] [She'd] been in different roles. So, [she'd] been doing this role for four years [...]” (Alice, unit nine). This resulted in a culture of minimal change where there was little staff turnover. It was thus understandable from the close-knit community within the AU that training and support, as I discussed in section 6.4, was provided internally. This will be discussed further in the next subsection (6.6.3). However, unit four was an exception to this trend as one permanent part-time BS was employed there with additional support from a temporary part-time staff member. These temporary AUS who completed FL work needed to learn the role quickly. It was likely that temporary AUS entered into the role with fewer transferable skills and with less knowledge of the AU and medical school procedures. Collectively these temporary AUS had a wide range of transferable skills, which meant that some suited the role better than others. Therefore, the training needs became more apparent for temporary AUS. The training of temporary AUS will be discussed in the next subsection (6.6.3). It had also been suggested that temporary staff had less investment in the role than full-time long serving staff (Rousseau and Wade-Benzoni, 1995) as temporary staff have a transactional contract, where they place an emphasis on the economic benefits of the role, while permanent staff had a relational contract, where they were committed to the organisation and valued job satisfaction (*ibid.*).

This may be detrimental in temporary AUS's attitudes towards taking up training. Next, I explore the main form of training AUS.

6.6.3 In-House Informal Training

In-house informal training was the main way of training AUS. This was understandable as no formal or job-specific training was available and there were multiple reasons why AUS did not take up non-job-specific training, as previously discussed in this section, although, some suggest that informal learning was of higher importance than formal learning (Boud, 1999; Garrick, 1998). Further to this, Boud and Middleton (2003: 194) emphasised that “learning from others at work” in an informal way, as part of normal everyday work, was fundamental. In-house informal training was also most relevant as AUS were sometimes hired internally and because they were close-knit group. In addition, due to the *ad-hoc* and case-by-case nature of the training needs, in-house training by colleagues was the best way to fulfil these training needs. This was similar reasoning to the AUS's use of the internal *ad-hoc* support network presented in section 6.4 as the most appropriate way to address support needs.

For many AUS hired internally, there was a slow easing into the role where in-house training would be provided. Sheila explained:

No it's something that I've just picked up, I mean [the previous BS] always did it so when I started umm she was already doing the bequeathals so I sort of, I used to get involved a little bit in the office sending the packs out, taking the calls etc., I didn't really get involved in the paperwork so it's really just been on-the-job training, it's just things that you pick up.

(Sheila, unit 17)

Similarly, June (unit eight – non-recorded interview notes) described that she shadowed the BS before her; there was a long overlap

because June was doing another job at the university as well. June did not take calls for a while but would listen in. June felt this was the best way. This was also a similar case for Carrie, the senior technician at unit seventeen, who began to take on FL duties to support the MM part way into her role. Carrie explained the initial use of informal support:

I used to have somebody sat at the side of me sort of writing notes for me (laughs) and holding them up (laughs) [...] if it became apparent that I was going to fail [or if] they were particularly distressed or something and I just wasn't going to be able to handle it, then I would pass them on to my old boss. Umm otherwise, as I say, I'd tell them upfront that I'd not done this very often, umm "if you would prefer somebody else to do with ya, who's done it more often, and then that's fine, I'll get somebody else, otherwise I've got somebody at the side of me" [...]

(Carrie, unit 17)

Carrie said that she initially found it "terrifying" and that she was "mortified if [she] said something stupid." Informal in-house training and on-the-job experience was extremely useful for Carrie. Carrie, as with other AUS, particularly in the initial stages of their FL work, had a fear of doing it wrong. Therefore, having this informal support was very useful in helping AUS gain the confidence they needed to do their job. Also, allowing AUS to be honest with the family member and admit to the training they were receiving was useful.

It was Charlotte, the BS/MM at unit eleven, who provided the FL and practical training for the new mortuary technician.

We have done a little bit of training. So, I did a bit of a training manual for her, because sometimes she might also be in place to answer general enquiries from the public, just with common questions that get asked [...]. I've just really been testing her on a day-to-day basis [...] just making sure that she's got the knowledge [...]

(Charlotte, unit 11)

Such a training manual could be shared as best practice and used to train new AUS. However, tools like this remained in the individual AUs, which made it comprehensible why there were differences between AU practice. AUS explained that this was because training was specific to the AU. However, it was clear that similar FL training needs were arising within multiple AUs. It was also problematic for already overstretched AUS to provide this in-house training to an adequate level on top of their current duties. This was why some AUS were forced to learn by being thrown in the deep end and training through experience. This was not ideal but was the best method in a difficult situation.

It was also the case that this in-house training provided by senior colleagues was not always productive, as the trainee technician found it difficult to be trained by her boss; this made her nervous. Hughes (2005) supported this as it was found that staff found it difficult to be trained by senior staff due to their supervisory and surveillance role. The trainee then acted differently and put on a false display in order to present themselves as competent (*ibid.*).

I think she panics as well especially if I'm stood there listening to her but I kinda feel I have to, to make sure that she is not giving the wrong information [...] it definitely is experience and I think, you know, sometimes if you just throw somebody in the deep end they will struggle through but it's not that kind of situation where you can get it wrong.

(Charlotte, unit 11)

If this training was provided externally, it may be more productive for the trainees to overcome their fear of being trained by internal senior AUS. Charlotte made the point that the training tactic of throwing someone in the deep end, when formal and informal training was not available, could be bad in the BD context as AUS could not afford to make mistakes. Charlotte also explained that there was a tendency for

AUS to make things up in the absence of formal or informal training which was problematic. This was likely due to the added pressure due to the nature of the work. This should be avoided. Overall, in this section I made clear that in-house informal training was the most frequently drawn upon. Next, I explore why the AUS did their work.

6.7 WHY DID THE AUS DO THIS WORK?

Given the lack of formal recognition, support and training that AUS received for their work, it was necessary to comprehend why they did this FL work. Of particular interest was why they did the 'over and above' FL work that fell outside of the 'normal' routine timeline of work. I already highlighted in section 6.5 that AUS justified the donation as a coping strategy. AUS justified their work due to its essential nature, as did nurses (Lewis, 2005). From the interviews, ethnographic case study and participant observations while visiting AUs, it was abundantly clear that AUS enjoyed their job and they often described their job as a "privilege". This was also apparent in the length of time they spent in their roles. Sharp (2006) highlighted that OPOs were expected to have a short length of time in the role, but like AUS, they stayed in their role for a long time, in spite of the difficult nature of the work. Sharp (2006: 57) reflected: "When I began my research on organ procurement, I was informed repeatedly that the typical burnout rate for this line of work was around eighteen months, whereas transplant coordinators who worked with patients awaiting organs often remained in the job for a decade or more."

Alice and Jane used the terminology "privilege" and "special" to describe their roles, as did many other AUS. It was clear that the AUS appreciated the unique nature of their work and their role as deathworkers (Howarth, 1996).

Jane: It's a special job.

Alice: It is a special job and I do feel privileged and certainly feel that I'm privileged to have that contact with the families as well yeah.

(Alice and Jane, unit 9)

AUS also expressed that they found enjoyment in their roles, especially in the contact with the families of donors. June (unit eight), during the unrecorded interview, used terminology such as “amazing” and “lovely” when referring to the donors’ families. This was also echoed within other professions, such as nursing, where nurses were described as giving *EM* as a gift because they had a particular connection to certain families (Lewis, 2005). As with the AUS, nurses found joy in giving this extra work as a gift in order to make the experience positive for patients and their families. It was the families that June liaised with that made her job worthwhile. June explained that this was why she had been able to stay in her role for so long; she did not expect to. June emphasised: “You have to enjoy doing it.” June did however say that the job had its stresses because it was “obviously a difficult job” to do, and she explained that some people said to her “I don’t know how you do that job.” However, June explained to me that she planned to stay in her role until retirement (June, unit eight – unrecorded interview transcription notes). This enjoyment and connection to some families also explained the ‘over and above’ work that the AUS offered philanthropically to some families described in chapter five.

AUS also felt that their role was a necessary human part of the BD process as they provided vital support for families that were bereaved and grief-stricken around the time of death.

You do need a real person at the end of the phone [...]

(Jane, unit 9)

The importance of having a “real” person was discussed across multiple AUs. AUS felt there was a need for a human to respond to emails and answer phone calls. This was interesting as there was an increase in information and consent forms being available on medical school websites or being asked for via email even though there were also still situations where AUS met families face-to-face, such as when collecting ashes or at thanksgiving services.

6.8 CHAPTER CONCLUSION

In this thesis I have recognised the central role of FL work in AUS’s duties and in this chapter I have called for adequate support and training to be provided, along with recognition for these aspects of their work. Although there were similarities in the AUS’s support needs and how they were addressed, it was also evident that these were not the same for all AUS. Therefore, these differences in support needs and how they were to be addressed must be considered when proposing BPRs for all AUS in chapter seven.

The AUS identified multiple training needs that required addressing. However, this needed to be handled delicately, as the call for training differed greatly among AUS. For example, there was a split in the AUS who wished for there to be “official” and formal training and those AUS who liked that they were left alone to get on with their work and deal with situations internally on an *ad-hoc* basis. It seemed that in-house training was the most adequate way of addressing training needs considering the requirements and practicalities of their roles in absence of formal training; this was similar to the situation I described in section 6.4 where AUS drew mainly on their internal *ad-hoc* support network due to it being best suited for their needs. It was due to the nature of the FL work that AUS felt that it could not be easily trained formally or externally. Thus, a flexible approach must be taken to training, combining external and internal, formal and informal methods

to best meet their needs. It was also apparent that the AUS job was much more than was advertised and expected if training, such as bereavement counsellor training, were being put in place. Additionally, it was clear that DIs needed relief and respite from their training duties.

