The Psychodynamics of Death Investigation: A Case Study of the Office of the Chief Coroner for Ontario, Canada

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Abstract

Coroners, unlike police officers, emergency response workers and the majority of health professionals, are exposed to death on a frequent and ongoing basis. The types of anxiety that result from frequent and ongoing exposure to people experiencing considerable stress related to grief, shock, and anger are in many ways unique to a coroner's work. Investigating the circumstances that may have brought about the death of an individual, though clearly routine for coroners, is also a potential source of anxiety. In addition, coroners are also likely to experience anxieties typical to nearly any occupation including, but certainly not limited to, the expectations of management, timeliness of work performed and changes to procedure and policy.

One of the primary functions of an organisation is to provide the structure through which its mandate may be achieved in a manner that is optimally efficient and effective. An efficient and effective organisation is one that achieves its mandate while providing the means through which its employees may limit their experience of anxiety which may individually, or in communion, be overwhelming. The evolution of any organisation involves a process through which the functioning, the culture and the mandate of that organisation are created, modified and then re-created. This process occurs continually throughout the existence of an organisation. Since people are responsible for this process, it follows that the various aspects of an organisation reflect the conscious motivations of many different people. Psychodynamic theory suggests that the unconscious motivations of individuals are also inherent to an organisation and are manifest in ways that are not nearly as apparent as the manifestations of conscious motivations. Freud postulated that most unconscious motivations are solely oriented toward the avoidance of anxiety. As such, organisations not only consciously provide for the avoidance of anxiety, but also may do so unconsciously.

The primary rationale for this work is the opportunity to present qualitative research that illustrates the means through which an organisation may ensure the occupational health of its employees by limiting the amount of anxiety they experience in the workplace.

The Office of the Chief Coroner for Ontario is a division of the Ministry of Community Safety and Correctional Services and is responsible for investigating all sudden and unexpected deaths, as well as certain expected deaths, in Ontario. Approximately 20,000 deaths are investigated annually in the province by the 360 duty coroners employed on a fee-for-service basis.

This thesis is a case-study of the Office of the Chief Coroner for Ontario. Six coroners working in the Metropolitan Toronto Region were asked to comment on their work through unstructured qualitative interviews. Analysis of the data was conducted using principles of psychodynamics. Various themes arose during the interviews which suggest that the organisation, its policy and practice, provide multiple and often complex defences to its employees who are responsible for carrying out duties which many would consider unimaginable and unbearable.

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Chapter I: Introduction

Coroners in Ontario, Canada are required by statute to investigate deaths as defined in Section 10 of the Coroners Act (Revised Statutes of Ontario, 2003); (Appendix A). Coroners are routinely required to: attend scenes of death; handle dead bodies; communicate with people who are grief-stricken, angry, confused or even apathetic; travel to and from scenes in heavy traffic; and work on an on-call basis overnight, or for extended periods of time. The work of the coroner is unique in that these situations are encountered routinely and frequently. Though coroners may be subjected to a unique set of anxieties on a conscious level, they are also likely to experience unconscious anxieties.

Several psychoanalysts have suggested - most notably Sigmund Freud (1921) and Melanie Klein (1959) - that people utilise various defence mechanisms in order to alleviate unconscious anxiety. Wilfred Bion, one of Klein's students, applied these ideas about the unconscious to organisations which, he believed, functioned in much the same manner as individuals when it came to avoiding anxiety (1961). Bion (1961) suggested that individuals use their organisations, its rules and its regulations, in order to limit their own experience of anxiety. Organisations that are well equipped to defend their employees against anxiety are better able to provide for their employees' mental and occupational health.

This research is based upon qualitative interviews of coroners working out of the Toronto office of the Office of the Chief Coroner for Ontario. The unstructured interviews were analysed using psychoanalytic and psychodynamic principles. Various themes arose during the interviews, as did evidence of multiple defences against anxiety which are entrenched within the rules, regulations, policies and the organisational culture of the organisation. Though this research is not meant to downplay the professional acumen or *sang-froid* of any particular individual working as a coroner in Ontario, it is meant to illustrate the effectiveness of the

organisation in functioning to make possible work which many would consider difficult and wrenching.

There is very little turnover of coroners in Ontario which suggests that perhaps the organisation is playing a part in providing for the mental and occupational health of its employees, thus making a seemingly difficult occupation possible in the long-term. Coroners are able to use the organisation to protect themselves against work-related anxiety, including any vicarious anxiety which may result from working with families of a deceased person, or with police and other emergency personnel who may themselves experience considerable distress from the circumstances surrounding a scene of death.[7]

[7] My use of the term 'family' is not meant to exclude persons who, though they may not be considered family under the law, may have a close relationship with the deceased. I use the term 'family' for simplicity and I use it (as did the coroners that I interviewed) to include *anyone* affected by a person's death.

Chapter II: Background

The Province of Ontario is the largest province in Canada, with a population of 11,410,046 (http://www.statcan.ca). The capital of Ontario is Toronto, the metropolitan region of which (including: York, East York, North York, Scarborough, Etobicoke, and Toronto) is Canada's largest with a 2001 population of 2,481,494 (http://www.statcan.ca). In 2000 there were 58,374 deaths investigated by the Office of the Chief Coroner in Ontario, 14,730 of those death investigations were carried out within Metropolitan Toronto.[3]

There are 350 coroners currently working in Ontario including 1 chief coroner, 2 deputy chief coroners, 9 regional supervising coroners and 238 duty coroners who perform their duties on a fee-for-service basis. Of these 238 duty coroners 22 currently work in Metropolitan Toronto; under the direction of 2 regional supervising coroners and 1 deputy chief coroner, they investigate approximately 5,000 cases annually.

Coroners in Ontario are legally qualified medical doctors as required by Section 3 of the Coroner's Act (Revised Statutes of Ontario, 2003). Coroners are responsible by statute for the determination of the circumstances of a death in addition to: the identity of the deceased, the means by which a deceased person came to his death, the approximate time of death, the place of death, as well as how the deceased came to his death. Exercising these responsibilities requires that a coroner attend scenes of death, physically examine dead bodies and confer with police officers and other emergency workers. Often a coroner feels it necessary to speak with the family of the deceased - families who are frequently in considerable distress.

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[2] Ontario is the largest province in terms of population size and is second largest in terms of geographical area.
[3] Mortality statistics were provided by the Office of the Chief Coroner for Ontario and were available up to and including the year 2000. I cite the mortality reports for the most recent year available (2000) and have included the tables in Appendix A.

Coroners work on-call and are routinely required to remain on-call overnight. In the Toronto region there are three coroners working on-call at all times; one covering each of East, West and Central Toronto. Coroners in Toronto are on-call for one 24-hour period at the conclusion of which another coroner takes over. Coroners who work during the weekend generally stay on call for the full 48-hours and are relieved on Monday morning. Coroners continue working on the cases which they opened during their time on-call by contacting family, pathologists and police, and by completing the required paperwork. As these responsibilities extend past the coroner's on-call shift the coroner may be required to perform these duties while acting in their regular capacity as clinicians. As there are 22 coroners in the Toronto region each coroner may only be required to work on-call for a single 24-hour shift per week.

Typically, when a deceased person is discovered, someone in attendance calls 911 to request police attendance, emergency health services, or the fire department, depending on the nature of the death. Once emergency personnel have pronounced the death they contact the coroner through the coroners' dispatch service. The dispatch service takes note of the location of the deceased and subsequently notifies the on-call coroner responsible for the region in which the body was discovered. The coroner is provided with a few minor details about the death (eg. age of deceased, possible cause of death) from the dispatcher as well as the contact number of the unit in attendance at the scene. The coroner is required to contact the police at the scene of the death to request information about the identity of the deceased, the circumstances of the death, the nature of the scene, the location of the body and any other information that may be relevant to the coroner's investigation. If the coroner deems that the call is in regard to a deceased person who has died expectedly and in the care of a physician he may decline to investigate the death and the unit at the scene is instructed to inform those concerned that the family doctor may be contacted directly for the purpose of certifying the death. Families are then free to contact a funeral service.

Should the coroner feel it necessary to attend the scene he must advise the police in attendance about what should be done (or not done) until he arrives. The coroner must obtain directions to the scene, travel to the scene and begin an investigation of the death all within a reasonable amount of time; generally it is expected that the coroner be in attendance at a scene within one hour of being notified of the death by the dispatch service. A coroner may be required to offer direction to police and/or ambulance personnel who may be anxious or unsettled by the circumstances of a particular death. Once the coroner has been notified of a death - and has accepted the case - he must travel to the scene regardless of the accessibility of the location or the distance of the scene from his location.

