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**Investigating mortuary services in hospital settings**

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## **Executive summary**

Changes to the retention of human tissues and Department of Health guidance on good practice have resulted in the extension of the role of Anatomical Pathology Technologists (APTs).

In the twenty-first century the APT role demands a wide variety of abilities, including an adroit blend of clinical knowledge and communication skills.

The APT role is framed by a blurred occupational past. The need for clarity and a distinct professional identity is one of the driving forces behind the Association of Anatomical Pathology Technologists calls for standardisation of education, training and regulation.

Currently, there are two qualifications for APTs provided through the Royal Society for Public Health (RSPH): the Certificate in Anatomical Pathology Technology and the Diploma in Anatomical Pathology Technology. These have been developed and accredited by the RSPH since 1962.

APTs in teaching hospitals or with high-risk facilities - although not usually part of the formal education process for any clinical staff beyond pathologists - are in a position to establish best practice as they are involved in 'lifting the lid' on what goes on in the mortuary.

In this hospital, APTs promoted the work of the mortuary by going 'out' into the hospital and participating in different forums, including formal and informal meetings. They also invited colleagues into the mortuary.

Identifying the deceased person as a patient rather than a body was a highly symbolic effort to 'join up' the work of the mortuary with the rest of the hospital, ensuring that the deceased person remained a patient of the hospital until they left the premises.

An association with death was a potential barrier to communicating with colleagues outside of the mortuary, as the APTs found themselves stigmatised by what they perceived to be and what would be called sociologically their literal 'embodiment' of medical failure. This could be isolating for the APTs, to the point that when they went to other hospital departments, they were treated with caution.

There is a strong case to be made for national regulation as part of the professionalisation of the APT role, in order to align individual's responsibilities with accountability at the level of the regulating professional body itself.

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## 1. Introduction

A small number of published accounts have detailed the work of mortuaries and their staff in the United States (Cahill, 1999; Gassaway, 2007; Timmermans, 2007), South Africa (Brysiewicz, 2007), Ghana (van der Geest, 2006) and Australia (Horsley, 2008). Comparable insight from the UK is missing. To date, what insight exists has come from observational photography (Grant, 1999) and a recently published autobiographical book intended for the consumption of a niche market (Williams 2010). A comprehensive study on what goes on behind the scenes of a funeral directors' mortuary (Howarth, 1996) is as close as we have come to examining the everyday world of those who deal with deceased people.

The practice and professional identity of those who work within hospital mortuaries, anatomical pathology technologists (APTs), is largely invisible to the extent that the work and setting in which they work is absent in literature. Medical sociological work has to date been more focused on the experience of illness and dying than what happens *after* death.

This report details the findings of a case study of one hospital mortuary and the APTs who worked there. Conducted over a 12-month period, the project sought to address the following questions:

- What does the role of the hospital APT cover?
- What is the nature of their job in the public and professional interface of pathology services?
- How do APTs interpret their professional identity?

Currently, pathology services across England cost the NHS £2.5 billion a year (Department of Health [DH], 2006a). APTs make up approximately 700 of the 25,000 pathology workforce. Their role includes responsibility “for all matters pertaining to the deceased while the body is in the mortuary and is there to assist the pathologist during post mortems as well as to ensure the smooth running of the mortuary” (Burnett, 2004: p.5).

Our research questions emerged as a response to the above noted invisibility of APTs in literature, calls for advancement in hospital mortuaries (Richardson, 2001; Hock et al, 2002), changes to the retention of human tissues and the impact this may have on mortuary staff (see Carvel, 2002) and drives to develop the APT occupational role through the publication of a range of Department of Health guidance on good practice (2004; 2005a; 2006; 2006b). These Governmental drives have also involved wider consultation on the reformation of pathology services in England (DH, 2008a; 2008b), and reflected the establishment of standards in the provision of services for deceased and bereaved people, enshrined in statutes and guidelines such as the Dead Citizens Charter (National Funerals College, 1998), and the Charter for Bereaved People (Ministry of Justice, 2009).

## 2. Background to the report

Since the launch of the Department of Health Pathology Modernisation Programme in England and Wales in 1999, subsequently underpinned by the National Pathology Service Improvement Programme (as part of the NHS Improvement – Diagnostics scheme), there have been numerous Department of Health consultations, reviews and policy initiatives promoting efficiency and competency in pathology services. These have included<sup>3</sup>:

- DH (2005a) Modernising Pathology: building a service that is responsive to patients.
- DH (2005b) When a Patient Dies: advice on developing bereavement services in the NHS.
- DH (2006a) Report of the Review of NHS Pathology Services in England.
- DH (2006b) Care and Respect in Death: good practice guidance for NHS mortuary staff.
- DH (2008a) Report of the Second Phase of the Review of NHS Pathology Services in England.
- DH (2008b) Pathology: towards a competence based workforce.
- DH (2008c) Planning the Pathology Workforce: guidance for department managers.

The new millennium heralded public concern about mortuary practices with much of the impetus of a drive for change arising from a series of high-profile cases in hospitals around the UK where mortuaries and pathology departments were found to be retaining organs. A series of equally high profile inquiries into organ retention, such as The Royal Liverpool Children's Inquiry Report (2001), were conducted and widely reported on by the media in the early 2000s. The legacy of these inquiries still lingers with part of the DH's response being more detailed scrutiny of retained tissues, more comprehensive consent procedures and an increasing systematic approach to tracking any retained tissue samples.<sup>4</sup>

Within the Department of Health, the main drivers for reforming pathology services identified in the report 'Pathology: towards a competence based workforce' (2008b) also include:

- the aging demographic profile of those working in Pathology
- a general drive for greater NHS efficiency and responsiveness
- the need to deliver 24/7 services
- changes in regulation for healthcare professionals
- the increasing use of technology, and
- technological innovation.

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<sup>3</sup> Consultations have also been undertaken by the Royal College of Pathologists about the role of the APT in coroners' cases and autopsies (1995, cf. Burnett, 2004: 133; 2002, cf. Burnett, 2004: 133).

<sup>4</sup> A good overview of the chronology of the cases can be found in Johnson (2011).

Published in 2006, the Department of Health's *Care and Respect in Death: Good practice guidance for NHS Mortuary Staff* set out 8 principles of good practice for those who work in mortuaries, in providing a:

- i.** service responsive to individual needs
- ii.** service that shows respect
- iii.** service that is safe and secure
- iv.** service that is confidential
- v.** reflective service committed to improvement
- vi.** service which values effective communication
- vii.** service that is fit for purpose
- viii.** service which values its staff.

A comprehensive guidance report, this document established the need for basic standard operating procedures for the handling of bodies, valuables, working with external agencies such as the coroner, and the values of confidentiality and dignity that underpin mortuary services. It further established the need for consistent and transferable standards within mortuaries and benchmarking of professional competence for those who work in this environment. APTs are necessarily a part of this.

An organisation to represent APTs was formed in 2003. The Association of Anatomical Pathology Technologists (AAPT) is not yet a statutory body, so its 300 members to date have joined voluntarily. Upon joining, they agree to abide by the AAPT Code of Conduct, which states that APTs should:

- Uphold the dignity and reputation of the Association by applying the highest standards of conduct, honesty and integrity in their personal and professional behaviour.
- Exercise their professional practice and skill, within the agreed and known limits of their professional knowledge with judgement and responsibility.
- Maintain, develop and keep up to date their professional competence and skills.
- Observe the legal and ethical framework appropriate to their current and future roles.
- Recognise the beliefs and values of the wider general public, the users of the service and professional colleagues, treating them on a fair and equitable basis.
- Ensure their own beliefs and values do not prejudice or compromise their ability to carry out their professional roles and duties.
- Educate professional peers, colleagues and the wider general public about anatomical pathology technology and its practice.
- Promote the study and activity of anatomical pathology by promotion of the values, aims and objectives of the Association of Anatomical Pathology Technology.