I use these findings, along with those from chapters four and five, to inform the BPRs that I provide in the next chapter. I recognise the need to be cautious when making BPRs as there was a danger in formally recognising, supporting and training for the *EM* that AUS completed which may thereafter become a waged and expected part of their work, and thus deemed EL as a result (Hochschild, 1983). This may subsequently inhibit the AUS's ability to derive job satisfaction from completing work that was 'over and above' as a form of philanthropic *EM* (Bolton, 2000).

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS FOR BEST PRACTICE

I have recognised in this thesis that FL was a key part of AUS's work both at the refusal of bodies and after acceptance. I applied and developed two key lines of theory in this thesis to explore the AUS's FL work. The first, *gift exchange*, drawing from Mauss (1990), affected the AUS's FL work and the relationships between families and AUS. I examine this in subsection 7.1.1. Implicated in this FL work was *EM* (Bolton, 2000). I argued that it was better to term this *EM (ibid.)* than *EL* (Hochschild, 1983). This formed the second of the two key lines of theory that I addressed in this thesis and is further clarified in subsection 7.1.2. In this chapter I first discuss the contributions I have made to knowledge, including reflections on contributions to *gift exchange* and *EL*. After this, I put forward BPRs for AUS to act as a guide to practice. These should not be taken as a rigid set of guidelines but a tool that can be referred to, which brings together examples of best practice across fifteen UK AUs. Finally, I outline the limitations of this thesis and make suggestions for further study. Now, I turn my attention to the contributions I have made to knowledge.

7.1 CONTRIBUTIONS TO KNOWLEDGE

In this thesis I contributed to the overall understanding of the body donation (BD) process in England, Northern Ireland and Wales by considering the process from the perspective of those that facilitated it; a perspective which had received little academic attention. There had been some research around the work that AUS did with students in the UK (see Black, 2018; Goss, Viswanathan and DeLisser, 2019;

Hildebrandt, 2010; Prentice, 2013) and the facilitation of body donor monuments (Bolt, 2012), but nothing that had examined the work of AUS throughout the whole BD process in the UK. In this thesis I have provided recognition of the 'normal' and 'over and above' FL work by bringing it to light as it was clear that the AUS received little formal or informal recognition for this work.

I have drawn on the data to critically analyse the interactions between AUS and the families of donors where the AUS were the subject of the study. I have gathered data from the fifteen AUs that responded out of the eighteen included in the initial recruitment process. Included in this study were various AUS at each AU that performed FL including MMs, BSs, and technicians. Due to the high response and inclusion rate, and a sample of representative roles at each AU, I therefore consider these data to be illustrative of the AUS's work. The ethnographic approach allowed me to gain an in-depth insight into the FL that AUS performed at one AU. The ethnographic case study was not analysed separately but was integrated into the thematic chapters. This supplemented the other data collection methods in order to gain an immersive and realistic understanding of the daily FL that AUS completed. I was able to establish rapport with my participants during interviews, participant observations and particularly within the ethnographic case study which further increased my access to a field which was hidden.

I have, for the first time, collated the numbers of bodies accepted and refused on average per year across fourteen out of eighteen AUs in England and Northern Ireland in the survey. From this, refusals came out as a key theme, which was unexpected. Through the interpretation of these data it became clear that there was much FL involved in refusing bodies and much additional work involved in avoiding refusals, such as referring bodies to other AUs and *EM* with the

relatives of donors. I reflect further upon the contributions this work has made to *EL* theory in subsection 7.1.2.

My research has also opened a new arena to understand *continuing bonds* (Klass, Silverman and Nickman, 1996). I have evidenced that *continuing bonds* processes were acted out by families of donors in their contact with AUS and their sending in items. AUS were the recipients of such efforts as they were the ones who were caring for the physical body of the donor after acceptance.

I argue that it can be seen throughout the whole process that the AUS's FL work, especially their 'over and above' work, was fuelled by a duty of care to reciprocate the gift of BD; this draws from *gift exchange* (Mauss, 1990). I examine this further in subsection 7.1.1. I also extend upon Bolt's (2012) work by developing her concept of gift relationships in BD further to show that there were multiple gift relationships evident throughout the whole process rather than just in the giving of body donor monuments.

The data have likewise contributed to the existing understanding of the tools used to close the relationships with the families of donors. Bolt (2012) said that body donor monuments were a key tool in offering a final stage to the process. I have extended this further, finding that the thanksgiving stage was where closure was established; this included thanksgiving services as well as physical monuments. However, I have evidenced that closure can similarly be attempted earlier in the process if the family chose to have no further contact, opting not to attend events or collect ashes. This reduced the AUS's FL work but made for unexpected extra work during other stages in the process due to the closure being unfulfilled in some circumstances. Yet, it was clear in many cases across multiple AUs that there was continuing contact during the BD process, where the contact was either continued or re-initiated usually by the family but occasionally by AUS. Again, the

re-initiation on the AUS's behalf could be understood through a duty of care and reciprocation of the gift of BD.

When considering the recognition for the AUS's FL work, it could be seen first and foremost that the HTA and universities did not officially recognise this type of work. The AUS were backstage; they keep the BD process running, yet they did not expect or indeed receive external recognition for this work, although AUS at some AUs received informal recognition from the families of donors, and in the additional notes section of the HTA AU inspection reports in one out of the fifteen AUs included in this study.

This backstage role was conducive to the fact that most of the training was completed on-the-job on an *ad-hoc* basis. There was one e-course available from the HTA which had been removed and not replaced. It was considered to be the duty of the DI to provide training for the AUS. It was usual for the AUS to be hired because of the transferable skills and previous training they had within their past roles, as some AUS had previous jobs in related fields, such as funeral director or police family liaison officer. However, there were also individuals that learned their FL work on the job, such as administrative staff. Much was expected of AUS and they often took on tasks akin to that of bereavement counsellors, for example, with no extra training.

In addition to identifying the lack of formal training provided, I have also identified that most of the support AUS drew upon was *ad-hoc*, where they drew upon the support of colleagues. AUS also employed multiple coping strategies, of which dark or gallows humour was the most prominent across all AUs. This was similar to those coping strategies used within other professions such as police work (Joyce, 1989; Mitchell, 1996).

I have outlined the contributions the data have made to knowledge. I next delve further into the contributions these data have made to the theories of *gift exchange* and *EL*.

7.1.1 Contributions to The Theory of Gift Exchange

In this thesis I have adopted the key premises of Maussian (1990) *gift exchange*, namely giving, receiving and reciprocation to illuminate the complex relationships and transactions that were present throughout the BD process. I have already explored the academic theory, conceptualisations and debates around *gift exchange* in chapter two, thus I will only provide a brief overview here to contextualise the contributions this thesis has made to *gift exchange*.

The key principle in Mauss's (1990) theory was the obligation to reciprocate. However, this *obligation* had been debated in the literature and I too agree that a legal or social obligation was not present in the BD process. Rather I agree with Testart's (1998) premise that an individual reciprocates due to a *feeling* that they should. This helped to appreciate why AUS completed their 'over and above' work; because they *felt* they should, in reciprocation of the gift of BD. For example, those anatomical professionals in Bolt's (2012) study *felt* that they should provide a monument in reciprocation of the BD. Bolt (2012: 621) described that one anatomist, who initiated the building of the monument, did so because "[a]fter 40 years of teaching human anatomy he searched for a way to demonstrate the value of BD to students [...] he also wanted to express his gratitude." Furthermore, Mauss's (1990) premise that reciprocation was obligatory, repaid with interest and a continuous cycle, is illuminating of why it was difficult to close the gift relationship in some cases. This

offered insight into why contacts continued and further layers of the gift relationship were evident.

Another key foundation of Mauss's (1990) work were the social bonds, relationships and community that were created. Borrowing from Durkheim (1974), it can be comprehended that gifts created social cohesion through solidarity. Sykora (2009: 18) wrote that one meaning of the gift was: "[...] a tool of social mutual relations based on reciprocation." I discovered that it was this meaning of gift that was evident within BD, where a set of relationships were developed based on reciprocation. I argue that this in a sense was creating a new complex community, a social network, between strangers underlined and controlled by gift relationships. In a similar guise, Titmuss (1971) argued that blood donation created social cohesion between strangers in a society. As Titmuss (1971) saw from anthropological studies, it was the social relationships created by these gift relationships that were important, not the gift itself. I have evidenced that the support the AUS offered to the family, in exchange for the gift of their loved one, was valuable in this social relationship. It provided support for the family through their bereavement, which was affected by the gift giving itself. The AUS were fulfilling a crucial role in offering their support in reciprocation for the donor's and family's gift. I have demonstrated that social cohesion could also be seen between families of donors at thanksgiving services as a result of the BD. Bonds were created between AUs too, where exchange relationships and regional alliances occurred. I have evidenced that establishing and maintaining positive relationships was also crucial in developing good public relations and avoiding bad publicity. Next, I continue with this theme of social bonds to explore refused gifts.