The responsibility of a coroner once at the scene, is to establish the identity of the deceased as well as how, where, when and by what means the death occurred. This responsibility requires that the coroner examine the body *in situ*. After investigating the scene and examining the body, the coroner will generally explain to those in attendance what has occurred. It may also be necessary that the coroner consult with emergency personnel, the deceased person's family doctor, or anyone who may have witnessed the death or who may have discovered the body. Any concerns the coroner may have as to the circumstances of death may be communicated to the next of kin at this time. Likewise, the next of kin is free to ask questions or voice concerns to the coroner. The coroner may directly indicate to the next of kin his wishes as to the extent of the post-mortem investigation of the body (e.g. autopsy), the destination of the remains (i.e. which morgue facility), and a likely time at which the remains may be claimed by the funeral home for disposition. Should the coroner feel it necessary, he may request that the police call a Victim Services Unit[4] to the scene to ensure that the situation remains manageable. Once the

[4] The Victim Service Unit is a division of the Ministry of the Attorney General and is divided into several specialised services including the Victim Crisis Assistance & Referral Services (VCARS). This programme, "is a community response program providing immediate on-site service to victims of crime or disaster, 24 hours a day, seven days a

coroner has finished examining the body, the body removal service is contacted to remove the remains to the morgue. Contact details are provided for the next of kin should they feel the need to contact the coroner to inquire about the deceased. The coroner, in most instances, will not leave the scene until the body has been removed. The family does not accompany the deceased to the morgue.

Though much of the information about a death is collected at the scene, the coroner may feel it necessary to engage in ongoing discussions with family members of the deceased, the deceased's power of attorney, the police, the public trustee, and/or the pathologist. A single case may require the coroner to communicate with several different people over a period of weeks or even months. As a coroner may be working on many different cases at the same time the coroner is often required to deal with a considerable number of people concurrently.

Coroners are responsible for deciding if an autopsy is required to determine, or confirm the cause of death and other necessary information about the deceased. The coroner may consult with a supervising coroner in order to make an informed decision as to whether or not an autopsy is required; the responsibility for this decision is, ultimately, that of the supervising coroner. Consent for an autopsy from the next-of-kin is not required.

Coroners are regularly in attendance at scenes involving many types of violent death, though the majority of the scenes attended involve natural deaths (Appendix B). It is also not unusual for a coroner to attend scenes at which there may be more than one body. People whose bodies are not discovered for some time or who have died in a warm place may be discovered in a decomposed state. The responsibility to determine the identity of the deceased as well as how,

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week. With the consent of a victim, police officers call on VCARS to send a team of trained volunteers to provide on-site, short-term assistance to victims and make referrals to community agencies for longer-term assistance" (http://www.attorneygeneral.jus.gov.on.ca/english/about/vw/vcars.asp).

when, where and by what means that person has died remain, notwithstanding the condition of the body.

Rationale for Study

Psychodynamics offers a way of thinking about mental and occupational health in a manner that accepts the complexities of people's emotional lives, and the nuances of organisational culture. Psychodynamic theory has been used to describe the organisational dynamics in many health-related fields including, for example, nursing (Menzies, 1970; Menzies-Lyth, 1988; Frenkel 2002; van der Walt & Swartz, 2002; van der Walt, 2002), mental health services (Gibson, 2002; Sterling, 2002; van den Berg, 2002), and medical education (Christian, Mokutu & Rankoe, 2002). Coroners are unique in that their occupation places them in immediate proximity to deceased persons as well as a number of persons who may be experiencing considerable anxiety due to their relationship with the deceased, or due to the nature of the circumstances surrounding the death. Though it would seem that coroners are subject to a great deal of occupational stress there is a paucity of literature addressing the occupational health of coroners, medical examiners, pathologists or medical investigators. Psychodynamic theory offers a unique perspective from which to understand how coroners function in an environment so laden with anxiety, and how the organisation makes possible this very difficult work.

Chapter III: Literature Review

Much of the literature addressing the psychodynamics of organisations begins with the concept of the unconscious. Scholars have long proposed the existence of hidden aspects of mental life. It was Freud (1921), however, who is credited with developing the idea that the unconscious motivates, and manifests itself in, an individual's thoughts and behaviours. Though much of an individual's thought and behaviour may have a conscious rationale, there are also unconscious motivations for these same thoughts and behaviours. Freud's theory of the 'pleasure principle' suggests that people tend to seek pleasure and, perhaps more importantly, to avoid pain. The unconscious, according to Freud, is influenced by the range of emotional experiences which occur during childhood and infancy, including experiences of frustration and suffering (1921). This suffering was, he believed, an inevitable result of the conflict between the realities of the external world, and the individual's innate desire to pursue that which brings pleasure, and avoid that which brings pain. For Freud, development is characterised as a process whereby the fundamental desires to increase pleasure and avoid pain come to be modified in the context of external demands and constraints which enable society to function cooperatively (1921).

Melanie Klein (1959), like others before her, believed that individuals develop mechanisms to defend themselves against anxiety. By observing children at play, Klein developed a method of psychoanalysis that involved the interpretation of those means undertaken by children to alleviate feelings of intense and irresolvable anxiety (Hinshelwood, 1994). Fundamental to Klein's ideas about anxiety is the assumption that perhaps the most effective defence mechanism against anxiety is the process of relocating one's anxiety outside the self (1959). That is to say, the process of isolating that which causes anxiety within the self, and relocating it elsewhere – external to the self – makes anxiety both bearable and controllable. Individuals separate from themselves that which causes distress and then project it upon an external figure where the cause

of the distress can be controlled and manipulated. Thus, one's own distress becomes manageable when located in another individual.

Klein noted that children often represent feelings through play; often through imaginary characters or animals (1959). Children represent their feelings through figures external to themselves in differentiated forms that generally represent either good or bad. Klein referred to this process as 'splitting'. Splitting is usually followed by a related process of 'projection', which entails the relocation of feelings outside the self. It was Klein's opinion that these two mechanisms combined to allow children to resolve feelings of overwhelming, and otherwise debilitating, anxieties. Klein referred to this process as the paranoid-schizoid position and suggested that such a position is a child's principal means of defence for avoiding pain. Essential to the maturation of the child was a stage during and after which a child is able to integrate the previously isolated feelings into an integrated reality; Klein referred to this stage as the depressive position (1959). The depressive position inevitably provokes painful feelings of guilt, concern and sadness - feelings which inspire a longing to make reparations for previous injurious behaviour.

Klein's ideas were the basis for the work of Wilfred Bion who is well known for his psychoanalytic theories concerning the unconscious processes that occur in groups:

> Bion distinguished two main tendencies in the life of a group: the tendency towards work on the primary task or *work-group mentality*, and a second, often unconscious, tendency to avoid work on the primary task, which he termed *basic assumption mentality*. These opposing tendencies can be thought of as the wish to face and work *with* reality, and the wish to evade it when it is painful or causes psychological conflict within or between group members (Stokes, 1994, p. 20).

A group characterised by basic assumption behaviour works toward meeting the unconscious needs of its members. This unconscious desire of the basic assumption group

reflects its need to avoid anxiety, and becomes manifest in the group's anti-task behaviour. The emotional life of a group parallels the emotional life of the individual, thus similarities can be seen in the mechanisms relied upon to avoid anxiety. Isabel Menzies was one of the first scholars to apply the ideas of Klein and Bion to understanding anxiety in organisations involved in health care (1970, 1988).

In the 1960's the Tavistock Institute of Human Relations undertook a number of projects to investigate the relations between, "...the internal world of object relationships [and] the external world of society" (Menzies, 1988, p. viii). Isabel Menzies, working with the Tavistock Institute, published *The Functioning of Social Systems as a Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital* to explore the techniques used by a nursing service to contain and modify anxiety. Menzies discovered that, "the nursing service [...] bears the full, immediate, and concentrated impact of stresses arising from patient-care" and that they are, "...confronted with the threat and the reality of suffering and death as few lay people are" (1970, p. 5). The nurses' work, "...involves carrying out tasks which, by ordinary standards, are distasteful, disgusting, and frightening" (p. 5). Menzies drew heavily on the ideas of both Freud and Melanie Klein to demonstrate why nurses, in particular, are vulnerable to feelings of overwhelming anxiety; "there are deeply unconscious phantasies concerned with human aggression, and the damage done, in phantasy, by that aggression"[3] (Hinshelwood & Skogstad, 2002, p. 5). Nurses are confronted with situations which, "...bear[...] a striking resemblance to the phantasy situations that exist in every individual in the deepest and most primitive levels of the mind" (Menzies, 1970, p. 5). Not all of the anxiety a nurse feels is the result of interactions with patients; in fact, "the direct impact on the nurse of physical illness is intensified by her task of meeting and dealing with psychological stress in other people, including her [*sic*] own colleagues" (p.7). Such circumstances threaten to overwhelm nurses with anxiety; thus, mechanisms to avoid

[3] *Phantasy* is meant to refer to unconscious phantasy, whereas *fantasy* refers to conscious fantasy.

or mitigate this anxiety must be developed within nursing institutions, such that nurses have access to the means to make their work bearable.