As the APT job is not a regulated occupation, the AAPT has joined the Voluntary Registration Council for Healthcare Scientists (VRC for HSC). Effectively, this

means that members of the AAPT can voluntarily register through the VRC for HSC. The AAPT publicise on their website that this is an important stepping stone to recognition of the APT role as a profession requiring education and training, and registration.

These developments are taking place at a time when a healthcare scientist career framework is being developed and trialled (DH, 2010a; 2010b). The intention of the HSC framework is to establish a general curriculum, map key skill requirements and competencies, and strengthen opportunities for career development within HSC occupations, of which the APT is one.

### 3. Outline of the research

#### 3.1 Research Questions

This small-scale project explored the role of the hospital APT. It was funded by the British Academy. Taking place over a 12-month period, it was an ethnographic<sup>5</sup> exploration that specifically set out to answer the following three questions:

1. What does the role of the APT cover?
2. What is the nature of the job in the public and professional interface of pathology services?
3. How do APTs interpret their professional identity?

As sociologists working in the area of death and dying we were keen to explore an area of work that, while essential to the health services, is concealed and associated with the stigma of death. This has been referred to elsewhere as 'dirty work' (Gassaway, 2007).

At its simplest, sociological research challenges the assumptions that underpin how things are (or appear to be) and this is what we set out to do. Using an ethnographic approach specifically, we could provide greater insight into what happens in the mortuary as well as how the service providers interpret their role. Further, mortuaries are settings that are not open to the public gaze and being able to describe the space and the pathology services more generally was essential to the study. The settings in which people work and their encounters are as much a significant part of their role as how they talk about what they do.

#### 3.2 Methods

This ethnographic approach involved periods of direct observation and semi-structured interviews with APTs, bereavement care officers and service managers. We spent a total of five days in the mortuary conducting fieldwork. In total, we interviewed eleven members of staff including, service managers, APTs and bereavement officers.

Prior to each interview we provided written information on the project via a leaflet (see appendix 1) which was sent in advance and also handed out at the time of interview. We obtained written consent to the interview and observation via a consent form (see appendix 2). At the commencement of each the interview, participants were given an opportunity to clarify any concerns or queries.

Each interview was transcribed and the transcript returned to the interviewee in electronic format to enable him or her to amend what they had said. In the event two

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<sup>5</sup> Ethnography is a research method that involves being 'in' the setting in which the study is based. It can include observation and interviews.

participants chose to do this. All data was secured according to the Data Protection Act 1998. We used a simple themed analysis from codes generated by the interview data.

Part of the requirement for such a project, which guides sociological research and stipulated in the British Sociological Association guidelines (2002), is the need to keep the identity of participants confidential. In interview quotations in this report we have changed the name of the participants.

### **3.3 Access and ethical approval**

Negotiating access to a good practice setting was key and as principal investigator on the project Dr Komaromy discussed the proposed study by telephone with the chair of the Association of Anatomical Pathology Technology (AAPT). Later, as researchers, we met with the manager of the mortuary where we wanted to do the fieldwork and spent half a day discussing the project. The manager was interested in the proposed study not least because s/he thought the APT role would benefit from being standardised and that a system of registration should be a requirement across the entire profession. At interview s/he explained:

“There is such a variation up and down the country of the role of APTs; their training, education, autonomy, ownership of what they do, regulation, expectation, and the service they provide.... (W)e need to become a registered profession, whatever form of registration or regulation that takes.” (Alex)

The process of ethical approval for the project involved three stages. First, we gained provisional approval from the Open University, where the project was hosted and the principal investigator employed. Second, when the grant was approved, we sought formal approval from the Human Participants and Materials Ethics Committee (HPMEC) at the Open University which was granted on completion of minor amends. Third, we sought NHS approval through the IRAS system. Initially, we were advised by the chair of the IRAS committee that the fast-track ‘proportionate review’ route would be suitable for a project of this nature and submitted documentation accordingly. However the committee which met to consider our project did not feel secure in making this decision and so a full IRAS approval process was followed by scrutiny at an ethics committee which we both attended.

Following this, the project received full ethical approval and we were then assigned a research and development contact in the proposed study hospital. Once we gained permission from the host site, the manager with whom we initially negotiated access formally agreed to the project. We then made appointments and began the fieldwork and data collection. The lengthy process beyond the time we had allowed for ethical approval meant that the project was delayed for 3 months. As a result, we used only one hospital site due to the complexity of ethical approval and the possibility of jeopardising the project altogether.

### 3.4 An introduction to the study setting

The project was conducted in the mortuary of a large teaching hospital. It is situated in the basement of the hospital and located next to the public entrance to the car park with the outer door to the mortuary shielded from public view by a substantial tiled wall. This car-park-level position is required for access<sup>6</sup>.

This mortuary was part of the bereavement services provided by the hospital where there are three bereavement officers and an office manager (who was also an APT). The Bereavement Service was under the remit of the Cellular Pathology Department. Further, the Bereavement Service is overseen by the Deputy General Manager for Haematology, Oncology and Cellular Pathology, who was trained as an APT in the study hospital. At the time of the study working in this mortuary were: the Cellular Pathology Service Manager, the chief APT and mortuary Manager, two senior APTs, one APT and two trainee APTs.

The study mortuary had established itself as a specialist service in particular types of post-mortems. This included perinatal, maternal mortality (from death in the ante-natal period and up to twelve months post-natally), receiving referrals from across the country<sup>7</sup> and high risk cases which included CJD and other infectious diseases such as Hepatitis C. However, the APT staff were clear that were not a neuropathology centre.

On average, the mortuary dealt with 25 deaths a week and around 10-15 post-mortems. This worked out as approximately two post-mortems per day (Monday-Friday). The mortuary operated from 8am – 4pm, although APTs often stayed longer than this either to finish post-mortems, including cleaning the post-mortem room, and/or to complete and process paperwork.

The mortuary also offered an out-of-hours service which meant that the senior APTs followed an on-call rota. They were paid for this on-call service which was available to provide advice and assistance to hospital and external staff, such as funeral directors, 24 hours a day, 365 days a year. This might include attending for any viewings and/or forensic/coroner post-mortem examinations. They would also need to be present for the release of patients in the event of non-heart beating tissue retrievals.

The Department was part of the National and Regional Emergency Plan, and the staff formed part of the major incident unit for the city. This meant that senior staff members would need to attend in the event of a major incident and all APT staff be available to receive deceased people in the mortuary. Further, in the event of a major incident all staff would be called to attend the mortuary and expected to stay until the hospital declared a 'stand down' from major incident status.

As well as offering support to relatives of deceased patients and tasks that relate to the safe storage and care of deceased patients, the role of the APT involves ethical dimensions related to human tissues. The Human Tissue Authority Codes of Practice (2000)<sup>8</sup> and recommended good working practices in pathology (DH, 2008a) require

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<sup>6</sup> For funeral directors predominantly.

<sup>7</sup> Most referrals were from the wider urban area.

<sup>8</sup> <http://www.hta.gov.uk/policiesandcodesofpractice/codesofpractice.cfm>

that staff follow strict guidelines. We discovered that tissue collection was a complex and time-consuming part of the APT role. During the study, we were told that as well as tissue tracking information management systems were being put in place for: the declaration of death; organ donation; porters; mortuary reception; post-mortems; registration of deaths; cremation cheques and release for funerals.

### **3.5 Physical layout**

Public entry to the mortuary was from the main entrance controlled by an intercom and camera system. The public entrance led to a family waiting room which was equipped with comfortable chairs and access to a toilet and washbasin. It was decorated in relatively bright colours with pictures on the walls. This room, which had a curtained viewing window along one wall, led into the viewing room which was small in size and contained a bed for the deceased person and would accommodate a cot for the viewing of deceased babies.