7.1.1.1 Refused Gifts? Why Refusals was an Issue

If refused gifts in BD were conceptualised through the lens of Maussian (1990) *gift exchange* it can be comprehended that the social bond was dismissed in the refusal as “[...] to refuse to receive is to reject the social bond [...]” (Goldman-Ida, 2018: 341). In Mauss’s (1990) theory, the refusal of a gift showed a fear that the receiver could not repay and thus they lost power and dignity. Furthermore, Fox and Swazey (1992: 40) asserted that there was a moral and psychological burden caused by the unreciprocated gift: the “tyranny of the gift.” Thus, the refusal of the gift of BD may have caused the AUS discomfort to such an extent that it elicited their ‘over and above’ FL work as I discussed in section 4.3. This was also in part because AUS comprehended that BD was difficult for some families (discussed in section 4.2). Thus, AUS did what they could to make up for the refusal, for example by referring bodies to other AUs when the reason for non-acceptance was due to non-medical issues, such as a lack of storage facilities, because the AU was closed, or because of staff shortages (discussed in section 4.4). AUS *felt* obligated (Testart, 1998) to aid and facilitate the acceptance, even if their AU could not accept. However, I argue that this was not an absolute obligation as per Mauss’s (1990) *gift exchange*. Next, I justify my use of gift language throughout this thesis.

7.1.1.2 Using Gift Language

Despite my recognition of the critiques around *gift exchange* that I discussed in chapter two, such as there being no such thing as a gift (Argyrou, 2013; Derrida, 1992), that there were free gifts (Testart, 1998), or that social settings different from Mauss’s population rendered it inapplicable (*ibid.*), I adopted gift language throughout this thesis as this was the language that the AUS, the families and the

donors used when referring to the gift of BD. Thus, the gift and gift language could not be ignored. This language denoted processes that were similar to Maussian (1990) *gift exchange*; in that the body was given, received and reciprocated, and the various associated social pressures, such as some families believing there was an obligation for the AUS to accept the body, as discussed in chapter four. I now turn my attention to explore gift relationships throughout the BD process.

7.1.1.3 Gift Relationships in Body Donation

In this thesis I have added to knowledge by extending Bolt's (2012: 618) "gift giving in body donation to science" diagram (figure seven), demonstrating that gift relationships (and *feeling* that one should reciprocate the gift or indirect reciprocation) were evident throughout the BD process, not just in the giving of monuments that were the focus of Bolt's (2012) study. I have thus used Bolt (2012) as a starting place to explore the complexity of gift relationships in BD and the additional layers of giving, receiving and reciprocation throughout the whole BD process.

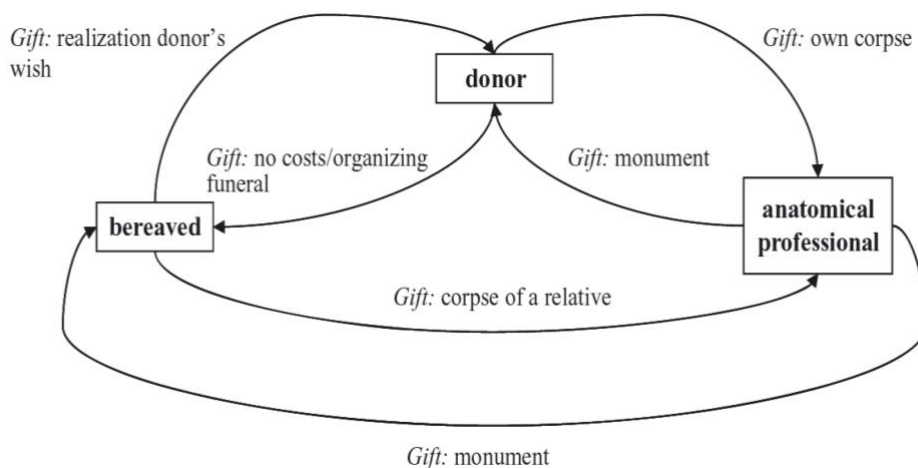


Figure 7: Bolt's (2012) gift giving in body donation to science

First, I dispute Bolt's (2012: 618) representation that there were multiple new independent "gifts"; I argue that some were indirect reciprocations. I thus assert that Bolt (2012) mistakenly labelled these as independent new gifts in her diagram. However, Bolt (2012) did acknowledge in text that monuments were given out of the desire for anatomical professionals to reciprocate the BD. Furthermore, Bourdieu (1977) postulated the importance of time in gift relationships; there must be time allowed for there to be counter-gift or else it would be direct reciprocation. I agree that the BD timeframe must be taken into consideration when exploring these gift relationships, as I argue that they were connected and bound within the BD timeframe. This further supports my argument that the "gifts" (Bolt, 2012: 618) were instead counter-gifts or indirect reciprocations given after a period of time in response to the initial gift of BD. For example, I assert that the giving of the physical monument was an indirect reciprocation to the initial gift of the body rather than a new gift. Similarly, I argue that the free funeral and thanksgiving service were indirect reciprocations rather than new gifts. This is in line with Titmuss (1971: 88) who would describe the free funeral as a "fringe benefit"; hence its very nature as a true altruistic gift is disputed. Even though these acts of giving, receiving and reciprocating were distanced in time, I argue that they were related acts bound within a timeframe and should not be seen as separate gifts.

Second, drawing upon the data, I have made several amendments to Bolt's (2012) diagram which are illustrated in figure eight. Firstly, I argue that rather than the realisation of the donor's wish, it was better to call this gift the fulfilling of the donor's wish, as the families must not just realise this but make the phone call in order to fulfil the donor's wish; the family was active in the BD process. Secondly, I have added further layers to the gift relationships within the BD process as I argue that Bolt's (2012) diagram did not encompass all of the gift relationships that occurred in England and Northern Ireland as her

focus was on monuments only. In the initial reciprocation layer to the gift of the BD I evidenced that it was not only monuments and a free funeral that was given as a reciprocation by the AUS but also thanksgiving services and 'over and above' work too. The students also reciprocated the gift of the BD by giving offerings at the thanksgiving service.

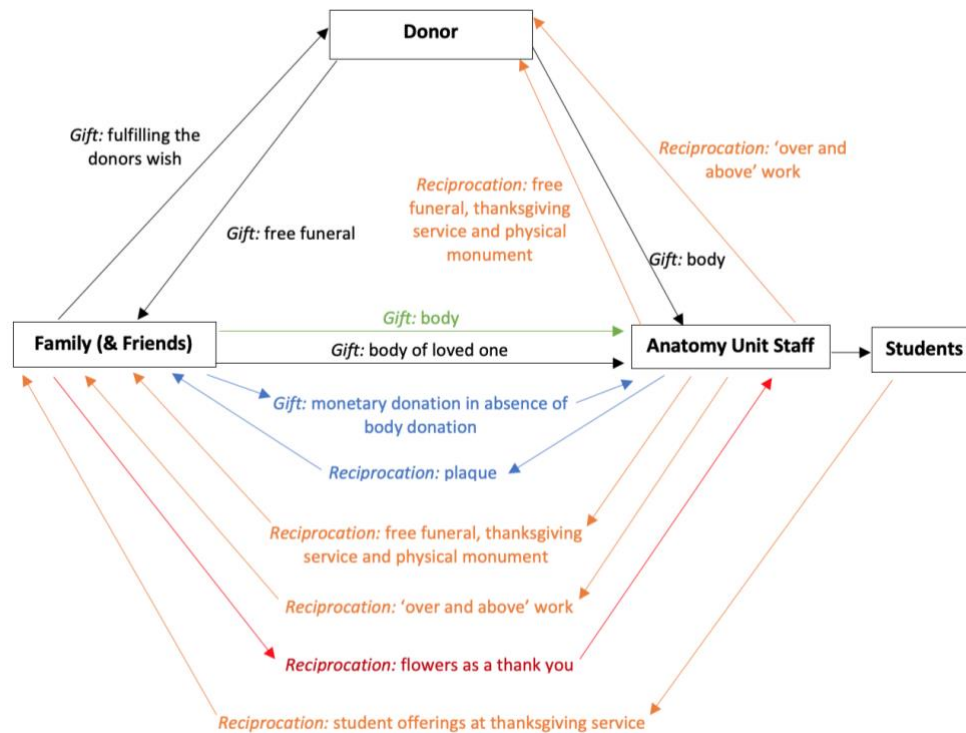


Figure 8: The gift relationships within BD for medical education in UK Medical School Anatomy Units

The initial gifts, adopted from Bolt's (2012) diagram, are signified in black. The initial gift was made by the donor giving their body, and the family and friends giving the body of their loved one to the AU. Borrowing from Mauss's (1990: 31) assertion that "the objects are never completely separated from the men who exchange them", it could be interpreted that families did not just give the body but also give part of themselves. Thus, Weiner (1992) may be useful here to appreciate that families were *keeping-while-giving*, as while they gave the physical body, they still held on to a connection to the individual.