Menzies believed that members of an organisation use the organisation to defend themselves against anxiety and, in doing so they develop unconscious and, "...socially structured defence mechanisms, which appear as elements in the structure, culture and mode of functioning of the organisation" (1970, p. 10). These unconscious defence mechanisms may manifest themselves in practices which in themselves, "...are social and overt, [but] what drives them is personal and unconscious and can only be inferred" (Hinselwood & Skogstad, 2002, p. 4). The defensive techniques identified by Menzies, involved organised systems of detachment and depersonalisation which relied upon Kleinian mechanisms for dealing with anxiety (Menzies, 1988). Thus, splitting and projection become instruments of defence which are manifest in the 'socially structured defence mechanism' of the institution under which they operate. The mechanisms identified by Menzies included the: "splitting up of the nurse-patient relationship", "depersonalisation, categorisation, and denial of the significance of the individual", "detachment and denial of feelings", "attempt to eliminate decisions by ritual task performance", "reduction of the weight of responsibility in decision-making by checks and counter-checks", "collusive social redistribution of responsibility and irresponsibility", "purposeful obscurity in the formal distribution of responsibility", "reduction of the impact of responsibility by delegation to superiors", "idealisation and underestimation of personal developmental possibilities", and "avoidance of change" (1970, pp. 10-23).

As these mechanisms are inherent to the institution, all new nurses are, "...required to incorporate and use primitive psychic defences..." (Menzies, 1970, p. 35). In protecting the individual from experiencing anxiety, the institution prevents the nurse from constructively dealing with situations which evoke anxiety. The "...true mastery of anxiety by deep working-

through and modification is seriously inhibited" and thus, "...nurses will persistently experience a higher degree of anxiety than is justified by the objective situation alone" (p. 25). Ultimately, "the forced [and enforced] introjection of the hospital defence system, therefore, perpetuates in the individual a considerable degree of pathological anxiety" (p. 35). This pathological anxiety conspires with normal and unavoidable anxiety to interfere with the performance of a nurse's duties and, ultimately, with the group's ability to effectively pursue its primary task. Menzies postulated that the functioning of the institution as such is contrary to the realisation of conscious (and unconscious) desires to assuage the pain, suffering, fear, and anxiety in others. Frequently, it is precisely these desires that motivate many individuals to become nurses in the first place. Menzies also suggested that those nurses who are, perhaps, best suited to the demands of the nursing profession, are for this reason the most likely to quit training, or resign their positions.

Many of Menzies' observations have been similarly identified in nursing institutions elsewhere. Frenkel (2002) noted similar socially-sanctioned defence mechanisms in a burns unit of a South African children's hospital. Frenkel cautions that any intervention intended to address such psychodynamic processes must be developed and instituted slowly to prevent creating new anxieties, and to minimise resistance to such an intervention (2002, p. 501). Van der Walt and Swartz, in their article *Task Orientated Nursing in a Tuberculosis Control Programme in South Africa* (2002), contend that intervening with the intention of changing an ineffective system of nursing is particularly difficult, as it requires that the existing work system - the nursing profession's primary defence against anxiety, and hence part of the many nurses' own defensive repertoire – be altered or abandoned. They contend that changing such a work system must begin with the premise that, "nurses as primary care givers also need human support and caring" (van der Walt & Swartz, 2002, p. 1008).

Dealing with death in an occupational environment is not unique to nursing; it is a routine aspect of police work, clinical medicine, emergency medical services and, of course, coroners' work. There is literature that addresses both the effects of both ongoing exposure to death, and exposure to single-incident mass fatalities in other professions such as military (Jones, 1985; Shalev, 1994), police (Brown & Campbell, 1994; Colbach & Fosterling, 1976), and ambulance personnel (Stewart, personal communication, April 19, 2004). However, many authors have noted the absence of literature addressing the psychosocial processes at work among those involved in death investigation (Jones, 1985; Brown & Campbell, 1994; and Ursano & McCarroll, 1994). As very little literature exists addressing work-related anxiety among coroners it is perhaps useful to consider research in these other fields as analogous.

Much of the literature addressing the exposure to sudden death in the context of police-work also addresses the issues of appropriate and effective interventions to 'debrief' police officers, and to reduce their work-related anxieties (Brown & Campbell, 1994; Colbach & Fosterling, 1976; Lewis, 1994; Shalev, 1994; Ursano & McCarroll, 1994). Unfortunately, most of the literature is biased toward single interventions following exposure to a single traumatic event or 'critical incident'. Brown & Campbell (1994) do, however, address routine stressors, as well as interventions at the organisational level in policing services.

Chapter IV: Research Methods

Theoretical Construct

The insight offered by this research is based upon psychoanalytic principles. It is intended to gain a sense of the psychodynamics not of individuals but, rather, of an organisation, in this case the Office of the Chief Coroner for Ontario. The research seeks to explain how the organisation provides for the occupational health of its employees who are exposed on a frequent and ongoing basis to circumstances which are inherently and unavoidably stressful. The various aspects of a coroner's work involve exposure to high levels of anxiety and distress which many would consider a nearly impossible environment within which to function professionally, effectively and efficiently on a long-term basis.

The study design for this research is the 'instrumental case study' of the Office of the Chief Coroner for Ontario, and the interpretive framework is based upon principles of psychoanalysis. Using Robert Stake's definition, an instrumental case study is intended, "...mainly to provide insight into an issue or to redraw a generalisation" (2000, p. 437). The methods of such a study, "...draw the researcher toward illustrating how the concerns of researchers and theorists are manifest in the case" (Stake, 2000, p. 439)

The case study is the traditional unit of analysis in the psychoanalytic tradition as it allows the analyst to, "...describe the process of the work, to demonstrate key aspects of the interactions, to show the significance of history and even to retain a sense of the real person or people who are being spoken about" (Gibson, 2002, p. 79). Depth of interpretation is essential to the psychoanalytic approach, as such, the case study is well suited to demonstrate the complexity of the organisation as a whole in a manner that appreciates the individuality of those in its employ. Additionally, as this research is oriented toward the description of the stresses that the specific demands of coroners' work place on occupational health, or perhaps more precisely,

the mental health of those individuals who work as coroners, it is necessary that the research design be suited to elaborate upon the intricacies of human experience and the effects of such experience on the mental health of persons who operate within the organisation. This emphasis upon the description of experience is a methodology commonly referred to as the hermeneutic tradition. The hermeneutic tradition "...recognises the role of interpretation throughout the process of investigation, from the inevitability of interpretation in the participants' accounts of themselves to the interpretations of the researchers who write about them" (Gibson, 2002, p. 81). This emphasis on recognising the subjectivity of the researcher is as important to the practice of interpretation as the accounts of the participants themselves. The question then becomes 'how rigorous is a study design which recognises and incorporates the subjective interpretation of the researcher?'. Many authors have suggested ways to ensure validity within the context of hermeneutic methodology. Spence (1988) suggests that internal and theoretical consistency, coherence, comprehensiveness and the critical scrutiny of one's colleagues may all serve to ensure the validity of a study. The methodology which supports this research relies heavily upon these methods to ensure validity of interpretation and, as such, the rigour of the research design.

The hermeneutic tradition necessitates a certain, "...self-consciousness on the part of the researcher" (Gibson, 2002, p. 81). In my case, this self-consciousness included the recognition that I was both an 'insider' and an 'outsider' in this organisation. It is appropriate to consider that, though none of the study participants were known to me prior to beginning this research, I have, for nearly ten years, held numerous positions which put me into contact with coroners, medical investigators, medical examiners, police officers and pathologists. I am not unfamiliar with the workings of those responsible for death investigation and disclosed my experience to all of the research participants. Though I do not believe that I was viewed as an outsider, I feel it important to note that my background and those of the coroners are very different. I am not a medical doctor, rather my background is in the social sciences; as coroners in Ontario are medical

doctors I was, in this regard, an outsider. As Gibson noted in her work with community consultation work in South Africa, "in my position I 'knew' many things about the particular consultation relationships, but was also clearly caught in a particular inter-subjunctive relationship with them" (2000, p. 85).

Though not always an easy task, it is hoped that, "if you reflect on your own role sufficiently and discuss these reflections openly in your research, the idea is that you can create a more transparent understanding of the way in which you, as the researcher, have shaped the research" (Gibson, 2002, p. 86). It is interesting to note that while this research is ultimately aimed at assessing the occupational and emotional health of the coroners working within this particular organisation, my experiences as an employee within various organisations which either support or are directly involved in death investigation were not always what one might consider 'healthy'. In accordance with the hermeneutical tradition I shall, whenever appropriate, reflect on my own position as a researcher, and as someone formerly involved in the process of death investigation.

I feel, undoubtedly, that my background was beneficial with regards to gaining access to research participants as well as to conducting interviews which ultimately produced what seemed to be very honest commentary on the nature of the work of the coroner. It is my experience that people who are unfamiliar with death investigation tend to ask questions out of some sense of 'morbid curiosity' and that often such questions are intended to elicit sensationalised responses. Frequently, when one offers honest responses to such questions they are met with grief, fear or, most commonly, revulsion. Therefore, I have - as have the many people with whom I have worked - made a habit of either providing dishonest yet 'safe' replies to such questions, or I have simply avoided responding. At no point during the interviews did I recognise that I was being provided with 'safe' responses to my questions and none of the coroners avoided or refused to answer any of my questions.