From the viewing room there was a second door which led to the non-public area of the mortuary that contained fridges for the storage of deceased patients and deep freezers for longer-stay deceased patients. On the fridge doors were white boards where patient names and the date of their arrival in the mortuary were recorded in colour-coded markers. This made it possible to see at a glance how long a patient had been in the fridge.

To the right of this area and opposite a hatch to the main post-mortem room, was a very small staff room containing computers, printers, photocopiers and drink-making facilities, including a small domestic fridge. This was where staff did their paperwork and took their breaks.

Immediately opposite the staff room and across from the storage area for deceased patients was a very large post-mortem room containing six post-mortem tables, accessed by a corridor to the right of the fridges. Adjoining the PM room was a separate smaller room where high-risk post-mortems were conducted. The high-risk room had a viewing room connecting to the main storage area (containing the fridges), where observers could watch through a window. The main PM room had an open tiered viewing gallery along one wall which could be accessed from the back entrance to the mortuary. This is where interested parties, such as doctors and nurses, could view post-mortems without entering the main PM area. Staff could also look into the PM room via a wide hatch which facilitated the removal of specimens without having to enter the room itself.

A corridor that led to the post-mortem areas contained three small changing rooms, shower and toilet. Everyone who attended a post-mortem was expected to change into suitable clothing, including scrubs, hairnets, glasses, masks and wellington boots. Further protective clothing such as water resistant gowns, plastic aprons, respiratory protection, eye protection and gloves were kept in cupboards in the PM room. The shelving area near to the hatch in the main PM room was where samples from the PMs were stored. Many of these contained brains suspended in formaldehyde in the process of being fixed prior to samples being dissected.

Both the main PM room and the high-risk room contained benches where pathologists dissected organs for inspection and sampling. The benches were large and made of metal. Hosing equipment was used during and after PM examinations. The floor contained large drainage channels to take away this effluent. On the supporting pillars adjacent to the dissection benches were boards where details of the PM, such as the weight of organs, could be scribed.

It was possible for up to six post-mortems to be conducted simultaneously and one in the high-risk room.

Overall, the atmosphere and layout of the PM room was one of clinical order and cleanliness. This contrasted with the area described earlier where deceased patients were stored. During the day, there could be numerous people in this area going about their daily business. These included doctors, porters, cleaners, and funeral directors. If the viewing room was occupied, the APTs would remind visitors to the mortuary to be as quiet as they could.

It is possible to speculate that when the mortuary was designed most space was given to the storage areas and post-mortem rooms, suggesting storage and dissection were the most important aspects of mortuary work. We observed that the comparatively small and cramped office space, shared by all staff on duty, made it difficult for them to work effectively on their paperwork. Further, the size of the waiting area and the comparatively small size of the viewing room indicates that when the mortuary was designed, it was anticipated that more time would be spent in preparing for and recovering from viewing than in the viewing itself. The position of the mortuary in the basement of the hospital, with no signage and with a discreet and concealed entrance, suggests that despite considerations about the ease of transfer of deceased patients to other premises (mostly funeral mortuaries), the hospital mortuary was something that needed to be concealed from public view.

#### 4. The Emergence of the Anatomical Pathology Technologist

The APT role was formalised in 1962 when it came under the remit of the Royal Society for Public Health. Prior to this, the training of APTs was not an issue in which any health-related organisation had shown any interest (Burnett, 2004). Most of the mortuary staff working in hospitals were employed as mortuary attendants, assistants or porters and trained on an ad-hoc basis by the pathologist and the more experienced attendant.

In 1991, the Handbook of Mortuary Practice and Safety was introduced by the Royal Institute of Public Health (now called the Royal Society for Public Health). Commonly referred to as 'The Red Book', the handbook was a great success and was last updated in 2004 by R.A. Burnett, a consultant pathologist and chairman of the Board of Education and Examination for Anatomical Pathology Technology, of the Royal Society for Health. The Board also contributed to the updating of the book, as did a number of other specialists (see Burnett, 2004: iii). The updated version reflects how over the last decade the APT role has expanded as high-risk cases become more common place, technology develops and human tissue legislation has been introduced (see job description in appendix 3).

The establishment in 2003 of the Association of Anatomical Pathology Technology (AAPT), formed with support from the Institute of Biomedical Science (IBMS), the Royal College of Pathologists (RCP) and the Royal Society for Public Health (RSPH), has provided the foundation for a national professional identity. This was recognised by the study APTs as a clear delineation of the mortuary work 'of old' and for some was reflected in the boundary between hospital and public mortuaries. Those APTs participating in this study with knowledge and experience of public mortuaries<sup>9</sup> were clear about the more task-focused work of the APT in the public mortuary setting and the depth of knowledge and understanding they were required to demonstrate in this hospital setting, as well as the extended role beyond that of the traditional mortuary worker. For example, when we interviewed the APTs they were clear that they were required to uphold NHS clinical standards. The APTs therefore saw their role as one with a scientific remit and clinical responsibilities that was distinct from the blurred occupational boundaries of the mortuary porter/technician of the past.

The APT role of present is thus framed by a blurred occupational past. The need for clarity and a consistent professional identity is one of the driving forces behind the AAPT's calls for standardisation of education, training and regulation.

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<sup>9</sup> Mortuaries operated by the local authority.

## 5. The APT role at this hospital

The NHS Foundation Trust in which we conducted the fieldwork recruits and trains APTs in the areas of: clinical; scientific; technical; management and communication skills. Recruitment adverts list the detailed skills that comprise these elements of the role. The job description also includes an expectation that staff will subscribe to the values of the organisation (see appendix 3). There are no pre-requisites for the post in terms of qualifications and experience, although applicants with GCSEs are welcome, as is an understanding of science subjects. In talking to the APTs we discovered that vacant posts are highly oversubscribed.

APTs at the study site displayed a high level of awareness of themselves as key professionals in the bereavement care team. They were responsible for the reception, release and transfer of deceased patients to and from the mortuary. They were also responsible for their safe handling while there. This might include the cleaning of deceased patients and the removal of any tubes before releasing them to the funeral director. One participant outlined the protocol to follow when a deceased person arrives in the mortuary:

“[When] the patient arrives in the mortuary their ID is checked by the APTs .... we check if the patient has any belongings, for instance they may have a wedding band on their finger, they may have jewellery on, and sometimes you find people from many different religious backgrounds have different sorts of keepsakes with them. So we check if they have any of those, all information is correct, then the patient is put in our register.

Then we have to weigh and measure the patients just in case you may get, you may not know that the patient is going to have a PM or not, we always need weights and measurements anyway, so that saves time for us, and also the funeral directors like to have the weights and measurements of a patient for when they do coffins, so we do it anyway rather than keep pulling the patients in and out the fridge when they call and they want to know the measurements.

So the patient gets weighed and measured, then, if for instance we happen to get a patient who may have had any central lines in or anything like that and they may have been taken out or a patient is just leaking from them, the patient will have a clean over. We will give them a clean over, wrap them in new sheets, put them in a new shroud and into a body bag. Then the patient goes into the fridge and their details are kept on the fridge and in our register so that they both coincide with each other and everyone is aware of who is where and for how long they have been here. So that’s the process in the mortuary when the patient first comes down”  
(Aaliyah)

As most deceased people in the mortuary do not require post-mortems, this process of reception, release and transfer formed a regular part of the everyday work. However, much of the APT role required substantial periods of time involving clinical, scientific and technical skills associated with clinical pathology work in the

post-mortem room and this was where staff spent a considerable part of their day. Many of them particularly enjoyed working in the PM room.

The post-mortem work involved APT staff in preparing the deceased person for the procedure and evisceration. The process of dissection provided visible clues for cause of death. The first level of examination involved the APT in an external examination. Next, under the direction of the Pathologist, the APT would remove the organs of each system and hand them to the Pathologist who at a dissection bench examined them in detail before taking samples for further investigation. It was also the role of the APT to take tissue and body fluid samples.