This could explain why some families continued contact with the AUS while the body was in the AU, as the body donor was inextricably linked to the family members and this link was mediated through the AUS. These families were *continuing bonds* (Klass, Silverman and Nickman, 1996) – holding on while letting go. However, Godelier (1999) asserted that for Mauss (1990) “inalienable” means “non-exchangeable” (Godelier, 1999: 62). This put BD in a unique position, as the physical body was gifted while families still held on to some of the individual. BD was also implicated by the fact that a body cannot be legally owned. Thus the body was gifted rather than legally transferred to the recipient; thus, bodies, like blood (Titmuss, 1971), were inalienable gifts (Gregory, 1982, 1997). There was a difference then between commodity and gift economy, where BD falls in the latter camp. Donors who opted for the funeral the AU offered were also giving the gift of a free funeral to their family. The family were also giving the gift of fulfilling the donor’s wish, although some families chose to not fulfil the donor’s wish, which caused complications, as seen in chapter four. If this gift was refused by the AUS, this could also cause complications as seen in chapter four; thus, AUS completed ‘over and above’ work to avoid this refusal where possible. This ‘over and above’ work is encompassed with the reciprocation I have signified in orange discussed further below. Refusals resulted in the reciprocation of the free funeral, thanksgiving service and physical monument also being withdrawn.

In the event of non-acceptance, some of these refused donors’ families contacted the AU. One family even made a monetary donation to the AU. This family were giving a new alternative gift in lieu of the body being accepted. I described in chapter four that this was in line with the family’s wishes to uphold the non-donor’s donation narrative. In this case the money was used to put up a monument (plaque) recognising donors. This was a reciprocation of the monetary gift as

the monetary bequeathal was given to donors through memorialisation. These acts are signified in blue.

The AUS (and students) then reciprocated this gift in multiple ways; these reciprocations are highlighted in orange. The AUS reciprocated to the donor and their family by providing a free funeral, thanksgiving service and physical memorial (where applicable). The students also reciprocated the gift through offerings at the thanksgiving service, such as readings of poetry, personal experiences, music, note trees, flowers, candles and speaking with families before and after the service. Even in those cases where families had wished for no further contact or did not attend the thanksgiving service, the donor's name was still read. This showed that the reciprocation was given to the donor too, not just the family and friends, and was given despite the families' non-attendance and receiving of this reciprocation. The AUS also reciprocated the gift from the donor and their family by doing 'over and above' work. I argue that this work was likely to be due to a duty of care they felt towards the family and the donor and a reciprocation of the gift of the body. The perceived social contract created in the gift relationship to reciprocate the gift of BD could justify the 'over and above' work that AUS did. This was integral to this thesis, as much of the FL work (which is seldom recognised, trained for or supported) was completed because of this gift of the BD, and the AUS's duty to reciprocate this and make the process positive for the families of donors.

There were some circumstances in which further reciprocation was offered by the families and friends after the disposal, ashes or thanksgiving stages, for example, the giving of flowers after a family member collected ashes to say thank you to the AUS member for her FL work. These are highlighted in red. The AUS liked being thanked and having recognition for the 'normal' work and 'over and above' work that they did.

Finally, the last stage of the process was another gift where family members or friends may go on to donate their own body. This is signified in green. Here a new process would start.

I have revealed that gift relationships were central in comprehending the complex layers of giving, receiving and reciprocation throughout the BD process. I have demonstrated that this went further than expected. Next, I explore the contributions I have made to *EL*.

7.1.2 Contributions to The Theory of Emotional Labour

In order to understand the nature of the AUS's FL work (addressing research question one) it is important to first recap those theorists that have come before, previously discussed in chapter two, in order to situate the AUS's work and detect the elements of these theorists work that did not sit well with that of the AUS.

7.1.2.1 Emotional Labour

I start by unpicking and disputing Hochschild's seminal work (1983: 7), which coined the term *EL* to describe "the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has an *exchange value*." The first issue I encountered when applying *EL* as a lens to understand the work of AUS was that AUS FL was not recognised by their managers and thus I argue could not be directly sold for a wage as the managers did not control and were not aware of this type of work. Of course, the AUS's FL work was completed as part of their job, but managers were not directly controlling this work in the same way that was true for the flight attendants and debt collectors that Hochschild (1979, 1983, 1990) observed. I argue that AUS had agency in their FL work which

they chose to give as a reciprocation of the gift of BD as discussed in the previous subsection.

The second issue I uncovered with Hochschild's *EL* was its claim of universality. I, as with others such as Bolton (2000), argue that Hochschild's (1983) definition of *EL* was not comprehensive enough or sufficient to explain all the AUS's FL work. I assert that this term cannot apply to all types of emotion management in all contexts. I have revealed that the AUS's FL work was more nuanced than the term *EL* allowed for. Instead I have developed Bolton's (2000) 4 Ps: prescriptive; pecuniary; presentational; and philanthropic, to unpick the motivations and sources of the AUS's work and demonstrate that there was not just one type of *EL* occurring but instead multiple types of *EM*. I return to Bolton (2000) later in this subsection. I have exposed the unique nature of AUS's work, presenting that they did not do prescriptive *EM* like other workers, because of the indirect commercial gain and the fact that AUS were not formally prescribed, expected, recognised, supported or trained to do their FL work. I argue that AUS had agency and autonomy, but this was through a lack of training and recognition rather than being encouraged to do so; this was due to "abandonment rather than empowerment" (O'Donohoe and Turley, 2006: 1445), although I recognise that whilst this work may not be prescribed by managers it was still completed within a professional context; this was still productive work.

The third issue I observed in *EL* literature was its conceptualisation of what constituted productive work. There were some accounts of counterproductive *EM* in AUs which disputed Hochschild's *EL* premise that all *EL* was productive. Bolton (2000) contended that literature often terms all types of organisational emotionality as *EL*, even that performed during social encounters in the workplace (Fineman, 1993; Hearn, 1993, Taylor, 1998). This complicated the classification of what organisational emotionality was productive *EM*. In this case *EM* in

social encounters was a key part of working life yet was not productive in terms of commercial gain. Although the AUS's work was not prescribed in the same way as those Hochschild (1979, 1983, 1990) studied, it was still productive work; it maintained positive relationships between the AU and the families of donors, made sure the process ran smoothly, warded against bad publicity and even encouraged future familial donations. However, there were also more complex instances such as that presented in chapter five, where I demonstrated that some AUS organised the funeral to be sooner than expected because the family were finding it hard to deal with their loved one being in the AU. In this case the AUS's *EM* in easing the upset of the donor being in the AU was not commercially productive for the AU as it resulted in the loss of a valuable teaching aid. Yet, it ensured a positive experience for the family who were in distress at this time.

The fourth issue I discovered with *EL* literature, which follows on from the third issue, was that there had been insufficient questioning and minimal critique. I realised I needed to draw upon Hochschild's (1979; 1983) seminal work giving the emotive context of the AUS's work, however I did not want to use this framework blindly. Thus, I have taken on Grandey and Gabriel's (2015: 20) encouragement for "[...] researchers to question and test assumptions about emotional labor" and overall I have found *EL* to be inapplicable and inadequate to understand the work of AUS. Much of the literature from Hochschild (1979) onwards had taken the concept of *EL* and the associated terms of deep acting and surface acting at face value and had not attempted to critique what the terms meant and thus if they applied to the field they were studying. I argue that AUS acted in part because of naturally felt emotions. These, I assert, were a consequence of the relatable and personally significant nature of the AUS's work which triggered strong responses in empathetic people. Naturally felt emotions at work were conceptually different to *EL*'s surface acting and deep acting, as these emotions were authentic and did not require regulation

(Randolph and Dahling, 2013). Randolph and Dahling (2013) argued that this was a third type of *EL* strategy. This spoke to Hochschild's (1983: 7) premise that "[t]his kind of labor calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality." However, I assert that Hochschild (1983) was incorrect to group this kind of labour within *EL*. This natural self was what made it naturally felt rather than deep acting, as natural emotions did not require regulation to be effective in the workplace. Some theorists even posit that some service employees only acted naturally in front of customers and did not use surface or deep acting at all (Diefendorff et al., 2005), thus disputing the key premises of *EL*. This had positive benefits for staff such as job satisfaction (Cheung and Tang, 2010; Mesmer-Magnus, DeChurch and Wax, 2012). It could be understood that the AUS, when acting purely from naturally felt emotions, also reaped such benefits and I argue was why they continued to do such work, especially that which was 'over and above'.

I have thus referred to this work as *EM* throughout this thesis as it was clear that *EL* was not sufficient to capture all the types of *EM* that AUS were completing. This was because AUS were performing different types of *EM* at different times or concurrently. I have therefore used Hochschild (1983) as a theoretical starting point but after finding this inadequate I have adopted Bolton's (2000) conceptualisation of this work (discussed next) as a framework for understanding AUS's emotion management.

7.1.2.2 Multidimensional Typology of Emotion Management

I now turn to Bolton's (2000) multidimensional typology of *EM* to separate the types of work that AUS were completing. In this typology more than one type of *EM* could be completed at one time, thus,

moving on from the reductionist *EL* approach. I now address each of the 4 Ps and apply these to the AUS's work to demonstrate the particular aspects of each which were present, or indeed not present in the AUS's work.

Firstly, when applying the concept of prescriptive *EM* (that which was commissioned by managers according to organisational rules of conduct (Bolton, 2000)) it was clear that AUS were not directly commissioned by their managers to complete such work, but it was completed because they considered this to be integral to BD. For example, AUS did this work because this was what was required to facilitate the BD process and maintain positive relationships; however, the means by which they fulfilled this duty were not specifically prescribed. The specific type of work, in this case *EM*, was not explicitly outlined in their job description or within the recruitment process, but, was the way AUS adopted to fulfil their duties. Therefore, the term prescriptive did not fit well with the type of work AUS were doing.