Drawing from the above theoretical standpoint, this research aims to offer insight into the functioning of an organisation which is responsible for making coroners' work possible. This research aims to achieve the following three objectives:

1. To describe the functioning of the organisation, its rules, its mandate and its responsibility as a government agency, and to explain how the organisation operates with respect to these functions.
2. To document the views of those working within this organisation, as well as an understanding as to how these people use the resources available to them to function within the expectations of the organisation while minimising their experience of anxiety.
3. To interpret, understand and reflect upon the theoretical ideas about psychoanalysis and psychodynamics to suggest how, psychologically at least, the organisation functions to achieve its mandate while mitigating the experience of anxiety of the coroners.

Material & Methods

The Office of the Chief Coroner for Ontario is divided into nine regions. Two of these regions (Toronto East and Toronto West) are managed out of the Head Office located in downtown Toronto. Consent for the study was obtained from the Head Office and access to the coroners was negotiated with one of the Regional Supervising Coroners. Purposive sampling was used to select respondents from the pool of 20 duty coroners, 2 regional coroners and 1 deputy chief coroner, all of whom operate out of the Head Office in Toronto. Skinner & van der Walt define purposive sampling as, "a sampling method in which the researcher purposively tries to obtain a sample that represents all important subgroups of the population" (1997, p. 179). Coroners were considered for an interview based upon their availability for the period during which data were collected. An attempt was made to introduce variation of experience into the sample by requesting that coroners be selected based upon their availability regardless of: their

position (supervisory or otherwise), their length of employment, the region in which they operated, or their previous medical experience. The final sample included both male and female coroners, coroners working in the East Toronto and West Toronto regions, coroners in supervisory positions and coroners in non-supervisory positions, as well as coroners with minimal and with lengthy experience in death investigation. The sample also included coroners of varied medical backgrounds, though all but one of the coroners interviewed had specialised in emergency medicine.

Names and phone numbers of available coroners were provided by the Regional Supervising Coroner. Coroners were contacted by telephone and were asked if they would care to participate in the research. All of the coroners approached were willing to participate though the availability of the researcher and time constraints limited the sample to six coroners. Coroners were interviewed individually and at a time and place of their convenience. Prior to commencing the interviews coroners were provided with an information sheet and a consent form (Appendix C). Coroners were interviewed for approximately one hour and all of the interviews were audio recorded. Participants were informed prior to commencing the interview that all, or any portion, of the audio recording would be deleted at their request. None of the six coroners requested that the audio recording of their interview be deleted in whole or in part.

The unstructured interviews began with some questions regarding the coroner's responsibilities and the various operational aspects of the organisation within which they work. Coroners were asked to describe how they operate in the context of the organisation and how they feel about certain circumstances that they routinely encounter in the process of carrying out their work. Finally, coroners were asked to describe situations, either hypothetical or from their own experience, that have caused them considerable anxiety and they were asked to describe how, if possible, they were able to avoid experiencing such anxiety. As the qualitative

information was elicited through 'guided conversations' the disclosure of information was entirely at the discretion of those being interviewed.

The interview material as a whole, as well as the consistencies and inconsistencies within and among interviewees, was interpreted in accordance with psychoanalytic and psychodynamic theories about the nature of anxiety and the functioning of organisations. The structure of my analysis draws a great deal from long-standing principles of psychoanalytic and psychodynamic theory as defined by Freud (1921) and Klein (1959) and as applied by Bion (1961), Halton (1994), Hinshelwood & Skogstad (2002) and, in particular, Menzies (1970, 1988). The data were interpreted from the theoretical assumption that one of the primary concerns of any organisation is to mitigate the work-related anxiety of its members. Additionally, two of my colleagues (L.S. & J.H) reviewed the data and offered independent analyses of the material. Comparing the interpretation of the researcher with that of other qualified researchers is intended to ensure both validity and objectivity.

Minor changes were made to the content of the interviews to ensure the anonymity of the participants. No names or specific identifying characteristics are mentioned in the narrative[6]. Speech mannerisms which may suggest the identity of a particular participant have been removed and all participants, regardless of their gender, are referred to in the masculine.

[6] I believe that were I to divulge the demographic and occupational information about the participants in this study, their identity could easily be determined; therefore, it must suffice to say that my final sample included individuals of both genders, younger (<40 years of age) and older (>40 years of age) coroners, coroners with more experience as coroners (>5 years) and those with less experience (<5 years), coroners who underwent their medical training in Canada and those who underwent their medical training abroad, coroners with medical training in emergency medicine and coroners with training in other medical fields, and coroners in supervisory positions and those working as fee-for-service, duty coroners.

Chapter V: Results

Multiple themes arose during the interviews. Coroners were free to discuss any topic they felt relevant to the purpose of the interview, that being to discuss their work as coroners. Though I made every attempt to ensure that coroners had thoroughly discussed any topics upon which they had touched during the course of the interview, I did not limit their interview in any way except to bring it to a conclusion after a sufficient period of time had elapsed or when thematic elements began to recur.

For the most part, all six interviews were thematically consistent, however, there were several themes that were raised by only a few of the respondents. Not surprisingly, those coroners who had been employed as coroners for only a short time expressed concern with their investigative abilities and the quality of their work. These coroners were predominantly concerned with establishing a 'system' or a 'routine' which would ensure that no aspect of their investigation was overlooked. The less experienced coroners also expressed the desire to please their respective supervisors, whom they had described as "supportive", "mentoring" and "helpful". Coroners with more experience spoke about dealing with the media, a topic not raised by the newer coroners.

Topics that were raised by all of the coroners included: their reasons for becoming a coroner, their previous occupational experience, training, scene attendance, the types of calls which create or exacerbate anxiety, communication with families of the deceased, conflict with the family of the deceased, as well as occupational support.

Reasons for becoming a coroner

Surprisingly, all six subjects were familiar with the process of death investigation before considering it a potential career for themselves. Three of the coroners had worked in emergency

medicine with another physician who was an acting fee-for-service coroner. These three coroners all reported having expressed interest in death investigation to the coroner with whom they were colleagues, and all reported having been encouraged by their colleague to pursue work as a coroner. One of the three coroners recounted his experience attending scenes of death with one of the emergency doctors with whom he had been working: "I liked the way he interacted with the police, with the families, I just, I think that's how it all started". That coroner went on to say, " I really liked it [coroners' work] and I think a lot of the reason I liked it was because, just like anything, if you have a good teacher who takes an interest in... who likes their job and who takes an interest in you, and is sorta fostering that you will like it too; then, I just got to like it".

Two of the coroners interviewed had undertaken their medical training overseas. While medical schools in Canada do not traditionally offer an elective in forensic medicine, many medical schools in other countries do. The two coroners who had received their training overseas had completed an elective in forensic medicine as a medical student and both credited their interest in coroner's work to their instructors.

In addition to the encouragement coroners received to consider a career in death investigation, coroners offered several other explanations for their interest in coroners' work. One coroner (who had been working in emergency medicine) indicated that the public safety element of the position was appealing to him, as he had clearly seen much in the way of avoidable death and trauma during his time working in emergency departments. [7] Another coroner stated that one of the reasons he had pursued death investigation was due to frustrations he had encountered while working in emergency medicine: "I was getting tired of working in emergency in the middle of the night and helping 25 patients and no beds and I thought 'OK, I'll move into investigating dead bodies' ".

[7] One of the responsibilities of the coroner is to, whenever necessary, hold Coroner's Inquests which are intended to serve the public interest through recommendations directed at preventing similar deaths in the future.

Occupational Experience

Coroners felt that their previous occupational experience had provided them with many of the skills necessary to successfully undertake work as a coroner. Supervising coroners were quick to note that the following types of occupational experience were particularly likely to have equipped coroners with the skills to deal effectively with work-related anxiety.

As is required by section 3 of the Coroners Act (Revised Statutes of Ontario, 2003), all coroners in Ontario must be licensed physicians.[8] The coroners offered may reasons for this requirement. One coroner indicated that being a physician is ultimately of benefit to a coroner's occupational health and to the occupational health of his colleagues:

> ...since our people are doctors they are more willing to come and say, 'I'm having a problem, I'm stressed out and I'm really not feeling well'. Because [coroners] have patients coming [into their medical practice] - we're no different from [the patients] - and they advise patients to go and see people [to deal with anxiety]. So, we find that [coroners] are much more likely to come and say, 'can I take time off? I think I'm stressed out it's affecting my work practice' or, 'this death has really affected me and I'm going to go see someone'.

Coroners also believed that should their work begin to affect them negatively their colleagues, being experienced physicians, would intervene:

> But, I mean, we've got a group of doctors that are going to be the same as any group of professionals, you'll have some of them that deal with this by drinking too much, or taking Valium, or taking pain-killers because they've got all that accessible to them; but they are much better...probably more importantly, their colleagues, who are doctors, will recognise it and will go to them much more easily than a lawyer will go to another lawyer, or a police officer will go to another police officer.