When the post-mortem was complete, the APT was responsible for the reconstruction of the deceased person. All the APTs we interviewed told us how carefully they worked to make the deceased person look good enough for viewing by relatives and or friends. Sometimes this demanded a high level of skill, as one participant illustrated in the following example:

“We had a case, it was a man who came in and he’s been hit by a train and he was in, obviously his hands and things were like sort of hanging off, bits of him were off and everything and it looked like, you know a phone book, if you can imagine somebody tearing a phone book in half and it was like he had been torn in half. And then his bottom was front wise because he was completely flipped over and I think I must have been in there until about half past two reconstructing him. When the coroner’s office rang and they received the body back, they couldn’t believe the family were actually able to view, they just thought there was going to be absolutely no way. But luckily because of the stitching and then there’s certain ways of putting the bandages and stuff, they could look at his face so things like that are sort of the best part.”

(Amanda)

Many of the participants expressed their enjoyment at this reconstruction part of their job:

“The best bit of my job, wow. The post-mortems. That’s the bit I, it’s not just the post-mortem side, it’s the taking care of the patient as well. I do love the fact that I take pride in taking care of my patients, you know I would be mortified if I came into a viewing room and somebody had bits of tissue sticking out their nose that families could see and it is the patient care side of it. I love doing the post-mortems and I love learning but I love also taking pride in how neat my suturing is, you know, I put the upmost effort into making sure that I do the smallest amount of sutures possible and make sure my patients are clean and dry and dignified, it is, yes a lot of it, the majority of it is the patient care for me.”

(Emma)

Post-mortems were of two types: planned ones which were booked in to the mortuary and unplanned post-mortems, such as the one outlined above, but which were also conducted on site. As stated earlier, the study hospital mortuary specialised in specific types of post-mortems which included highly infectious cases, coroner’s cases,

neonatal and maternal deaths. In these post-mortems deceased adults and babies could be transferred from other hospitals within the locality.

In summary, the APT's role in the post-mortem included a deconstruction of the deceased person and after the examination, the reconstruction of that person.

## 6. Communication skills

The professional and public interface was an important part of the APT role. In addition to handling deceased people, staff were required to receive and support bereaved people visiting the mortuary and be present during viewings.

Many found this mix of ‘brain and brawn’ in the physical movement of patients, dissection, and dealing with pathologists and families personally fulfilling:

“It’s the right blend of practical skills and knowledge. You have to have a broad knowledge, a good memory and work hard and I just like it. I like the relationships that you have with people and it’s just fantastic, and the levels of communication are just right for me.” (Steve)

“This was the best of both worlds for me because we do get to practice some forensics when we have murder type cases that come in, but then I get to get hands on, there’s patient care involved which I enjoy and I learn everyday in this job which I adore. (...) I just find the whole thing amazing.” (Emma)

The job thus required an adroit blend of clinical knowledge and communication skills. Some members of staff felt more comfortable and capable in one area than another. The need for skilled communication was exemplified particularly well by a participant who reflected on what it is like to speak to newly bereaved people about what is happening to the deceased person’s body in the mortuary:

“It’s like an odd mixture of trying to sound sympathetic but also trying to be really clinical and explain why you need to chop off bits of this tissue, so its weird but I think it’s like with anything, it’s just more practise and you just get used to it.” (Amanda)

Another told us about how they would deal with visitors who attended for viewing,

“The best part of the work I would say is knowing that the patient has actually left the mortuary in good condition and the family are happy with the whole service throughout the patient’s hospital stay, even if it has been a short stay, such as if a patient has been through A&E and they happen to have passed away there. It is just knowing that some relative, family member is happy with the whole process all the way through... sometimes you find a patient pass away in A&E for instance, they [the family] come down to the mortuary, and sometimes they look at the patient like ‘Why are they looking like this? It is your fault’, kind of thing. You can understand the person is in bereavement at the moment, a lot of things are going through their heads, so it is just knowing that someone is happy with the service that we can give them, and if there is anything else we could do for them.” (Aaliyah)

A disjuncture between the caring side of the role and the scientific elements of dissection was further illustrated by a participant who commented that they enjoyed

the feeling that they were restoring the dignity of the deceased person and helping their family, but then less than a minute later reflected on how much they enjoyed the scientific component of their job – where the patients were effectively transformed into objective specimens with causes of death requiring determination:

“The beauty of this job is that you can actually see, like with your own eyes sometimes, how somebody died, you can see Thrombosis, you can see Aneurysms and all sorts of things like that. There isn’t another job, I don’t think where you can hold a human brain or a heart or something, it’s just, anatomy is sort of amazing to me. So, there is no other way I’d be able to see parts of the human body, even if I was a surgeon or something, I’d only get to see little bits of it.” (Lucy)

It is not surprising that the ability to bring together technical and scientific skill, as well as human empathy, is particularly looked for in applications for vacancies:

“You don’t want somebody that’s just here just for the anatomy side of it and they don’t care about the families ..... basically just someone that actually wants to do the job and isn’t just doing this as just, just come into work, earn my money and go home again because its not that kind of job at all. You do have to have some kind of, you have got to have a lot of patience I think with the families, and you have got to care about what you are doing.” (Helen)

We were told at interview about others who had found that the job did not suit them and who left during training. This included examples given of individuals having nightmares about the sight of post-mortems; finding the work too hard physically; and someone who was too emotionally involved when babies and children died and identified too strongly with the family loss.

For the most part therefore ‘successful’ APTs were able to manage a sense of emotional detachment from both the deceased patient and bereaved families. However, there could be isolated occasions when someone’s death impacted upon them - as one participant told us (below). The management of their emotions was part of being professional. In this example, it was not just that the APT identified with the person’s age and gender, it was also that the death had been very recent and that the deceased person was still warm:

“I mean one that possibly, not upset me - but I definitely went straight to the pub for a pint after work - she was literally brought in off the streets, she was still warm. This girl was walking along, she was exactly my age, good looking girl and walking along and this truck jack knifed, and the driver was trying to stop it.... he snapped a tree and it’s just one of those freak accidents kind of thing, and the tree fell over on the street and just flattened this woman. And she was on her way to her first day at work, fresh out of Uni., you know trotting along. And we got a call from the police or ambulance saying ‘will you accept her?’ We said, ‘Of course we will’. And when she came in, I mean she was still covered in leaves and she was still warm, which we are not used to, so that kind of freaks us out a bit when they are still warm. And I thought she’s exactly my age, beginning of her life, going off to work. That kind of

pulled on my heart, just because it can be like that, you know, so sudden. Nice summers day and bang, all gone. But that's the kind of only time it's really kind of, I mean I didn't, I mean shed a tear, I welled up but I didn't cry. Just that kind of wow, it could all be taken away so very easily." (Georgie)

While the combination of the technical and personal skills required for the post was striking, it is not exclusive to the APT role. For example, in healthcare work, medical, nursing, midwifery and ancillary support staff are required to be able to perform or assist in technical procedures on patients as well as deploy a high level of effective communication skills<sup>10</sup>. The main distinction is the status of these professional groups. In other words, care staff on the front line, such as trained nurses, need to use a range of skills, both scientific and interpersonal, and it is more likely that they will have professional recognition because they are dealing with *living* patients. Correspondingly, medical, nursing and midwifery staff are regulated occupations, with a strong professional status and standardised registration procedures (Davies, 2004). APTs however are currently not regulated. This is something that is central to this enquiry and will be further considered in the discussion section of this report.