Secondly, addressing the AUS's FL work as pecuniary (*EM* completed for commercial gain (Bolton, 2000)) it could be said that there was an indirect association between the AUS's FL work and commercial gain, as this work indirectly elicited commercial gain through the facilitation of the BD process, thus enabling students to study in exchange for fees. This was indirect because it was unlike other workers such as funeral directors, where their *EM* directly led to custom. I argue that this was not the reason for the AUS's FL work; this was rather an indirect benefit. I agree with Bolton (2000) that there was an overemphasis on commercial gain in *EL*. Bolton (2000: 158) asserted "[...] that an over concentration on the "pecuniary" category of emotion management, and attempts at its quantification, can lead to the neglect of vital parts of organisation's life." Although the pecuniary aspect existed, it was not a central motivation. This was also true for other

workers such as nurses (Bolton and Boyd, 2003) and to a lesser extent newspaper In Memoriam (IM) writers (O'Donohoe and Turley, 2006) that mainly performed philanthropic *EM* with commercial gain as an indirect benefit.

There were also other dimensions of work that could not be directly linked to commercial gain such as *EM* carried out collectively for worker solidarity (Bolton and Boyd, 2003; Lively and Weed, 2014). I demonstrated in chapter six that AUS were a close-knit group who drew mainly upon the internal *ad-hoc* support network of colleagues. Therefore, it was understandable that AUS, exercising their agency, completed *EM* to help each other during social encounters. This was similar to Bolton and Boyd's (2003) discovery that airline cabin crews made a special effort to help colleagues during social exchanges in the workplace.

Thirdly, much of AUS's *EM* can be described as presentational (that which was completed due to general social rules Bolton, 2000)); they were humane and good people – this was why they were recruited in many cases. This Grandey and Gabriel (2015: 20) termed “person-job congruence” where the “person matches the emotional requirements” of the role. This included emotional traits, motives and abilities. In this, Grandey and Gabriel (*ibid.*) posited that “[o]ne assumption is that people who are a better fit will need to do less emotional labor.” This may be why some AUS were seen to perform *EM* derived from naturally felt emotions rather than surface or deep acting. It was useful then to separate the types of *EM* that AUS were doing and consider the motivations and reasons for employment, such as personality traits, to comprehend exactly the *EM* that AUS were doing. This could be applied beyond AUS to other workers. Further to this, AUS often commented that if AUS were not of this nature and did not “feel something”, they should not be doing the job.

Finally, as with O'Donohoe and Turley (2006) examining newspaper IM writers and Bailey (2010) examining funeral directors, I demonstrated that some of the AUS's *EM* was philanthropic in character. Bolton (2005: 97) described that philanthropic *EM* was that effort which "offer[ed] a sense of stability and ontological security to participants." This was evident in the counterproductive *EM* work of some AUS, such as ending the BD process sooner. Most AUS did such work for those "nice" families for whom they wanted the experience to be positive; AUS were empathetic to the family's needs.

I have evidenced several examples of philanthropic *EM* throughout chapters four and five, exemplified in the AUS's 'over and above' work. Other times AUS were giving philanthropic *EM* simply because they wanted to and because they liked the families. Some AUS formed in-depth relationships with some families. However, there was a spectrum where some AUS completed more philanthropic *EM* than others. This type of *EM* caused AUS enjoyment and job satisfaction; key reasons why AUS performed such work. Thus, enjoyable *EM* could form a separate category of *EM*. This was completed as part of the AUS's professional roles in two ways: that which is given to the family, for the family; and that which is given to the family, for the AUS. This demonstrated that even Bolton's (2000) typology was not wide enough to capture all types of *EM*. For example, encompassed in philanthropic *EM* could be acts which did not cause the AUS enjoyment, and those separate instances, where the AUS liked the family, which caused AUS pleasure in fulfilling the family's wishes.

Following on from identifying this enjoyable *EM* it was also clear that the AUS were completing this work because they wanted to. O'Brien and Linehan (2018) and Bolton (2005) demonstrated that HR staff were active in the *EL* process rather than passive (Ashforth and Humphrey, 1993); HR staff made an effort to perform *EM*. Zapf (2002) also found that *EL* varied in required effort. Theodosius (2006) also

noted that the nurses in her study wanted to do their *EL* work and gained enjoyment from this. I assert that AUS also had agency in their *EM*, a trait which was assumed to be missing in emotional labourers in Hochschild's (1983) definition, where employees were automatons who were controlled by organisational feeling rules (Bolton and Boyd, 2003). However, there were a couple of examples of employee agency in Hochschild's writings on *EL*, but these were negative, such as the flight attendants spilling a hot drink on a passenger who was racist. Next, I summarise and situate the AUS's FL work within current *EL/EM* literature.

7.1.2.3 Situating AUS's Emotion Management and Contributions to Emotional Labour

I have revealed that this 'normal' and 'over and above' work, that was constituted of much *EM*, was completed as part of the AUS's job but AUS had agency in this, they enjoyed this and gained job satisfaction from this. This was not just one type of *EM*, but multiple types that manifested in a multitude of ways from a number of motivations. This, I assert, could not be constrained within *EL* (Hochschild, 1983) or the 4 Ps (Bolton, 2000).

I have thus made a case for moving on from *EL* and indeed even Bolton (2009) herself made a case for moving on from the 4 Ps typology. I too argue that Bolton's (2000) typology did not capture the complexity of the AUS's *EM*. I thus used both Hochschild's (1983) *EL* and Bolton's (2000) multidimensional typology of *EM* as ways to analyse and situate the work of the AUS within current literature on *EL/EM*. I argue that neither have the explanatory power to capture all labour processes across multiple contexts. What I did not do was provide a specific set of explanatory tools for which to understand a multitude of *EM* in organisations. What I did do was tease open the current literature and call for further studies to apply such literature and

question its applicability, as I have shown that AUS indeed completed complex and nuanced *EM*.

To illuminate what I am adding to the theory on *EL/EM* I bring together two key theoretical lenses used in this thesis: *EL* and *gift exchange*. I argue that the AUS were performing *emotional reciprocity*, a specific type of *EM*, within their professional role, in addition to the other types of *EM* exemplified above. This *emotional reciprocation*, I argue, was due to the combination of the unique gift relationship in BD along with the AUS having agency in their *EM*. This was because AUS *felt* they should reciprocate the gift of BD. In their agency AUS decided to perform *emotional reciprocation* because they enjoyed this and gained job satisfaction from this. This was hidden and 'over and above' work done on a case-by-case basis. *Emotional reciprocation* thus functioned because managers stepped aside somewhat and the final decision on approach to practice was left to the AUS. This was very different to other workers that had been analysed through an *EL* lens, such as flight attendants, as their work was highly regulated by managers (Hochschild, 1983). The AUS were different because it was they who controlled their FL work; the HTA, the medical school and even DIs who were not completing FL work themselves did not have much input, if any, in the AUS's FL work. Thus, this was not completed because AUS were commissioned to, but because AUS *felt* they should and because they wanted to.

What I did not attempt to do in this thesis was routinise the *EM* work that the AUS were completing. There was a danger in routinising the AUS's *EM* as it was the agency that AUS had that was important in their doing this work. It was the AUS's way of reciprocating the gift of BD. It was the flexibility of the AUS's work and their decision to do this work from which they gained enjoyment and job satisfaction; the very reasons why this work continued to occur. If such work was routinised, recognised as 'normal', expected and no longer hidden, AUS may

have been less inclined to do this work. Routinisation would subsequently have a negative effect in reducing the enjoyment and job satisfaction that AUS gained from giving this work philanthropically, which was a product of their agency and flexibility in interpreting the guidelines for practice. This could explain why AUS completed so much 'over and above' work – especially that which was counterproductive. The BPRs, presented next in subsection 7.1.3, are therefore for guidance only rather than a rigid structure to adhere to as there was no one correct form of practice. This was apparent in the various examples of practice that achieved similar positive and desired outcomes. I agree with O'Donohoe and Turley (2006: 1446) that it was better to encourage a work environment where staff could be flexible and free to do philanthropic *EM* since "attempting to streamline or routinize it" may be counterproductive.

What I offer, however, is a recognition of AUS *EM* and a language which AUS can refer to and use to recognise their work. Bolton (2000: 156) argued: "Perhaps the employee, as a multi-skilled emotion manager, remains unrewarded for their efforts at this particular type of labour due to the lack of conceptual clarity when describing emotion in organisations." I am offering conceptual clarity, alerting the AUS to their work and giving the AUS a language to speak about it and comprehend it. This recognition will help AUS to create boundaries to their work. I offer methods of creating boundaries and establishing closure in the BPRs (outlined next), but this can only be applied if AUS recognise and comprehend their own work.