Having trained as a physician was cited as a reason for the low turn-over of coroners in Ontario: "I think it's easier if physicians are going into it because physicians have gone to medical

[8] The requirement that coroners be licensed physicians is not standard across Canada.

school and they've had six years to decide whether they like dead bodies and live bodies". Another coroner elaborated on this subject:

> So, our feeling is well, at the end of 6 years we're not actually being naïve coming into it, we've gone through all that, see, by the time you become a physician, you shouldn't be saying 'oh, I can't do this, I can't stand the sight of blood' so therefore, we get a very, very, very low turn-over in terms of coroners here. We have about 350 local coroners across the province and very, very few of them - a lot of them do it part-time - but very, very few of them ever resign. We have very little turn-over and it's partly because we're picking the right people to begin with. You know, they're doctors and we interview them to make sure and I think their medical background means they are much more likely to stay in it.

All of the coroners indicated that they drew from their experience in clinical practice in order to help deal with the family of deceased persons. Many indicated that they had a 'style', 'approach' or 'schema' for dealing with families which had been the product of years of having worked in clinical practice.

Supervisors discussed at length the practice of preferentially hiring doctors with experience in emergency medicine.[9] The rationale for this preference was explained to me as an important means of insuring that coroners possess appropriate skills and qualities which, it is believed, constitute a suitable foundation for work in death investigation. Three reasons were given for this practice. First, coroners who had experience in emergency medicine were familiar with both physical and mental trauma, as well as with the ways emergency teams treat trauma (this is obviously important when it comes to investigating cases where, for example, a patient has died during or immediately following medical treatment). Secondly, physicians who work in emergency medicine are experienced in dealing with emotional families. Four of the coroners commented that working in emergency medicine had offered them the opportunity to develop skills that allow them to communicate with the families of their patients. One coroner indicated

[9] It is not a requirement that physicians have experience working in emergency medicine in order to be considered for a coroner's position; however, coroners considered such experience a particular asset.

that his experience working in emergency medicine had helped him to develop techniques for dealing with people, "I do deal in emergency with life and death situations, I explain those kinds of issues and [in coroner's work] the same sort of life and death issues are being described...although it's death issues, I guess, by definition". Thirdly, working in emergency medicine requires that physicians communicate frequently and effectively with other emergency personnel such as police, paramedics and fire fighters. As the coroners repeatedly mentioned the issue of fostering good working relationships with other organisations, it was not surprising to me that having established working relationships with members of other agencies was considered by the supervising coroners to be an asset. In addition, one coroner stated that having 'seen life in the raw' was an important credential for future coroners:

> And, then, [emergency physicians] would have also seen trauma and in addition to that they would have seen the dirty side of life, so the drug addicts coming in, they'll know that not everybody tells the truth etcetera. So they won't have been working in a lovely, posh neighbourhood where people come to you and they've got a pimple and they want to see a plastic surgeon.

Training

The training regimen for new coroners was described by the coroners as consisting of a training session and 'ride-alongs' which involved accompanying one of the more experienced coroners on a series of calls. During these calls new coroners were encouraged to observe and ask questions. The training session consisted of a three-day course at which new coroners attended lectures given by the regional coroners and others. An ongoing series of courses is also offered for experienced coroners. One coroner mentioned that the training sessions are an important opportunity for new coroners to meet the supervising coroners - he suspected that once a coroner has met a supervisor it is more likely that that coroner will feel comfortable calling a supervisor from a scene. Once coroners have begun to attend scenes alone they are encouraged to call their respective regional coroner once they have reached a scene in order to

inform the supervisor of the nature of the call, to ask questions, or to request that the regional supervisor attend the scene as well. Coroners also indicated that they frequently asked questions of police officers as well.

> Yes, they'll do ride-alongs initially and after they've done that then they'll go out, but their cases will be monitored by the Regional Coroner. And, they're told if in doubt, for anything, just lift the phone. And, they're told, 'you are not the expert, in a few years you may be the expert, but there are people out there with you at these things, such as the police, so don't be going around saying, 'I'm a doctor and you're just a police officer', drop your medical hat and listen to these police officers, they may well be more experienced than you and you can learn a lot from them'.

The training of new coroners is, thus, a combination of formal lectures and practical experience either with supervising coroners in attendance, or on the telephone to provide direction or assistance. None of the coroners interviewed referred to their training as inadequate, although a few mentioned feeling anxious when first attending scenes alone. When asked about this, all of the coroners noted that their response to this initial insecurity was to call a supervisor and all indicated that they did not feel anxious after speaking to their supervisor.

Scene Attendance

All of the coroners interviewed indicated that once they had accepted a case - upon being notified of a death - they would nearly always attend the scene of death. Only two coroners reported having accepted a case without visiting the scene. One of the coroners had been driving through a blizzard to a call involving a natural death and had been unable to reach the scene due to the weather. In this instance the coroner requested that the body be transferred directly to a funeral home where he had examined the deceased the following day. The coroner stated that on occasion when a scene of death constitutes a major traffic obstruction, and the coroner is unable to get to the scene quickly, the coroner may decline to attend the scene and request that the body

be transported directly to the morgue for him to examine. Several of the Toronto region coroners simply indicated that they always go to the calls that they accept regardless of the circumstances of the death. In Metropolitan Toronto coroners are "advised" to attend scenes, one coroner stating that coroners "have to go" to scenes if they have accepted the case.

Coroners are expected to attend scenes regardless of the hour at which the call is received. Calls during rush-hour and in the middle of the night are common. Many of the coroners found it particularly taxing to drive long-distances to attend scenes, especially in rush-hour traffic. None of the coroners mentioned having a problem being woken in the night to attend calls. When I asked two of the coroners if they found attending scenes in the middle of the night to be exhausting they both responded by saying that, though they were expected to attend every scene, they rarely found themselves working all night. Ultimately, none of the coroners claimed fatigue to be a problem - though two coroners did tell me that they tried to schedule a day off following their shift in order to give them time to rest before returning to their clinical practices.

Specific Anxieties

All of the subjects reported experiencing anxieties specific to certain types of scenes of death. The types of scenes mentioned included those involving: children, those scenes that cause considerable or prolonged disruption to traffic, suicide, persons of low socio economic status, and deaths due to natural causes.

Children. Four of the six respondents made reference to paediatric deaths during their interviews. One of these four indicated that though he understood that paediatric cases were difficult for some coroners, he did not personally find them particularly distressing. Deaths involving children were considered particularly distressful if the death was the result of homicide.

One coroner, when asked about scenes he found disturbing, suggested that those scenes involving children who were 'innocent victims' were particularly difficult to reconcile:

> Children I think, always have [been emotional], especially if it's a fire death, or you know, a stupid road accident where they were, um, you know 'innocent' victims, it wasn't their fault, or their driver's fault. Or, sometimes the parent who's under the influence of something and unfortunately an accident happens.

Two coroners claimed that, while they themselves did not feel anxious at calls involving children, they did acknowledge that these types of scenes are the most emotionally charged and the most traumatic for others, including family, police and other emergency personnel. One coroner described the effect, albeit on the police, of a particularly gruesome homicide of a child:

> The two homicide detectives [at the homicide] had to quit after that, they could not cope [with having] seen that little baby, because they came in and gave the baby mouth-to-mouth and the bowels were hanging out...so they just couldn't cope with that.

It is the coroner's responsibility at a scene to determine if a death is possibly the result of homicide. As many homicides involving children are perpetrated by one of the child's parents it is the coroner's job to consider whether the parents could have been involved in the death of a child.

> ...one of the things we always have in the back of our mind is that we want to make sure the child wasn't killed. Because unfortunately, you know, children have been killed. And, you know, when young children have been killed in the past it's often been the parents who have been the perpetrators. So, we go in there to investigate the death and to support the families and so on and so forth, but we also have another role, you know, ruling out homicides and it's, it's in some ways viewing parents as suspects even though they most likely are not...and, you know, we tell [the parents] that we have to look into it, and we have to look around, we look around the house, look in medicine cabinets, we're really thorough about it.

One of the coroners described a scene that he had attended that, though perhaps typical of scenes involving children, had made him feel particularly uncomfortable:

> I remember I had a case once, a girl died and it turned out at the end of the day to be a natural death, but she was dead on arrival at the hospital, so you know, I mean, we've gotta go to her house. So we go trotting off to the house, these police officers and myself, and you know everybody's, the family members are all standing around the house crying and [are] understandably upset, and meanwhile we're walking through the house and the police officer's got these great big boots on, and tramping around like, you know, sorta checking it all out and it was…I felt a little uncomfortable.

Traffic. Accidental deaths due to motor vehicle collision numbered 930 in Ontario in 2000; 139 of these took place in Toronto. In 2000 there were 49 suicides resulting from collision with motor vehicles, trains and subway cars in the province with 28 of these occurring in Metropolitan Toronto.