Despite their current lack of occupational status, the APTs we interviewed talked with pride about being part of a professional team which was delivering a service to the patients of the Trust, as well as those who were referred for post-mortems from other Trusts. As one participant commented:

"The rationale for why we are doing this because actually it needs to be done so let's do the best we can, let's care for the person the best we can whilst doing what we have to do. I think that then helps people to strive to do the best dissection possible, the smallest incisions, the least amount of damage to the deceased person, the cleaning of the deceased person properly, the aftercare, the reconstruction, the dressing of them, the drying of them you know, the wrapping them with care, making sure they look as good as they can if not better than they did when they came in." (Alex)

A sense of pride was often articulated by participants as contributing to the patient care provided by the hospital. As participants noted:

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

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

"(W)hen a doctor will knock on the door to see a patient for cremation papers, they are in a main corridor as well, I've come to see a dead body and you go do you mean a patient doctor? And we do explain to them as far as we are concerned until that deceased person or patient leaves these premises they are

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<sup>10</sup> See NHS Knowledge and Skills Framework:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4105475.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105475.pdf)

a patient of [name of hospital]'. Just because they have died doesn't mean that they are no longer the responsibility of this hospital. They are patients."

(Emma)

"(I)t really gets to me, they are still patients, can't you see that? You get some doctors coming down to do cremation papers and they will buzz at the door, and they will have to see the patient before they can sign off the cremation paper part of it, they buzz on the door and say 'I've come to see a body' and I'm like 'No you haven't, you have come to see a patient' and they will come in talking about the body and I'm 'would you please stop that, you wouldn't do that if the patient was alive on the ward would you?' 'Oh I've got to see that body in bed number 10' you know, so it really annoys me the fact that it is just not noticed"

(Aaliyah)

This way of referring to deceased people as patients was something that the directorate had fought hard for and as illustrated above, was an ongoing issue in terms of encouraging other hospital staff to regard the deceased person in this way. Not surprisingly, with this approach dignity was a central feature of patient care for the APTs:

"Our main focus is patient care which most people don't understand in the wider public. Our first priority of call is when patients come in our first role is to check the patient's identify matches what we have been informed on the removal forms, keep our patients in a clean condition. One of our biggest bugbears sometimes is if a patient comes down in a poor condition such as they have been leaking and left in a dirty sheet and just because you are deceased doesn't mean that your dignity stops when your heart stops beating. So we keep the patients as clean and tidy and presentable, for their dignity and also for their families when they come in and wish to see them. We perform post-mortems so we are the ones that will eviscerate the patients, remove their organs so that the pathologist can then dissect the organs, and again a large focus from our part isn't what the cause of death is, it's the patient. So the patient is kept clean at every possible stage of the process."

(Emma)

Identifying the deceased person as patient rather than a body was a highly symbolic effort to 'join up' the work of the mortuary with the rest of the hospital, ensuring that the deceased person remained a patient of the hospital until they left the premises.

## 7. The Bereavement Service

The mortuary service in the study site had been set up as part of a broader bereavement care service which also included the Cellular Pathology Team. This meant that an APT was involved mostly in the handling of the deceased person, any post-mortem and discharge from the mortuary. The bereavement office would deal with the administration that accompanied a death.

When a death occurred in the hospital, the bereavement officer arranged for all of the necessary paperwork to be completed and made any viewing appointments. One bereavement officer described the role as follows:

“I get the notification of death and deal with it, so they will come through, we will go through the paperwork and contact the doctors, have the medical certificate and everything else completed. We liaise with the family all the while that’s going on and then we will have them come in and we will arrange for various bits of paperwork, make appointments and so on so. It’s quite involved”  
(Michelle)

A lot of the time, bereavement officers were involved in chasing information and cataloguing details of the deceased patient. When asked what a typical day included, one bereavement officer explained:

“Its different every day, we could be looking after or talking to relatives, listening, obviously chasing up doctors to get paper work completed - tracing next of kin, contacting the police, the coroners - organising funerals for people that haven’t got any next of kin, or next of kin not wanting to do the honours. It’s varied, chasing property, dealing with complaints, pacifying people who have been upset on wards. Every day is different”  
(Roger)

Often such a level of involvement was required so that when the next of kin attended the hospital the death certification was completed and all belongings at the bereavement office, in order that the next of kin only had to make one visit. In addition, a registrar was on site three days per week so that people could register the death. This considerably enhanced the service. It also meant that people could register the death without meeting people registering births or getting married, which is the risk for people who register a death at their local registry office.

While this meant that only one visit was necessary, family members or people close to the deceased person could choose to view the deceased patient in the hospital mortuary more than once. The bereavement service also offered financial advice and cancelled any pension payments and benefits. Further, in some cases, all service providers such as local authorities and community care would be notified.

The liaison between the bereavement care officer and the APTs was crucial in this service. The APT would prepare the deceased person to be seen in the viewing room in the mortuary and would be present during the viewing. If the patient had died on a ward, the protocol was for a ward nurse where the patient had died to meet the

relative and take them to the mortuary for a viewing. This was considered to be good practice in that the relative was with someone known to them and the hospital therefore able to offer a continuing service. However, this could be a source of tension, as described here by one bereavement officer:

“According to the [hospital] policy here families must be escorted by one of the nurses from the particular ward in which the person has passed away. So our responsibility is to get one of the nurses available to escort the family to the viewing room. And it is a difficult task, in its own way.” (Enitan)

It could be problematic in terms of someone known to the family being available to escort them to the viewing. One APT explained a further difficulty, not just in not knowing the deceased patient and family, but the member of staff also not being familiar with conducting viewings:

“They (nurses from the ward) don’t necessarily know them. We have had them before where, you know, health care assistants have been the only person available. So they just send them down, which has its problems because the health care assistant has never done a viewing before normally. They don’t know where they are going.” (Helen)

Helen went on to explain how important it was for nurses to understand the work of the process of viewing and what happened in the mortuary:

“There has to be somebody there who can support them (families) properly, so you have to... you know, help them, support them, call help if they need to.” (Helen)

We were also told of instances when nurses had gotten lost in the hospital or taken the family to the non-public entrance to the mortuary.

Sometimes when hospital patients died no next of kin could be found, despite the best efforts of the bereavement officers. This meant that the deceased person might spend a long time in the mortuary fridge while the search was conducted. After one month, the patient would be moved into the deep freezer to be stored for a total of up to six months; after which time the hospital would arrange for their funeral. It was also the case that neonates might be kept in the mortuary freezer while parents decided about any funeral arrangements. While we were conducting fieldwork three patients were being stored in the freezer; one embryo, one baby and one adult. This lengthy stay could be a source of concern for the members of the bereavement care team and demonstrates on the one hand the need to facilitate the right treatment for patients leaving the mortuary, and on the other hand the logistical role of APTs in overseeing the available space for patients in the fridges.

Finally, part of the role of the mortuary and bereavement team included training other hospital staff in their work on what happens in the mortuary; categorised as part of the communication section of the APT job description (see appendix 3). While we were on site, filming was taking place for an online delivery of induction training and the role of the bereavement care services team (including APTs) was part of that training.

The participants talked to us about their involvement and expressed the need for recognition particularly by the nursing and midwifery staff in their work. They were also keen for any relevant staff members to be offered the opportunity to witness a post-mortem and to understand what happened so that they could inform those relatives who needed to know. This is detailed in the next section.