7.1.3 Supporting the AUS: Best Practice Recommendations

From this thesis, based on the thematic analysis of empirical data from fifteen AUs, I am able to provide BPRs which will be distributed to AUS

in England, Northern Ireland and Wales. In this section I outline those BPRs that can be drawn from each of the three thematic data chapters: 'Refused Gifts?'; 'After Acceptance'; and 'Recognition, Support and Training' (outlined in table five, six and seven respectively). These guidelines offer examples of best practice that would not otherwise be shared across AUs. In the interviews and ethnographic case study the AUS thought this was a good idea and encouraged me to do this. This research is the first to bring these practices together and explore what happened at non-acceptance and after acceptance where there was clearly much FL work being completed by AUS which was unrecognised, unsupported and for which no training was provided. I hope that this will reduce the gap in practice and encourage best practice sharing – however, I appreciate that AUs wish to maintain their individuality. I have also identified that there was a spectrum along which many AUS wanted to give this work, especially philanthropic *EM*. I thus present these BPR as guidelines only, as a toolkit of case studies for how to do FL well and professionally, in a way that will help the families of donors and reduce the impact such work had on AUS. These guidelines may become a reference bank of information and may be a useful training tool. For those AUS who were intentionally performing such work, these may simply be useful as a way in to think about the consequences of their FL work. However, if such work was completed unintentionally then these BPRs will be useful guidelines of how to manage this work. It also must be kept in mind that these guidelines were written in 2019 based upon empirical data collected in 2017, therefore differences in practice may appear after these BPRs are distributed.

7.1.3.1 Best Practice Recommendations from 'Chapter 4: Refused Gifts?'

The following BPRs from chapter four focus on ways in which refusals could be reduced both before and at the phone call stage. I also offer

a final recommendation for how to deal with negative family reactions to refusals.

BPR

AUS could refer bodies to another AU where possible.

The possibility of the extra cost of transportation and the prospect of referral could be stressed as early in the liaison process as possible. Some AUs even wrote this into their information sheets that were initially sent out to the prospective donors and their families. For example, one AU wrote in their information booklet: "If a bequest is accepted from outside our normal catchment area your next of kin or executor will be asked to pay the costs of transporting your body to the University. Please ensure that your relatives are aware of this." Another AU, on the consent form, wrote: "I consent for my body to be used at other UK Medical Schools & Surgical Training Centres for anatomical examination, education, training and research." Alongside this was a tick box which the potential donor could choose to tick. This made it easier for this AU to know whether the donor wished to be referred to another AU and could be a way to overcome any confusion around referrals at the time of death. I recommend that this be added to the information too as the more information that was given at the early stages the better and it would mean that AUS had documented proof if disputes occurred at a later stage. It is important that the family and the donor are aware of the possibility of non-acceptance and the reasons for this.

It was clear that geographical priorities may arise where AUs, usually at the end of the year of intake, prioritised the very few spaces they have left for donors within their own geographical area. It was also understandable that priorities were given for certain individuals where AUS may try a bit harder to facilitate their acceptance due to a multitude of reasons, including increased contact with certain individuals and building relationships. It was understandable why this happened. However, where possible donors could be considered on a first come, first served basis.

AUS could pre-empt refusals if the opportunity arises. Some AUS offered alternatives, such as specific research projects related to the potential donor's condition. This approach of presenting the prospective donor with alternatives and being explicit and honest, however difficult this conversation may be, was beneficial for both the potential donor and the AUS. This was because the difficult liaison work at the time of death, in not accepting the individual, could be avoided and discussed before death. The prospective donor could then take time to understand this, discuss this with their family and consider alternative options. When the family were not aware of the possibility of non-

acceptance or had not had the time to consider alternative options, this caused extra FL at the time of death that could have been avoided. This BPR thus would reduce AUS workload at the time of death and reduce upset to the family.

AUS could stress the importance of the potential donor speaking to their family; many AUs also presented this within the information they sent out to potential donors and their families. In a similar guise it was also important to make non-acceptance clear in the paperwork. I want to reiterate here the importance of AUS encouraging the potential donor to speak to their loved ones about their decision to donate and the possibility of non-acceptance, whether this be by the AUS emailing the potential donors, in the information booklet sent to potential donors and their families, or when speaking with potential donors via telephone. This could be written clearly and concisely in the paperwork given to potential donors and their families at all AUs. For example, one AU wrote in their paperwork: "It is advisable to inform your relatives, executor and doctor of your intention." Some AUS wrote this multiple times within the information. Some encouraged potential donors to give the paperwork to their family. The information documents could thus be used a tool to facilitate this crucial conversation. A family hand out could be created in addition to the information pack to encourage potential donors to initiate discussion with their families.

AUS could be better prepared to deal with negative family reactions to refusals. Some AUS reiterated that non-acceptance was made clear in the paperwork and that the potential donor was encouraged to discuss this with their family, for example. AUS also referred those with specific medical conditions to research programmes such as a Tumour Bank where the individual would still fulfil their wish in donating to academic research. Overwhelmingly though it was clear in this study that AUS completed 'over and above' work at this point in being a listening-ear for the family members as they often just needed someone with whom to talk. AUS should be mindful of completing such 'over and above' work even if job satisfaction was derived from such work.

Table 5: Best practice recommendations from 'Chapter 4: Refused Gifts?'

7.1.3.2 Best Practice Recommendations from 'Chapter 5: After Acceptance'

The following BPRs from chapter five focus on ways in which extra FL work could be avoided after acceptance.

BPR

AUS could craft the information sent to the families of donors to prevent further contact. A re-wording of phrases in the paperwork sent to potential donors and their families such as, “feel free to contact the unit with any questions”, to something such as, “if you have any queries regarding the (specifics of body donation)”, could be beneficial in reducing family contact. The information could deter families from contacting at any time for any reason as it was evident that some families were taking advantage of this.

There was a fine line between building rapport and building a relationship and thus a continuing relationship with the families of donors. There were many examples of where AUS felt attached to a particular family. This was derivative of job satisfaction, but AUS should be mindful of the extra FL work that they were completing for these families with whom they maintained contact. Thus, AUS could strike a balance in building rapport but not encouraging a continuing relationship

The completion of special requests, such as making amendments to the funeral offered by the AU, was ‘over and above’ work and was the AUS’s choice to fulfil these requests and wishes. It is therefore suggested that where possible these could be reduced but it is the AUS’s discretion. I have highlighted this as ‘over and above’ work which could help AUS recognise that they could reduce this type of work.

At some AUs it was the funeral directors that liaised with the families regarding the funeral and the collection of ashes from the crematorium or funeral directors. This reduced FL work for the AUS during the disposal (stage four) and ashes (stage five) stages. Thus, AUS could delegate their workload where possible.

Mediator deathwork, where AUS became mediators in family feuds for example, was also a cause of extra FL work that was ‘over and above’. Some AUS were successful in reducing their mediator deathwork by encouraging families to discuss their issues among themselves, or by re-directing, so it was not the AUS who are mediating. A counsellor or lawyer in some cases could also be suggested.

Some AUs made clear in their paperwork that contact initiated by the families after acceptance was unusual. Especially for *no further contact* families where communication would usually end at acceptance as these families wished for

no contact after their loved one was accepted. For example, one AU wrote in their information booklet:

“There will normally be no further communication with the relatives or executors once the initial formalities have been concluded. If the family have requested that they are informed of the Committal Service and/or to receive the tributes written to the donor, we will arrange this. If the family have requested that the ashes of the donor are made available to them following cremation, we will contact the named relative/executor informing them of the location of the ashes, and the date when they will be available. An invitation to the Memorial Service will be sent to the family within the appropriate year.”

It is useful to make this clear in the paperwork to set the boundaries of what is normal and expected from families to manage such contact.

In this thesis I highlighted that there were both unintentional and intentional causes of extra work after acceptance. Those unintentional cases caused by mistakes, practical and logistical reasons could be managed. One practical cause of extra work was those cases where families were unaware that the timeframe that the body was kept was not always three years. It was useful to make clear in the paperwork and on contact with potential donors and their families that the timeframe was not always three years. It may be useful to provide an example of where a body was used more quickly so that the family are aware. For example, it could be useful to write: “There are some circumstances where donors may have finished their time with us in a matter of months, for example when being used for a surgical training course.” There were also issues around *further contact* families who did not inform the AU that they changed their mind and wished for *no further contact*. AUS contact on disposal in such cases caused upset for families. AUS could encourage families to inform the AU if they changed their minds. Also, potential donors could be encouraged to discuss their post-death choices with their families, as it was the case that some donors opted for their next-of-kin to have no further contact when in fact the next-of-kin wanted further contact. To counter this discrepancy, one AU sent a letter to the family at the point of donation to check that their wishes were in line with the donors. However, it was understandable that some families did not know how they would feel until the situation occurred.

There are eight strategies that could limit interaction between AUS and families:

1. In some cases, the AUS organised cremations earlier because some families were not coping with their loved ones being in the AU. This made the BD process easier for such families and reduced contact from these families, although this had financial and practical implications for the AU.

2. Some AUS arranged for the families to collect the ashes from the AU; for some families that contacted the AU regularly this was a way in which the contact was brought to an end sensitively. As previously mentioned, this work could also be delegated to funeral directors. Thus, managing the collecting and couriering of ashes could prevent further contact.
3. It was useful to develop a final point of contact as closure and make this clear sensitively. For families that opted for no further contact this could be made clear in the paperwork or on death when liaising with the family to facilitate donation. For those families who wished for further contact it could be established that the cremation/burial, thanksgiving (if applicable) or collection of ashes is the last point of contact.
4. Thanksgiving services that families were invited to and physical memorials that families had access to were useful ways to close contact with the families. One AU did not invite families to attend the thanksgiving service, but they did offer to send the order of service to families who wished to receive a copy.
5. Some AUS arranged for some families, who were particularly upset around the time of death, to attend a thanksgiving service that was closer to the time of death. This was beneficial for such families and could reduce the extra FL work by preventing continued contacts.
6. It was the case that some family members wished to attend multiple thanksgiving services and, in some cases, AUS permitted this. However, it was useful for AUS to stress that the services were for the current donors and that places were limited.
7. Of those thanksgiving services I attended, it was productive to make time for interactions between families and AUS/staff/students. Some AUs simply had some time before or after the service and some provided refreshments and light food. Those families who wished to stay for this extra time could do so and contact could be made at this point rather than at a later date.
8. It was beneficial for the families to interact with students at the services to understand how they had benefitted from their loved one's donation. Students who attended the services were very forthcoming with the families and provided them with comfort that could not be achieved otherwise. It was also productive for AUS and other medical school staff to attend as families also wished to speak with staff about the BD.