Deaths which either directly or indirectly involve transportation systems were referred to frequently by coroners as a source of considerable anxiety. Many deaths involving transportation systems (particularly motor vehicle accidents and suicides involving trains and subway systems) cause considerable disruption to local traffic. Many people commute into downtown Toronto and the majority of these people commute by car (via highway 401) or by subway. Coroners indicated that the pressure to facilitate these calls in order to limit traffic delays was a considerable source of anxiety, "…you have a body there on the track and you've got a whole city that wants to get home from work, you know, it just causes chaos with commuting". Dealing with other agencies at a motor vehicle or train death can also slow down the time it takes to remove a body from the scene:

> And, the police sorta want to do a, they've been trained to do a full investigation in that case, you know, get all the details, talk to all the witnesses, tie up the rail lines for hours, and hours, and hours while

> nobody can get home from work. I mean, these people gotta go pick up their kids, they might want to go to a movie, they might want to go see their doctor, who knows, and to delay them and, unless there's a good reason, it's just not the way to go. So what we do in that case is, we'll go and we'll sorta take charge of it and direct how it's going to go. But sometimes dealing with the different agencies can be difficult.

Another coroner indicated that it is occasionally necessary to decline attendance at motor vehicle accidents as traffic delays as a result of an accident or suicide may affect the coroner's ability to travel to a scene in a reasonable amount of time. Coroners in supervisory positions indicated that they occasionally attend scenes which are likely to delay traffic in order to offer support to less experienced coroners.

Suicides. There were 1053 suicides in Ontario in 2000, of which 264 occurred in Metropolitan Toronto. Asphyxia by hanging was the most common. In Ontario, carbon monoxide poisoning, jumping, drug toxicity (overdose) and self-inflicted gunshot wounds were also common means of committing suicide - though the majority of deaths resulting from jumping occurred in Metropolitan Toronto.

Suicides were referred to frequently in relation to their impact upon traffic in Toronto. Suicides were also referred to in other contexts, namely the coroner's responsibility with regards to the determination of suicide as a cause of death, as well as the anxieties that often result from attending a scene of suicide. One of the coroners indicated that due to a 1990 Ontario Supreme Court (High Court of Justice) ruling, coroners were not to declare a death a suicide based upon the 'balance of probability' rather they were required to prove a 'high degree of probability' in order to deem a death the result of suicide (Beckon v. Ontario, O. J. 429). This ruling effectively alleviates the emotional burden of subjecting a deceased person's family to the stigma of suicide.

One of the other coroners spoke of the difficulty which arises when family members object to the coroner's determination that a death is the result of suicide:

> The other thing about dealing with families is that we have to certify the manner of death, you know, and classifying it as a suicide can cause some problems. In terms of they don't want their family member to have died of suicide, and it can also cause some practical problems with life insurance. So, that can be a bit of an uncomfortable situation.

One coroner described suicides as 'sad' particularly when there are family members involved for whom a suicide note has been left:

> ...a lot of suicides they sorta, they seem to sorta blame the family, like, they write this terrible note to their ex-spouse, 'it's all your fault' and things like that. So, yeah, for the most part it's been the families [who have made a suicide call upsetting for me].

Another coroner referred to suicides as 'disturbing' but went on to say that he 'a job to do' and that he is 'directed about it', clearly implying that as disturbing as he found such scenes to be, he mitigated this 'disturbed' feeling by focusing on doing his job.

Low socio-economic status. One of the coroners interviewed indicated that calls involving persons of low socio-economic status were often a source of emotional turmoil:

> The calls that I found very saddest were calls with really low, low socio-economic status families who, like, the dad is like a labourer, and he dies, and there's five kids and, you know, what are they going to do? Those are the kind of calls that I thought were very sad. And then you see them calling one of the really expensive funeral homes and we're not allowed to say anything about funeral homes, we're not allowed to say, like, 'no, don't call them!'. But you could just see the writing on the wall. You know they're going to get pinned with a $12, 000 funeral bill and they don't have any money and...what are they going to do? Those are the kinds of calls that I found really sad.

Another coroner seemed to feel a sense of responsibility to people of lower socio-economic status who, he believed, are often at higher risk for certain types of deaths and, therefore, should be the focus of public health interventions aimed at preventing such deaths. He went on to suggest that certain television news programmes are more likely to viewed by persons of lower socio-economic status and that it was his preference for public safety concerns to reach their target audience through such programming. He was, therefore, not averse to allowing such news programmes to interview him with regard to sensationalised deaths if he believed that it would raise public awareness among people most at risk.

Death from natural causes. In 2000 the Coroners' Office investigated 13,731 deaths due to natural causes. Of these 3,622 were investigated in Metropolitan Toronto. Natural deaths comprise the majority of the case-load of the Coroners' Office representing approximately 75% of the total case-load in both Metropolitan Toronto and in Ontario as a whole. Natural deaths are defined as, "...resulting from diseases of the body and not resulting secondarily from injuries or abnormal environmental factors" (British Columbia Ministry of Public Safety and Solicitor General 2000, p. 13).

Coroners often referred to scenes involving natural deaths during their interviews. Deaths from natural causes, perhaps more so than any other manner of death, were described as causing anxiety, confusion, and conflict with the family of the deceased. Newer coroners referred to natural deaths as problematic considerably more often than more experienced coroners. One of the more experienced coroners claimed that he did not like dealing with natural deaths presumably because, under most circumstances, a natural death can simply be referred to a family doctor who may, without involving the Coroners' Office, sign the certificate of death and then instruct the family to contact a funeral home. Deaths which are not clearly natural deaths, which

are problematic due to the inability to identify the body, or which may involve people who do not have a family doctor, are always dealt with by the Coroners' Office.

> The bulk of [the cases accepted by the Coroners' Office] are going to be natural deaths and sometimes they default to the coroners' office even though we don't *want* to investigate natural deaths, because either it's just the circumstances in which apparently the death occurred, how the body was found, where it was found, and when it was found because obviously, unfortunately you have a lot of elderly people who live on their own who have no apparent contact with the outside world, no friends etcetera and the first indication that something is wrong would be that someone in the apartment building complains of the smell [of the dead body] and then we end up, it defaults to us because we run into the problem of sometimes identification, who the individual is. Again it may well be a natural death but because of problems of identification, because of the state of the body we have to deal with it.

Even though coroners may not feel it appropriate to investigate deaths that are in all likelihood due to natural causes, they attend many scenes of natural death regardless. One coroner noted that even though it may be obvious to the family of the deceased, the ambulance crew and the police that a death is due to natural causes he will generally attend the scene anyway if the death is at home and if the police are present at the scene. Many coroners indicated that it was often unnecessary to investigate deaths that occur in long-term care facilities or in palliative care units of hospitals if the death is expected and if the family and the physician do not have concerns about the death.

Certain issues which are specific to natural deaths were brought up during the interviews. One of the coroners indicated his discomfort with natural deaths because of the presence of the family. Though there may be family present in any type of scene, it is far more likely that family will be present at the scene of a natural death compared to deaths due to homicide, suicide, or accident.

> Yeah, I think I'm…I tend to step out of that whole thing of the emotion. I mean I'm very, like, I try to show my compassion, try to show that, you know, this is really, really hard but I'm really trying to make sure that this is a natural death. Like, in the back of my head I'm thinking, 'OK, how did he die, did he have any medical concerns, you know, the normal nine-yards but I think I don't like it the most because you're examining the body when the family's there. [At a homicide] or a suicide or a strange, undetermined death – often the family's not there. Like in a hospital it's easy because the family's not often there, but you know the family's just there [at a natural death] and you have to be a certain way…

Coroners claimed that the most difficult aspect of natural deaths is dealing with families, a few of them confessed that they were often unable to think of something comforting to say to the family though many stated that they generally tried to say something, despite feeling that what they were saying would not alleviate the grief of the family. When I asked one coroner if he had ever left a scene feeling really unhappy he said:

> Um, yes, there was one lady who lived alone with this man for 72 years of her life, and I'm thinking to myself, you know, I just got married ___ years ago, and I feel like we're inseparable, and I'm thinking to myself, 72 years later with somebody, and you're thinking, how could you not feel like you're not, like you've not just died yourself? You know what I mean? Because you'd just feel like there's no life. Like you, you can't say anything to this lady to make her feel better about herself. You can't say 'get a hobby', you can't say 'get a cat', you can't say, 'seek support from your family who, you know, calls you once a month'. You know…what do you say?

One coroner discussed the feeling of confusion he felt at scenes of natural death. He noted that it is often difficult to anticipate how a family will react at such scenes:

> I think the thing that strikes me the most is just the aspect of the family and that whole scenario. Like, you're feeling very bad, because you're going [to the call] thinking that, seriously, this is the worst day of [the family's] lives. But sometimes their aspect is so different from what you [expect] or, because it's such a shocking feeling [when someone dies], there's a sense that some people actually look relieved, some people look sad…. There's so many emotions that you don't even know existed, or you [couldn't] even look at them and say that they're in grief, they just

> look like they're normal but they're just almost walking in a cloud and talking. It's a totally bizarre kind of thing.

Communication with Family

Nearly all of the coroners that I interviewed referred to their 'system' or 'schema' for dealing with families. Two of the newer coroners suggested that one of the reasons for having such a system is to ensure that all of the necessary information is conveyed to the family. The 'system' therefore was, for newer coroners at least, a means of ensuring that nothing is forgotten. All of the coroners insisted that though much of what they tell family at the scene will be forgotten, they felt it important to give the families as much information as possible at the scene.

> I like to try to address things right away and give them my card and say, 'please call me if you have any questions'. And, I want to get into the [question of the] autopsy right away, like, whether they feel they need, want to address anything.