## 8. Working with Others

During interviews, many APTs reflected on how they were perceived as ‘different’ from other hospital staff because they worked in the mortuary. Often, this association with death was a crucial barrier to communicating with colleagues outside of the mortuary, as the APTs found themselves stigmatised (Goffman, 1963) by – what they perceived to be and what would be called sociologically – their literal ‘embodiment’ of medical failure:

“Often the medical world will see it as a failure, a failing, something has gone wrong and it’s negative, they don’t want to always be reminded of that, and to some extent you can understand that actually it is best for the psyche of a Doctor or a Nurse, especially if they are saving people’s lives, would they need to take that hit to think ‘Someone else has died, there is another dead person, are we therefore not very good at what we do?’ and that might impact on their role.”  
(Alex)

An association with death could be isolating for the APTs, to the point that when they went to other hospital departments, they were treated with caution:

“I mean even when we walk around a department, yes we try not to publicise the fact that we are from. Like if I have to go to somewhere like the children’s wards to pick up notes I always go [whispers] ‘I’m from the mortuary’, and they go, kind of give you [rolled] eyes, ‘Oh the death squad are in’. But again I think it’s because of that, especially in a hospital as opposed to a public mortuary. Again it’s that whole attitude or ethos that you come to the hospital to get better and when the idea of people dying gets pushed in their faces I think potentially that’s when people kind of possibly freak out a bit and go ‘oh shit that might happen to my relatives’.... I mean loads of staff won’t even set foot in the mortuary.”  
(Georgie)

An anecdote from the same participant illustrated the stigma associated with the mortuary particularly well:

“We had one of the housekeeping managers, she’s a lovely lady, she is our cleaner’s supervisor. She came down and said have you got some air freshener and I was like ‘why?’ Very curious! Basically they are not allowed to buy air freshener in housekeeping and she said someone has been sick somewhere in the toilets, can she please borrow some and she’ll bring it straight back. And I was like yes of course you can no worries. And she came back and she was like I had to fight to get this back from people in the department, they were like (this is amazing, I love this stuff!) She said, ‘No, no it’s not worth my life, I need to take it, no please. Please!’ And she just went, ‘It’s from the mortuary’ and they went, ‘Urrgh!’ and gave it back.”  
(Georgie)

The stigmatising of the mortuary and APTs reflected an underlying belief that death should be obscured in the hospital environment, seen in the DH (2006) document *Care and Respect in Death* that states that bodies being moved to and from the

mortuary require to be concealed from public view as much as possible. As a result of their stigmatisation, the APTs were aware of the need to promote the visibility of the function of the mortuary. This was also because they felt that many of their colleagues were unaware of what they did:

“I don’t think they see it, apart from the people that we deal with all the time, I think basically we are just a place that nobody talks about and we are just there to move patients from place to another. I don’t think people actually know what we do.” (Helen)

APTs promoted the work of the mortuary by going ‘out’ into the hospital and participating in different forums, including formal and informal meetings. They also invited colleagues into the mortuary. This was particularly important with student nurses. APTs regularly attended meetings for trainee nurses and showed photographs of the APT team to discredit the idea that mortuary staff are either what they called, “the death squad” (Georgie) or “morgue dwellers” (Lucy). Student nurses are also actively encouraged by the APTs to visit the mortuary in part to address the aforementioned problem of not knowing the route to the mortuary.

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

“Student nurses that are about to sit their exams, they want to come and see a post-mortem just to see what happens, and it also teaches them for their exams, where different parts of the organs are and they are sometimes amazed that we know more than they do. They are about to sit their exam, but they are like ‘how do you know that this is?’ You know, ‘You only work with dead people, so you don’t need to know all of this’. And it’s like, ‘Yes we do’, because sometimes it’s vital in giving clues as to why the person died.” (Lucy)

“We encourage nurses a lot because it’s not mandatory any more and a lot of nurses don’t know that they can come and watch a post-mortem, so we do encourage it. The fantastic thing about post-mortems from a nursing and doctor perspective, text books these days are amazing but boy did I get a shock when I saw intestines for the first time. Text books look brilliant, there goes the large intensities, there’s the small one, meet in the middle, looks nothing like it in real life. So to actually be able to see it in the flesh and get hands on is a fantastic learning tool for medical staff.” (Emma)

Evidently, there were many reasons why the APTs thought it was important to get involved in nurse training, not least in introducing nurses to the physical location of the mortuary. Principally, it was about demystifying the work that takes place in the mortuary and the role of APTs who work there, overcoming what one APT referred to as the “CSI effect”:

“It’s the CSI effect I think a lot of the time these days, they imagine a giant big ‘Y’ incision and you know it is, to be able to educate other people in what we do and how then to educate the families and help them is of great importance to us.”  
(Emma)

Promoting the visibility of mortuary staff to other areas of the hospital was key to ensuring that the mortuary was continually on the ‘radar’ of senior management:

“It’s about not letting people [forget], don’t forget we are here, don’t let them. For the want of a better expression, don’t walk all over us or forget that we are here.”  
(Steve)

One key facet of being able to promote the role of the APT was their professional training, status and recognition. In what follows we discuss the education and training of APT staff.

## 9. Education and Training

Currently, there are two qualifications for APTs provided through the Royal Society for Public Health (RSPH): the Certificate in Anatomical Pathology Technology and the Diploma in Anatomical Pathology Technology. These have been developed and accredited by the RSPH since 1962. Details of these courses can be found on the respective AAPT and RSPH websites<sup>11</sup>.

Formally recognised and accredited qualifications were particularly valued by one APT:

“Once you’ve got your certificates, you can do whatever you like, you can go and work at a public mortuary, you could run your own mortuary. You could always go into other things, like funeral directing, because you’ve got back up. But most APT’s that I know would stay doing this job for the rest of their lives.”  
(Lucy)

However, there was disquiet among some participants as to the validity of these qualifications, with some calling for higher qualifications, as one participant reflected:

“In an ideal world I would say I think our profession should be noticed a lot more and not left in the dark. I think a foundation degree at least, I think that would be really good because people don’t realise how much involvement we have with patients... I think it is good to have an understanding as to why you are doing these things, also you know about the whole body system, the anatomy, it is really good to have that background and have more knowledge, and it makes your job more interesting.”  
(Aaliyah)

The DH (2006) document *Care and Respect in Death* clearly states that staff are encouraged to participate in education and training where appropriate (under principle 8). This was encouraged and practised at the study hospital: all participants either already had the above qualifications or were studying for them.

While these qualifications were regarded as important to participants as it meant they were formally qualified to do their job, many spoke about how much they enjoyed the ‘hands on’ learning that is required in their role. Senior APTs are typically allocated to train and mentor trainee APTs. In this way, particularly as a role requiring dexterity in the PM room, the training for an APT could be seen as “a good old fashioned apprenticeship” (Lucy), which was necessary as “You can’t really run your hands over a textbook” (Aaliyah):

“(It’s very much an apprenticeship. From my first day here I was given a tour of the facilities, shown where the scrubs were and taken into the post-mortem room to witness a post-mortem, straight away on my first day.” (Emma)

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<sup>11</sup> <http://www.aaptuk.org/>  
<http://www.rsph.org.uk/>

“It’s on the job training, so it was from the day I started here, just constant training.” (Aaliyah)

“I will do set homework, learn anatomy, read the books. But then obviously we are fortunate because we can apply it to the real thing, like the next day. So you learn the blood flow of the heart through the books and then you can come in and actually physically see a heart and follow the blood flow. Obviously the blood is not flowing any more but you can apply it like that.” (Georgie)

Innovation in training in this mortuary has been very important to its success. The introduction and implementation of log books as a means of recording training, for example, were mentioned by several staff as an invaluable learning tool:

“I mean having the log books that [the manager] devised were very kind of helpful tool, ticking off kind of thing, everything from simple things, Trust Policy, do you know where the security place is, do you know the skeletal system, can you remove the brain, can you do this? It’s just a nice kind of breakdown of what you are expected to know and when you are expected to know it by, it’s actually very good.” (Georgie)

“We have a log book which we keep and things have to get signed off. My log book when I first started, obviously it was blank, and as I went on, there were a lot of procedures that I had to do. First of all watch them being done, speak about them and then one of my seniors would watch me doing the whole procedure.” (Aaliyah)

Despite the positive response of many regarding current training, a view that hands-on training, including the use of log books, was adequate was not shared by all, with a few participants arguing the training component of the job needed to be *more* ‘hands on’. One APT also highlighted the structural weakness in training within the NHS with concerns over trainees (in general) being exposed to experiences and procedures for which they are not adequately prepared or for which there might be some comeback:

“Again with the NHS... if you are not doing something you are worried that that person can then take out a grievance against you, if they are not training you.” (Helen)

Despite this NHS structural issue, the sense of transferring knowledge between APT trainer and APT trainee was considered to be a valuable part of job satisfaction for both parties. This was further echoed by APTs who commented on how much they enjoyed learning about anatomy, disease and cause of death from the pathologists. The transfer of knowledge between the pathologist and the APTs benefited from the team being based in a large teaching hospital which had an ethos of learning. Overall, participants recognised the benefits accrued from new or trainee clinical staff typically keen to learn:

“We are a lucky hospital in a sense of we have got, it’s a teaching hospital, we have got pathologists that are interested in examinations where some. It’s a lot of work for pathologists because there’s not really a lot of support for autopsies financially, that’s quite political as well, but we are lucky in that we have got pathologists that will help drive that.” (Steve)

Not only this, the hospital had a significant number of specialities, so the work of the mortuary was varied and sometimes reflected the ground-breaking work (often surgical) taking place on site. APTs working at this hospital needed specialist knowledge to be able to deal with such cases. In addition, the mortuary had a high-risk post-mortem facility, where deceased people suspected of dying from a communicable disease could be examined. As a result, many coroner’s cases from across the city were referred to this mortuary. Only Senior APTs were allowed to assist in these cases.