Table 6: Best practice recommendations from 'Chapter 5: After Acceptance'

7.1.3.3 Best Practice Recommendations from 'Chapter 6: Recognition, Support and Training'

The following BPRs, emergent from chapter six, focus on ways in which AUS could manage their recognition, support and training needs associated with their important FL work.

BPR

It is important to make training needs clear. These needs cannot be fulfilled if they are not known. Firstly, training needs could be raised among colleagues within the AU, as many AUS had the same training needs that were not voiced. These could also be raised with the DI and the HTA who could seek further avenues in how to provide this training. For example, it was apparent that there was interaction between DIs, therefore DIs may be in a good position to act on these shared training needs, either resulting in training in individual AUs or across multiple AUs. The HTA may also have avenues that they could access to provide training for all AUS.

AUS could push for their FL work to be recognised. However, there was a danger in this work being recognised as it may then become practice and could result negatively for AUS as they may lose the job satisfaction they gained from voluntarily completing such 'over and above' work.

Enjoying the job and feeling privileged to complete such work, along with justifying the essential nature of the work, were successfully used as coping mechanisms for some AUS.

AUS could use the support networks available. There were some AUS, particularly BSs, who arranged to meet either regionally or nationally. These proved to be very productive and supportive environments. Many AUS said that they would like to have more of these informal gatherings. It was also evident that the bi-annual Institute of Anatomical Sciences meetings proved to be very useful in bringing AUS together. However, it was apparent that there was a reduction in the number of these types of events. Drawing upon these data there were no apparent formal meetings arranged by AUS or the HTA; especially when considering the evident shared training needs, a formal environment to share and train may be useful for some AUS. It was also clear that some AUS did not find these events to be useful. This was because much support and training was provided in-house, between colleagues and on an *ad-hoc* basis.

AUS should continue to use the *ad-hoc* support of colleagues and should not feel that the support need was too small to use formal support, such as the pastoral support provided by the university. For many AUS 'over and above' FL work manifested in them taking on the work of bereavement counsellors. However, these issues could be delegated to local support available such as hospital bereavement counsellors. It could also be useful to educate families of the AUS role; making clear that AUS are not bereavement counsellors and should not be used as such. This could be done in the information booklet for example.

AUS should continue to use their judgement on when dark and gallows humour can be appropriately used however, it was not something to be ashamed of or avoided. Dehumanising tactics, detachment and avoidance behaviours, and justifying the donation could also prove useful in coping with the unique and necessary service that AUS provided.

Table 7: Best practice recommendations from 'Chapter 6: Recognition, Support and Training'

In this section I have presented BPRs. These however should be used as a guide rather than a rigid set of rules. I acknowledge that there is a danger in these recommendations becoming practice as they could detract from the job satisfaction that AUS receive in voluntarily performing 'over and above' work. I have not only made recommendations for practice, but I have also offered ways to set boundaries and means of closing contact with families.

7.2 LIMITATIONS OF THE THESIS AND OPPORTUNITIES FOR FURTHER RESEARCH

There were limitations to the sample as not all AUs were included, as only fifteen out of eighteen AUs responded to all of the data collection methods. This was due to difficulties in recruiting, mainly due to AUS being extremely busy. The lack of response from some AUs resulted in my study only including AUs from England and Northern Ireland and not Wales as anticipated. Some AUs also chose not to answer certain questions in the survey which further reduced the response rate to some questions. This meant that this study could not be representative of all AUs; however, the findings, and thus BPR, may be transferred to other AUS and indeed other workers who deal with families and bodies post mortem. It would be beneficial to understand the work of AUS cross-culturally or complete an international comparison of FL practices. For example, the internationally completed studies around

thanksgiving services (Strkalj and Pather, 2017) were useful, but only cover one aspect of the BD process. It would be beneficial to comprehend how the process as a whole differed between countries.

There were some limitations to the reported data presented in section 4.1. It was evident that there may be changes in the numbers reported from year to year. For example, in the survey unit thirteen said that they accepted thirty-eight bodies and refused ninety-two bodies on average per year, yet on interview Nikki reported that they accepted forty-four and refused one hundred and seventy bodies. For some AUs the number of refused bodies may increase while the number of bodies able to be accepted may stay the same or, as at this AU, increase. Further work needs to be completed to investigate these numbers in more detail as the numbers may be numerically and qualitatively different from the numbers represented in section 4.1. For example, those donors that were not accepted to one AU and referred to another AU may be double counted as both a refusal and an acceptance. Furthermore, those donors that were not accepted due to family influence, which was discussed in section 4.4, may be recorded as a refusal. Therefore, future work needs to break down these numbers into categories of refusal reasons. It could be a recommendation to AUs to separate the reasons for refusals; however, this may not be feasible or deemed necessary for them to do on top of their already high workload.

Additionally, the ethnographic case study and in-depth interviews provided rich data that was illustrative of individual AUs. As such, there was an issue in applying these conclusions to other AUs internationally. The ethnographic case study was representative of one AU only and although general comparisons can be made, it is inappropriate to take the day-to-day practices of one AU as representative of all AUs within the study.

However, the thematic analysis of ethnographic interview data from fourteen AUs in England and Northern Ireland provided similarities, and key roles and duties between AUs. For example, it could be seen across all AUs that it was the BS, MM and DI, along with auxiliary staff, that had contact with donors' families and that these contacts occurred throughout the process. It can also be comprehended that recognition, support and training were similar, especially in the support networks the AUS used and the training needs they identified. Additionally, it was clear that liaison work was often brought to an end during the thanksgiving stage (if applicable) or the last point of contact the AUS had with the donor's family. It was also apparent, across all AUs, that the extent of family contact was high, although this was from some families more than others. The nature of the family contact across all AUs was to continue bonds, continue contact and continue relationships with their loved ones and, in some cases, continue relationships and contact with the AUS.

Although I tried to establish rapport and create an environment in which AUS felt comfortable to discuss issues, there may have been bias in their answers both to the survey questions and within the interviews, as AUS wanted to portray their AU in the best light. There was a competitive edge in each AU wanting to be seen as the best. There were also several instances where AUS talked off tape and made clear that they did not want what they discussed to be included as data; it was clear then that there was some editing of the information AUS wished to be included as data. However, it showed that they felt comfortable with me, the interviewer, to reveal such information off the tape. Next, I turn my attention to opportunities for further research.

7.2.1 Opportunities for Further Research

It would be useful to study the AUS longitudinally with a particular focus on how the AUS use the BPRs I provide and how the BPRs took

effect and helped AUS practice. This could be done by checking in on the AUS at designated times after the BPRs are distributed through a questionnaire, interview or telephone interview. Example time frames could be immediately after the BPRs are distributed (around two weeks), to understand what the AUS initially think of the recommendations, how the AUS think they will put them into use and what they think will not be useful. Then after six months, twelve months and eighteen months to comprehend how the BPRs have been used and what the AUS have and have not found useful.

It would also be good to gather information longitudinally on the number of bodies that AUs received, aimed to receive, refused, referred and the number of accepted referrals. This would develop from the groundwork laid in this thesis which was the first to reveal the number of bodies accepted, aimed to be accepted and refused in AUs in England and Northern Ireland.

It would also be extremely beneficial to focus on the families with the same aim of identifying good practice in the interactions between AUS and the families of donors after donor death in order to understand from the families' perspective what AUS FL efforts worked well and which did not. It would be very useful for the AUS to have a better comprehension of this to aid AUS in tailoring their practice. However, there would be ethical considerations and it is likely that there would be a bias, as only families who had a positive experience or indeed a negative experience may come forward. By focussing on the family this would allow for a better understanding of the BD process in its entirety. I would then be able to adapt the BPRs in light of the families' experiences. It would be productive to consult the AUS on this as families could be recruited through them. Some AUS noted, without prompt, in the interviews that they would be happy to recommend families that would be willing to participate. However, the AUS also highlighted that this could give a biased perspective as it would be

those families with whom they had developed a close relationship and continued contact with that would participate. It also would be upsetting to contact those families that had a negative experience; it was possible an ethical committee would advise against this, but this would also introduce bias.

Finally, gender aspects were also apparent. I recognised that BSs were all female, MMs were mostly male, and DIs were divided in gender. However, the scope of this research did not allow me to explore this theme. This was something that could be focussed on in further research.