It is important that coroners communicate effectively with families not simply to answer any of the family's questions and to let them know what is going to happen but also because often the family is an important source of information about the deceased's medical history. As collecting information about the medical history of a deceased person is often difficult, it is important to both communicate information to families as well as to 'be communicated with'. Coroners claimed that being approachable is integral to their work and to ensuring that people feel comfortable speaking to the coroner about anything that might concern them.

All of the coroners expressed their concern that families understand the 'process' of death investigation including: the activities of the coroner at the scene, the method of transportation of the body to the morgue facility, the extent of the post-mortem examination, the time it will take

until the body may be released to the funeral home and the means through which the family may contact the coroner to ask questions or to discuss the results of the investigation.

> I think you have no option, you have to talk things over with the family as soon as possible. Obviously if they're at a scene you talk to them, [to] explain to them what's going to happen – because no one knows what the hell's happening, is going to happen. That's what's important to let them know, because if you don't let them know, it's not knowing that bugs them most.

Another coroner spoke similarly of how he felt that the best thing he could do to help the family is to communicate with them, and to let the families know exactly what was going to happen.

> So if you really tell them, 'this is what you should do now, this is what you don't have to do now, this is what's going to happen, this when we'll talk'; just so they know what to expect. I don't know if it helps with their grief at all but at least…cuz all these people are in their house, and grandpa's dead, and 'how long is he going to be here is it three days, is it half an hour?' they don't have a clue, like, nobody knows that. So, I think it helps them when you just tell them what's going to happen.

All of the coroners interviewed indicated that they preferred to spend time with families at scenes to give them as much information as possible, and allow time for them to ask any questions about the death. Two of the coroners stated that they believed that at the scene people forget most of what is said to them and will often have to call the coroner at some time in the future. They both stressed that it is important to encourage people to contact them in order to ask any questions or to clarify any information that the coroner may have given them at the scene. One of the coroners told me that he always repeats everything twice at scenes: "I do think it helps to, um, explain to them *at least* twice exactly what's going to happen, hopefully they would get most of it, not because they're stupid, but just because it's too much information".

Some of the coroners also felt it important to offer some comfort to the family before leaving the scene.

> I'm starting to realise that if I tell them that, most likely, there was no pain involved in this death, that that's a really good thing to say. Because what do you say? You know, like, there's nothing good about death. Generally except [for] the fact that if you die you're going to die comfortably.

One of the coroners had mentioned to me that he found it particularly sad to deal with people who felt somehow responsible for a death. Not surprisingly, he felt it important to try to alleviate this sense of guilt by emphasising those things that families did to help the deceased before they died.

> I try to say something nice to make them feel better, though I'm sure you know that there's nothing to do to make them feel better. [But] you know, even in the stupidest situation you can usually think of something genuine to say like, 'gee, that's nice that they did that' or 'it was good that you checked on them' or 'it's lucky that he had a neighbour like you' or something like that.

Conflict with Family

The only other issue about which coroners appeared genuinely distressed was conflict with families. Coroners frequently appeared exasperated when discussing such matters and were quick to relate examples of either their own problems dealing with families or of being 'in the middle' of family conflicts. Though many coroners claimed that they understood why people became upset with them they often felt that families resented their authority, or that families suspected that coroners were 'covering-up' for doctors or hospitals. Coroners also claimed to frequently be placed in an uncomfortable position between feuding family members.

Conflicts involving the extent of the post-mortem examination were common particularly in such circumstances where an autopsy is required and the family objects on religious grounds. Though coroners appeared to find conflict with families generally distressing none indicated that they found conflict over the autopsy due to religious preference to be unreasonable. All of the coroners claimed to accept that dealing with this type of situation was an unfortunate, though necessary, part of their job and that most often they sympathised with families in this regard.

> That case I was telling you about, you know, they're yelling at me, 'who are you to play God' and that type of thing. They're very upset [and] were actually going on for quite some time, and everybody's upset, and finally I said, 'I just want you to understand that I don't enjoy exerting my authority and doing this like this, you know, I don't enjoy having people upset with me and yelling at me, and upsetting people, but this is what I have to do'. And, I think that, sorta, once they can see that, you know, if they realise that you're a nice sort of a guy, not being arrogant and stuff, it's a lot easier to take.

It is interesting that, despite the fact that the Coroners Act is quite clear in granting coroners the right to determine whether or not an autopsy should be performed, coroners always discussed this decision with the family even though this decision was a potential cause of conflict with the family. All of the coroners reported having developed a certain approach to dealing with families who object to an autopsy, their approach generally involved convincing the family that an autopsy was necessary, rather than emphasising their legal authority to have the autopsy performed.

> We expect [coroners] to say, 'look, I don't know how to say this to you when you've just lost your son, and I'm really sorry but I have to ask you the most lousy question, and I'm sorry but I don't know what other way to put it but we need to do an autopsy'. I say, 'now I've got the authority to do it, but I want to let you know that it's necessary to do it, and you're going to have to take my word for it, that although you don't want it now - I understand that - in 2 or 3 months time, if we don't do this, you're going to have so many questions that I won't be able to answer'.

Two of the coroners had encountered problems with people who had unreasonable expectations about the outcome of a family member's care. One coroner claimed that families frequently do not accept that death is a possible outcome of a patient's treatment; "...sometimes [I just try] to help families understand that people die. Sometimes that's nobody's fault...people die". Two coroners also recollected having problems dealing with family members whose anger, they suspected, had been motivated by guilt.

> I can remember this case; the woman was from a nursing home, had been in a nursing home for ten years, hadn't been visited by her daughter for years, you know, goes into the hospital and dies. And, all of a sudden the daughter shows up and says, like, 'the nurse killed her', and, 'I know she killed my mother, I know she killed my mother'; and she hadn't even been there in years. I know there's sorta this idea, that people have talked about, that it's guilt - she feels bad that she wasn't there for years so it must be somebody else's fault, that kind of thing.

Coroners also found people to be mistrustful of their intentions when it came to investigating doctors, hospitals or other medical services. It is the policy of the Coroner's Office to not assign blame when a person dies, rather, coroners are expected to describe the circumstances leading up to the death without considering fault. Deaths involving homicide, malpractice or negligence are investigated by the police who are responsible for enforcing the Criminal Code. The role of the Coroner's Office in a criminal investigation is to supply information to the police without assigning blame. Coroners felt that many families, particularly when they had suspected a doctor, nurse or other medical professional to be responsible for a death, expected the Coroners Office to investigate and declare fault.

Many coroners felt uncomfortable when dealing with families who were intent upon assigning blame. One coroner recalled such a situation:

> ...and the family's just furious and there's a lawyer involved and they're, I'm just feeling that they want me to be their case and obviously I can't do that. But, I told them, you know, I was very sympathetic, but they're just calling, and calling and you gotta return phone-calls.

Any feedback that the Coroners' Service offers to institutions or to medical practitioners comes in the form of a recommendation. Commonly this recommendation comes as a result of a Coroner's Inquest and is intended to ensure that preventable deaths are avoided. Several of the coroners indicated that they found making such recommendations very satisfying and all hoped that they could in some way play a part in the prevention of needless deaths. Coroners felt, however, that families were not always satisfied with a recommendation and that they expected the coroner to support them in legal proceedings. When I asked one of the supervising coroners to describe the nature of the grievances he dealt with he said: "[one] issue will be that, 'Oh, the doctors and the hospital killed this person and you guys are coroners and you're all doctors so you're covering up for doctors' ".

Another issue coroners frequently raised during the interviews was their discomfort dealing with feuding families. All of the coroners mentioned this issue claiming that it was a problem that, in their experience, was not uncommon. One coroner described such circumstances as, "the biggest source of problems that we have to deal with". Most of the problems that the coroners encountered involved family members who: do not notify other family members of a death, who request that the coroner inappropriately obtain and communicate information about another family member, who do not wish the coroner to divulge information to another family member, who are at odds over the circumstances leading to the death, or who disagree on whether or not they approve of an autopsy. Members of discordant families tend to communicate individually with the coroner who may be receiving phone calls from many

different people regarding the same death. Coroners claimed that the most effective way of dealing with such a problem is to insist that families appoint a 'spokesperson'.

> So, tonnes of [family members] are calling. So I say, you know, 'each camp of the family has to appoint a spokesperson, and I'm only speaking to three people'. Like, 'if you've got four sides to the story I don't care, you're going to have to get three'.

Another coroner recalled dealing with a family in a similar manner though with somewhat less success:

> Like, there was one family, family of seven, and I did, like, two phone conferences with all seven people on the phone. So, I suddenly said, 'one person has to be the spokesperson for the family'. You know what I mean? You can't be talking to different members. And, the problem is that they don't like each other. So I'm getting different family members saying, 'that's my sister, she's a real bitch!'. [And] then they'll warn me, 'if Bob calls don't talk to him, we want to know if Bob calls'. And, it's getting really crazy so I, you know what I did, so I basically told them to send a letter to the regional coroner.