APTs in teaching hospitals or with high-risk facilities - although not usually part of the formal education process for any clinical staff beyond pathologists - are therefore in a position to establish best practice for APTs as they are involved in cases that require considerable technical skill. Furthermore, they are actively involved in ‘lifting the lid’ on what goes on in the mortuary.

## 10. Recognition

The study site was in the process of establishing a flagship service which included an integrated approach to bereavement care and an extended APT role. The APTs participants interviewed were pleased to be part of such a team and it was clear that they saw their manager as someone with their interests at heart and someone they were willing to follow:

“Here [our manager] has actually ... thought for us to have that responsibility in order to give APTs a larger scope of what their career involves, which is good because it gives you a lot of responsibility, but it’s also quite scary *because* it’s a lot of responsibility and we have to be really more on the ball here because of that.” (Amanda)

However, accompanying the establishment of a flagship service was tension regarding the role of the APT in terms of accountability. Knowledge gained through education has altered the distribution of power between the Pathologist and the APT, with the latter able to question the Pathologist on the grounds of professional conduct:

“At the end of the day we know what the law states and if we allow the doctor to take tissue knowing they are not allowed to we are the ones that can get prosecuted. Which is, I personally feel is a very good step in the direction of our profession, because you can’t stand back any more and go, ‘Oh no, well the pathologist said it was okay’. So I said yes, that’s how things like Alder Hey happened, which we never want to see again!”<sup>12</sup> (Emma)

This level of accountability is part of the make-up of professional groups in health care. However, the APT’s accountability is not only without formal status; the APTs in this mortuary told us they had limited recognition of their occupational status from other colleagues within the hospital:

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

This lack of status could translate into distrust of the APTs’ ability to care for the deceased patients in their jurisdiction, which was particularly upsetting for some participants:

“What we do find sometimes offensive is nursing staff, because obviously when we do set out a viewing, obviously if there’s any purging or leaking or

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<sup>12</sup> Alder Hey was one of the hospitals involved in the high profile cases outlined in the background to this report.

anything like that we will clean them up as best we possibly can. We won't put them in [the viewing room] if we know they are purging, we will spend possibly half an hour, forty minutes if necessary to make sure they look okay and nice and clean. Now unfortunately we can't stitch mouths closed anymore which is a bit unfortunate because sometimes they do look rather corpse-like but it is considered an invasive procedure now, we could get done for common assault for stitching a mouth. So when we've laid them out, really a lot of care and attention [has been given] to this patient and the nurse who accompanies the family, for continuity of care from the ward where the patient has passed away... they ring the buzzer and they will come in beforehand, like without the family and we are like 'the family have to re-buzz? Can I ask what you are doing?' And they are like, 'Oh we just had to check the state of the patient' and it's just like, what on earth do you think! That's what gets us, that's the only thing we take offence at is kind of like, a blatant criticism, what we are going to do and what state we are going to leave our patients in." (Georgie)

Although not necessarily publicly recognised, APTs have made inroads into bolstering their professional image through initiatives such as not accepting gratuities from families or funeral directors:

"You don't go to the ward and give a nurse five quid, 'Thanks for looking after Gran, here's a fiver, give her an extra sausage at dinnertime' you know. Nurses don't do it. We are professionals, its not that we don't, we can't take it, we don't *want* to take it. It's not right, we think its wrong and that's the difference." (Steve)

The refusal to accept tips was a deliberate move on the part of the APT staff to not only be seen as professional, but also *feel* professional – as one of the many professional occupational groups working in the hospital.

## 11. Establishing good practice: the future

In creating a flagship mortuary service, APTs in this hospital have worked hard to engage their colleagues. However, much of the promotion of the mortuary and its staff is down to the work of a small dedicated group of individuals, of which the APTs were very aware:

“[Our manager] has worked very hard to make sure that we are a part of the things that we should be a part of, you know. Before he was the manager I think it was a case of ‘those little pasty people with no windows down in the basement. Oh don’t mind they are just the mortuary’. We are not thought of as ‘just the mortuary’ anymore, we have interaction with the tissue transplant teams like we should do.”  
(Emma)

This increased visibility suggested that there was a reliance on the substantial efforts of several highly motivated individuals, rather than a systematic inclusion of APTs within the hospital’s strategic planning processes. The APTs therefore constantly had to promote their work. This begs the question of other hospital mortuaries where such leadership and commitment is lacking: what happens to the mortuary and the status of the APTs?

A lack of nationalised standards across the country is detrimental to the occupational status of the APT. Two participants felt that the status of APTs could profit from the introduction and implementation of common standards:

“Because there is such variation up and down the country of the role of APTs, their training, education, autonomy, ownership of what they do, regulation, expectation and the service they provide, and actually their perception of the service they provide I think is so variable up and down the country. I think that is really behind what needs to be standardised, I mean why are we here as APTs?”  
(Alex)

“I mean the training is so vastly different from different mortuaries, again there’s no standardised or nationalised things in our profession.” (Georgie)

Until this occurs, as the manager told us:

“No regulation of APT staff, what does that actually say? We don’t really care who does what to those people [who have died]. To my mind that is what the Government is saying, whatever happens happens and nobody really cares, it is not worth regulating, it is not risk, it doesn’t pose a danger to the public and they are dead.”  
(Alex)

The lack of regulation arguably suggests that dead people are not worth caring about – echoed further afield by the lack of regulation within the funeral trade.

If regulation were to be introduced, however, it would need to be founded on an 'educational currency' that is recognised, accredited and therefore transferable. As the manager went on to tell us:

"I think the biggest driver for the profession is going to be regulation, we need to become a registered profession whatever form of registration or regulation that takes. Also [we need] to modernise our training and education, because if you actually look at the scope of practice or the breadth of APTs it is so wide and so diverse, yet our educational currency doesn't stack up against our peers and that's why APTs always going to suffer and be treated as second grade citizens which they are." (Alex)

For education to be meaningful it would need to be underpinned by a standardised structured qualification pathway that clearly indicates at what stage a trainee APT should be at throughout their training apprenticeship. This comes directly from the suggestion of a participant, who told us that the theoretical component of their training was neglected because of the demands on their time as they learned the practical requirements of the job:

"You have to have it within yourself to go home and pick up a text book and when you have been here all day and you have been busy you are not always willing. You may have people doing this job that have children that can't go home at four o'clock and go right I am going to sit down and study for two hours. So a more formal theoretical training programme would be good." (Emma)

A significant barrier to more structured educational pathways could be resistance from APTs themselves. In our interviews there was a suggestion of resistance to change within the occupation, and this would need to be addressed in order for the status of the APT occupational role to have an agreed remit within modern healthcare.