7.3 CHAPTER CONCLUSION

Overall, I have demonstrated in this thesis the importance of the AUS's nuanced and complex FL work and the central role it played in fulfilling the AUS's key aim of making the process positive for the families of donors and thus facilitating the BD process, avoiding bad publicity and encouraging further familial donations. I have called for this work to be better recognised, supported and for training to be provided. However, I have acknowledged that there was a danger in routinising such work as its recognition could lead to it becoming normal and expected practice and could detract from the job satisfaction that AUS got in voluntarily performing 'over and above' work. Most importantly this work was completed because the AUS wished to and felt that they should. Thus, the main outcome of this thesis, the BPRs, should act as a guideline only, or a tool kit of examples for which to consult when developing AU practice. I have also revealed a new arena - the AU - where *continuing bonds* processes were acted out.

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Appendix A: Survey



After body donation to medical science:
identifying good practice in the post
donation interactions between Medical
School Anatomy Unit staff and families.

Thank you for agreeing to complete this questionnaire

- It should take no longer than 10 minutes to complete. You may, however, take as long as you want.
- Your answers will be treated in the strictest confidence.
- Please return your completed questionnaire to: Zivarna Murphy (zivarna.murphy@hyms.ac.uk)

Survey Questions

1. How many bodies do you receive per year?

2. How many bodies do you aim to receive per year to meet your needs?

3. How many bodies on average are you unable to accept per year?

4. If possible, please provide an estimated percentage of how many donors have asked for their families not to be contacted after donation/at the time of disposal?

5. What kinds of involvement do Anatomy Unit staff have with families following body donation and before disposal?

6. What types of questions/what contact do you receive from families post donation?

7. What type of funeral service do you provide?

Individual

Collective

Other:

(a) Who attends the funeral?

(b) What disposal options are offered to the donors/families?

Cremation

Burial

Both

(c) What option is on average is most frequently chosen?

Cremation

Burial

(d) What items or facilities do you provide, if any? (for example a coffin, urn)

8. Do families collect the ashes?

Yes

No

Sometimes

(a) What happens to ashes that are not collected?

9. Do you hold a memorial service?

Yes

No

(a) If yes, how often do you hold a memorial service?

10. Do you have a physical memorial? (for example a plaque, bench)

Yes

No

(a) If yes, can you describe what this is and where this this?

(b) Who visits the memorial?

11. Please add any other comments below:

Thank you for your participation

Appendix B: Interview Guide

Anatomy Unit Staff Interview Topic Guide

Topic 1: The unit

- Can you describe your role within the unit?
 - a. How much contact do you have with family members post donation?
 - b. What's that like? Is it what you expected?
 - c. What kinds of things do family members ask you?
- Do you think there are some things that you do that are extra to what is required (from your job description)? What kinds of things? Why do you do it?
- Do you think there's any difference between how you speak about the donor to their family as opposed to colleagues? In what ways is it different?
- What kinds of training have you had to do your job?
 - a. Did this include training around family liaison?
 - b. What kinds of support do you have in the workplace?
 - c. Going on your own experiences of the job, is there any kind of training or support you'd like to undertake/would recommend is put in place for anatomy unit staff?

Topic 2: Death and the family

- In what ways do next of kin contact the unit to notify you that the body is ready to be donated?
- Do you think family members sometimes use their contact with your unit as a way of coping with their bereavement?
 - a. In what ways? Can you give any examples of this?

Topic 3: Donation process

- Can you tell me about the process of body bequeathal at your institution?
- What is the process if you are unable to accept a body at the time of death?
 - a. What are the reasons for not accepting at the time of death?
 - b. What are the families' responses to non-acceptance at the time of death?

Topic 4: Disposal of remains

- Can you tell me about the disposal process?
 - a. Do you use the same funeral director for all disposals?
 - b. Are all remains cremated? Any requests for burial?
- How are families notified when the body is ready for disposal?

- Some donors ask for their families not to be contacted at this time, do you have any ideas why this might be?
- Are families invited to the crematorium/cemetery?
 - a. Do most families attend?
 - b. What is that like?
- What happens to the ashes after cremation?

Topic 5: Memorial/thanksgiving services

- Could you tell me about the memorial/thanksgiving services?
 - a. How are they organised? Who is involved?
 - b. What happens at the memorial/thanksgiving service? (are donors' names read out?, do students speak? etc.)
 - c. Who is invited?
- Have you had any feedback from those who attend the memorial service?
 - a. How is this done? (email; telephone; letter etc.)
 - b. What kinds of things do people say?
- Do you have a physical memorial? (for example, a plaque or a bench)
 - a. What is it? Who decided on this type of memorial?
 - b. Where is it?
 - c. Do you know if it is visited/memorialised e.g., flowers etc.?
 - d. Do you know when visits take place?
- Do you feel okay about what we've talked about today?
- Is there anything else that you thought we might have talked about that we haven't?

List of Abbreviations

Anatomy Unit Staff (AUS)

Anatomy Unit (AU)

Bequeathal Secretary (BS)

Best practice recommendations (BPRs)

Body donation (BD)

Designated Individual (DI)

Emotional labour (EL)

Emotion management (EM)

Family liaison (FL)

Mortuary Manager (MM)

Notes on Terms

This section outlines key terms that are used throughout this thesis which can be used as a glossary for reference.

Anatomy Unit

In this thesis the anatomy unit (AU) is a space within a UK medical school where practices around body donation (BD) take place.

Anatomy Unit Staff

The anatomy unit staff (AUS) are those individuals who complete FL work after donor death at a UK anatomy unit (AU). The main roles within the AU I focus on are the Bequeathal Secretary (BS), Mortuary Manager (MM) and Designated Individual (DI). These roles are labelled differently dependent upon the AU – for example the BS may be officially known as the bequeathals coordinator, short courses secretary or administration secretary. This highlights that facilitating bequeathal is not their only or main role.

BSs are individuals who have many roles within the AU including the facilitation of body donation (BD). Their role differs between AUs but includes them being the initial and continuing point of contact for prospective donors and family members. They distribute and receive consent forms, update the hard copies and databases, liaise with families, General Practitioners and hospice workers. BSs also organise and facilitate committal services, ashes collection or delivery, and thanksgiving events.

The MM is the individual that runs and coordinates the storage, preservation and use of the bodies for teaching and external courses. In addition, they take on many of the same duties as BSs that I described, including much family liaison (FL). MMs also take on the role of BS when the BS is absent. MMs play the lead role in organising and facilitating the disposal and ashes stages. For example, they are the main point of contact for the funeral director. They also help organise and facilitate thanksgiving events.

DIs “have a legal duty to ensure that statutory and regulatory requirements are met. They are responsible for supervising licensed activities and ensuring suitable practices are taking place” (HTA, 2019a).

There is a hierarchy in these roles where the BS reports to the MM and the MM reports to the DI. Ultimately the final decision lies with the DI.

Those in auxiliary roles also have a part to play in the BD process. This is where technicians and admin staff within the AU take on the role of BS or MM part-time when the AUS in these roles are absent. They thus have less experience in completing such work.

Body Donation

Anatomical bequeathal or body donation (BD) is the voluntary donation of the body after death for the purposes of medical education. Medical students dissect the body donor (cadaver) to learn gross anatomy. Medical professionals, such as surgeons, may also use cadavers to practice surgical procedures, for example a hip replacement. BD is very different to body donation for research

(general), organ donation (live and deceased), and live blood donation.

Body Donor

Body donors are individuals who donate their body for the purposes of medical education. How the body of the donor is referred to within this thesis is important and is indicative of how the status of the body changes throughout the process. *Donor* is used to refer to the individual that has donated their body. *Body* will be used to refer to the physical body of the donor. This is used to refer to the body that is physically accepted. The body then undergoes a transformative preservation process where the body of the donor is objectified, given an anonymous number and thus becomes a *cadaver*. This can be seen as a rite of passage (Turner, 1969; Van Gennep, 1960) that the donor's body must go through in order to become an anonymised and objectified cadaver to be anatomically dissected. Processes of de-personalising, anonymising and objectifying the body (Howarth, 1996; Prentice, 2013) and the purposes for this, mainly to allow the staff and students to do their job in dealing with the cadaver, are discussed in chapter two.

Catchment Area

Anatomy units (AUs) have catchment areas from which they accept bodies. Prospective donors can find their nearest AU on the Human Tissue Authority (HTA) website by entering their postcode.

Committal Service

The committal service is planned and provided by the anatomy unit staff (AUS) and is comparable to a funeral service that would take place in 'normal' post-death situations.

Duty of Care

I refer to a duty of care throughout this thesis. By this I speak of the responsibility that anatomy unit staff (AUS) felt towards the families of donors which influenced their work. This does not have any connection to the term 'duty of care' used within medical or caring professions.

Families

When I speak of families, I refer to the families of donors. These families have a role to play in the facilitation of the body donation (BD) process as they are the ones who often make the phone call in order for the BD to happen. These families are the ones who are affected by the BD process in that they experience the disruption to the 'normal' post-death process which may in turn affect the way they cope with bereavement.

Management Strategy

When referring to management strategy I speak of the strategy used at anatomy units (AUs) by anatomy unit staff (AUS) to manage and cope with their work. This is a strategy developed by the AUS. This does not have any connection with the term *management strategy* in the business management field.

Physical Monuments

Physical monuments include plaques, benches, books of remembrance, or dedicated plots at a local cemetery or natural burial ground. These are ways that body donors are memorialised by anatomy unit staff (AUS) (Bolt, 2012).

Thanksgiving Services

Thanksgiving services are held by some anatomy units (AUs) in the UK. Family, students and staff usually attend these university planned services. Such services act to memorialise and thank the donors and their families (Strkalj and Pather, 2017).