Where this resistance originates from is a topic for future research, framed by the history of dealing with deceased people (Richardson, 1987) and modern professionalizing agendas within healthcare more broadly (DH, 2008d). In the context of this case study, one staff member suggested a resistance to reforming the APT role was primarily down to concerns about increased administration:

"I think [there is resentment], because I think eventually it will mean one day they may have to actually reach a certain standard, they may have to actually do some more paper work and a lot of them are against that." (Helen)

The generation of administrative paperwork, while potentially frustrating, is also indicative of transparency and accountability. Hence infrastructures (personnel, ICT, workload models and so on) for supporting APTs in managing their responsibilities need to be in place if further expansion and/or consolidating of the APT role and their corresponding education and training takes place.

What is more, regulation would require a formal and nationalised appraisal structure, a system to reward good practice and penalties for those who broke the code of conduct. It would also necessitate a robust and democratic system in place to ensure

that there was agreement and confidence within the APT community in the ability and capacity of those taking the profession forward.

Moreover, there are financial consequences for professionalizing the APT role. As regulated professionals, APTs would be able to expect higher rates of pay, in line with increases with other healthcare professionals of an equivalent clinical standing (see NHS Employers, 2011).

While income was not a priority for the APTs we interviewed (Helen told us “you don’t come into this job for the money”), one APT did note that increased responsibility and corresponding accountability should result in financial remuneration:

“I think the more we get recognised for what we do, I think it should be reflected monetarily as well which, I mean nobody does this job for the money at all. But sometimes there is that feeling of like we have so much responsibility and you don’t feel like you’re really being remunerated for it adequately, when you think ‘well I’m on the same as bin men’ or whatever.”  
(Amanda)

Education, regulation, and resources are therefore closely intertwined, alongside the broader issue of the stigma associated with death, which we will reflect on in the following concluding discussion section.

## **12. Discussion**

In this study we took a sociological approach to theoretically explore the nature of the 'dirty work' of the Anatomical Pathology Technologist – recognising that this complex role is largely hidden and unacknowledged in academic literature. We chose a setting where the manager of the services had actively campaigned to improve the profile of the APT and to gain professional recognition for this role. Further, the study was conducted in a teaching hospital setting where good practice was at the heart of patient care; with all members of staff expected to be committed to that mission. Indeed, for the bereavement care team the recognition of deceased people as patients was an important feature of raising awareness of the significance of the work of the APT as part of continuing care and excellence.

Further, the study data showed that the need for recognition was not just important at a local level – it was also important that the APT role should be afforded the professional status that the work demanded. There is a strong case to be made for national regulation as part of the professionalisation of the role, in order to align individual's responsibilities with accountability at the level of the regulating professional body itself.

### **12.1 What does the role of the APT cover?**

The APT role demands a diverse range of skills. The technical skills that are largely required in assisting with post-mortems need to be underpinned by scientific knowledge, not just anatomy and physiology, but also those associated with such things as tissue collection and storage; the safe handling of any 'matter' associated with potentially infectious deceased patients; and knowledge of all legal issues associated with consent and so on.

The communication skills required at all levels of interaction with visitors to the mortuary and, most significantly, with bereaved people affected by and involved with a death, demanded of the APT a high level of awareness and sensitivity. Further, the APT had to manage the reality that they were involved daily in the deconstruction and reconstruction of deceased people which could be hard physical and emotional work.

### **12.2 What is the nature of their job in the public and professional interface of pathology services?**

At each post-mortem examination there might be as many as 30 tissue samples collected for further analysis. Each sample had to be recorded and accounted for as it made its journey through hospital laboratory departments. Sometimes samples had to be sent further afield for specialist analysis. The APT was accountable for keeping track of these tissue samples.

The APTs also had to follow strict protocols around the safe handling of potentially contaminated matter – both in high-risk post-mortems and in those which were not identified as high risk but still required universal precautions.

The APTs talked to us about the accountability that they felt to those bereaved by someone's death, both in terms of the care of the deceased person in the mortuary and in the presentation of someone for viewing, especially following a post-mortem. Their role could extend to being present at funerals, including those of babies, when there was no-one else to represent the deceased person.

There are thus multiple levels of interaction for the APT. One of the striking aspects of the role which they talked about a lot was the need to demystify what they do – mainly with other members of the hospital staff. This they did through being part of the education strategy for the induction of nursing and medical staff and also in offering to show people what happens in the mortuary. At interview half of the APTs told us that they needed to change the image of 'dark', dangerous', disabled, older men to the reality that they were mostly young, sensitive and experts in their field. Indeed, one of the striking features of meeting the team for us was that the majority were women and all were comparatively young.

As sociologists, we would argue that APTs being the embodiment of death in the hospital is not so easy to sustain when the people involved are a young, caring and dynamic team. However, it was evident that the taboo nature death (in a hospital setting devoted to saving life and death thus carrying the stigma of failure) combines with the notion that the dead body is somehow dirty, and stigmatises those who work with dead people. Therefore, while the APT staff were convinced that by others seeing them not as the stuff of horror movies but as compassionate human beings they would change this attitude, we argue that the stigma and taboo nature of their role runs more deeply (see Douglas, 1984; Howarth, 1996; Goffman, 1963). The profoundly entrenched taboo status of the dead body is an area where the most significant challenges might lie.

### **12.3 How do APTs interpret their professional identity?**

The participants that we interviewed and observed were unanimous in the sense of pride in their role – expressed as providing continuing patient care. However, there was a tension at interview about the need to attain a nationally recognised and regulated professional status, and the obvious pleasure in the apprenticeship nature of the work with its immediate access to practical experience. This does not mean that the two are mutually exclusive, rather that it is likely that standardisation might affect the nature of the current training.

### **12.4 Conclusions**

The APT role is one that is framed by a blurred occupational past, stigma associated with death, scientific and emotional demands, and having skills that include anatomical, physical, communicative, administrative and technical abilities. In this

way, the APT role has much in common with many other modern healthcare professionals, balancing the ever-growing demands of patient care.

The APTs we interviewed spoke enthusiastically and with pride about their job. Being based in a teaching hospital has contributed to their sense of shaping the APT role of the future.

We identified several barriers to the APT role professionalising. This included resources and resistance from within as to the remit of responsibility for the role. In addition, infrastructures (personnel, ICT, workload models and so on) for supporting APTs in managing their responsibilities need to be in place if further expansion and/or consolidating of the APT role and their corresponding education and training takes place. Further barriers identified include the lack of nationally agreed clarity regarding the scope of the job itself. The establishment of the AAPT and its code of conduct goes some way to setting the foundation for the role and establishing clear occupational boundaries.

There is much potential for future research with APTs, including the background of employees and their career development, resistance from within the APT community to professionalisation, the material context of the mortuary in which APTs work, and of course, studies such as this replicated in other hospitals. There is also room for exploring the similarities and disjunctures for APTs who work in public mortuaries.

Finally, this report has demonstrated the variety of responsibilities the APTs in this hospital have, and the way they approach their work. It can be a stressful job when the mortuary is busy and there are many post-mortems. However, every APT made time to speak to us, and we are grateful to them and their manager for this opportunity.

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## **14. Appendices**

### **Appendix 1 - Leaflet**



## Appendix 2 – Consent Form

Site identification number:

Participant identification number:

### CONSENT FORM

Title of project: **Investigating mortuary services in hospital settings**

Name of Researcher .....

1. I confirm that I have read and understand the information sheet dated 9 March 2010 (document A1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I understand that anything I say will be kept confidential amongst the research team and that any recording made of any interview I give will be anonymised during transcription and the recording subsequently destroyed.

Please initial here .....

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview/observation and up to 4 weeks afterwards without giving any reason.

Please initial here .....

3. I agree to be interviewed for this study.

Please initial here .....

4. I agree to periods of observation for this study.

Please initial here .....

.....  
.....  
Name of participant                      Date                      Signature

.....  
.....  
Name of person taking                      Date                      Signature  
Consent

When completed: 1 copy to be kept by participant, 1 by researcher.

## **Appendix 3 – Job description**

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