Support

Finally, when discussing their work coroners constantly referred to the support they were afforded from both their supervisors and from other organisations. All of the newer coroners interviewed found the support offered them by their supervisors to be integral to their work and to their occupational health. One of the supervising coroners emphasised the importance of supporting coroners in order to minimize their experience of anxiety:

> And, [coroners are] supported as well. They're part of a team in terms of this office and the police and all the rest of it. So you don't feel like you have to take the whole load on yourself and the whole world is resting on your shoulders.

All of the newer coroners claimed that during the first few months after being hired they called a supervisor from nearly every scene. During these calls coroners and their supervisors would frequently do a 'walk-through' on the phone in order to ensure that the investigation of the death was both appropriate and complete. All of the newer coroners claimed to have continued this practice of calling a supervisor when in situations where they were even the least bit unsure of what to do. When I asked the coroners if they felt reassured or less anxious after speaking with a supervisor they each responded in the affirmative claiming that they always felt better having done so, one coroner saying that calling always made him feel "more comfortable". None of the newer coroners mentioned feeling awkward or apprehensive about calling a supervisor; coroners seemed almost surprised that their respective supervisors were so approachable, one of them telling me rather enthusiastically, "I've never had a problem, never been given bad advice, never been snapped at or anything". Another coroner described his supervisor as such:

> All the questions you ask are stupid at the beginning, they're just really dumb. And I ask the stupid questions and I always feel like, you know… [I'm] trying to pretend [I'm] intelligent and I know it all, so I ask, but he [the supervisor] makes you feel really good about asking dumb questions. You know, there are a lot of dumb questions, and I've asked them all, and he's been really good about it. He's not made me feel like, 'you should know this!'. Yeah… I think they, like, I get the sense that it's really a team thing. If there's anything that I'm kinda weird about [at a scene] I'll just give him a quick call. He seems really…he's so friendly. You don't find a lot of physicians with that kind of demeanour, and who want to help. And, he's good at what he does. I think he loves what he does. They want you to call. I think it would be abnormal not to call though. Like, I'm saying to myself 'you've got to call, you don't know this, you gotta call'.

Coroners also felt that if the circumstances of a case were to become difficult they could, without apprehension, either request that their supervisor join them at the scene, or that the supervisor assume responsibility for dealing with the family. One coroner discussed how he felt calling his supervisors for such assistance:

> They're great. Until you see every scenario a couple of times you're not comfortable. And, sometimes there are families that are just…wild. You know, you have to say 'no', and they want you to go higher. [They'll say] 'well, I'm not accepting that - you must have a boss!' sorta thing, and I'll say, 'OK, I'll call my boss'. And, I'm happy to do that.

The supervising coroners, for their part, expressed their desire that the coroners under their supervision feel that they can call for help whenever, and however often, they felt necessary.

> I want to tell you at 3:00 in the morning if you're at a scene and you don't know what to do you just lift the phone and one of us will give you advice over the phone. So don't be afraid, at 3:00 in the morning, that if you phone you're going to get chewed to pieces. We don't expect you…we need you there and we want - just if you have any doubt - to phone and we'll give you advice as necessary.

A coroner, having received a call in the middle of the night only a few days before I arrived, recounted the conversation he had with one of the duty coroners:

> He says, 'I'm really sorry to be calling you' and I said, 'well, why?' and he said, 'I'm out at this death and [the body is] cut into 3 pieces and I've never seen anything like this and I just want to make sure that I'm doing the right thing'. It took me 15 minutes at the most, on the phone. […] What's 15 minutes of my time? I just roll over and go back to sleep anyway, it's neither here nor there. […] So, it's just that they only have to do what they feel they can do, and they can pass it on to somebody who's full-time, and we'll give them advice in the middle of the night in the meantime.

It is the policy of the Office of the Chief Coroner that coroners must call a supervisor if the death is the result of homicide, if it involves a child, or if it is 'high-profile' or 'press-worthy'. Every weekday morning there is a meeting at the coroners office that is attended by the coroner who was on duty the day before as well as the regional supervising coroner and, often, the Deputy Chief Coroner. Cases are discussed at this meeting and decisions about the handling of the case are made collectively. One coroner claimed that at the conclusion of the meeting any

decisions about a case are no longer the 'decisions of the coroner', rather, they are the 'decisions of the Coroners' Office'. At the meeting it is determined whether or not a case is likely to be complicated or problematic in which case one of the supervisors will often take over the investigation.

Coroners repeatedly commented that they try to maintain good relations with other organisations (including the Toronto Police, Victim Services Units, the media, Toronto Fire Services and Emergency Medical Services) as they rely heavily on their support. Collaboration with and respect for the police was referred to as being of particular importance. Coroners claimed that during their training period the police were a valuable source of information and assistance. Long-term employment and low turnover of coroners was mentioned several times as being advantageous in terms of the experience needed to be a coroner and in maintaining relationships with other organisations, particularly the Toronto Police. One coroner told me, "...to work with the police is fantastic and they're very good to us and I sure try to be good to them".

Chapter VI: Analysis

What was, in my opinion, most striking about the coroners' accounts was their ability to discuss their work rationally and objectively without seeming insensible. I believe it a common assumption that people who operate in an environment which exposes them routinely and frequently to death are 'jaded' or 'aloof'. The coroners that I interviewed all expressed a concern about their work that suggested that they were willing and able to invest emotionally in their work, particularly when it came to dealing with a deceased person's family.

When I asked coroners to describe the mandate of their organisation each replied that their job or, as Bion (1961) puts it, their 'primary task' is to determine the identity of the deceased as well as how, when, where and by what means that person came to their death. With the exception of a very generalised concern with doing a good job and pleasing one's supervisor, coroners expressed very little conscious anxiety over achieving their primary task. It became very clear during the interviews that both the duty coroners as well as the supervisors felt that achieving the organisation's primary task was the result of collaboration of efforts rather than the responsibility of one coroner. No one coroner expressed concern that they would somehow fail to achieve their primary task, as all clearly understood that, as one coroner put it, 'you don't have to take the whole load on yourself'. All of the coroners were confident that if some aspect of their investigation was lacking, a colleague or a supervisor would assume that responsibility unquestioningly. All of the coroners interviewed had taken advantage of this situation in order to bring an investigation to completion.

I also found it interesting, though perhaps not surprising, that coroners did not seem to find the notion of death distressing, nor did any of the coroners express disgust or even dislike with regard to their frequent and obviously necessary contact with dead bodies. Coroners, in fact, reported that they rarely found seeing or touching a dead body disturbing in any way, with the

exception of one coroner's mention of having felt sad seeing "innocent victims", and another coroner's apparent fascination with the creativity that occasionally goes into committing suicide or, to use his words, "...I really found myself intrigued by the fact that people can really kill themselves if they want to, in really bizarre ways that you would never think of". I accept that perhaps the absence of any indication that coroners find dead bodies or the notion of death disturbing is, in fact, evidence that they find such things to be so disturbing as to prefer not to discuss it. However, drawing on my own experience I believe that coroners' seeming lack of discomfort around death is genuine.

Despite the resourcefulness with which coroners operated to achieve the primary task of the organisation and their unproblematic approach to coming into contact with the dead, there were numerous situations in which they found themselves subject to considerable and often unavoidable anxiety. This occupational anxiety was largely attributed to dealing with a deceased person's family.

The Nature of Anxiety

Though contact with family members is not usually integral to accomplishing the organisation's primary task, coroners seemed to find communication with the family essential. Supervisors described dealing with families as a coroner's responsibility, claiming that dealing with families is 'expected'. One coroner told me that he occasionally requests medical histories from family members; more commonly however the rationale for speaking to families was to "let them know what's going to happen".

When a person dies the death often inspires complex feelings in family members. Families may have feelings which they may not have experienced previously. Families members may feel any number of emotions when a person dies including, relief, grief, guilt, fear, anger and pity.

Family members who have cared for a person before they died may have particularly strong feelings about the death. Often people feel responsible for the death. Though they may feel relief that a dying person is no longer suffering, they may also feel that they have failed to care for them adequately. Families may feel reluctant to relinquish control over a deceased family member for whom they may have been making many decisions.

Death of a family member may create a tremendous and extremely stressful upheaval to the functioning of a family unit. Family members are not only forced to deal with the death but with the new and occasionally strained relationships with other members of the family. The death may inspire power struggles among family members and bring to the surface feelings which had previously been suppressed out of consideration to the family member who has since died.

The family's feelings toward the coroner may be equally complicated. People may feel grateful for the coroner's assistance, yet fearful that they are being investigated, or that the coroner feels them culpable in some way for the death. Coroners spoke a great deal about how they felt they were perceived by families and how this affected their work. All of the coroners I interviewed were convinced that people frequently resented their authority. A coroner's investigation may be considered by both the coroner and the family as a violation of the family's privacy. One coroner claimed that people often call him when they have no one else to talk to; he felt that often people called hoping to be consoled or counselled. While families may have many feelings relating to the loss of their family member, they may also be forced to assume new, and possibly often unwanted roles, within their own families, families which may or may not be in a state of discord.

Family members also may have complicated feelings toward the coroner. It is in this emotionally charged environment, within this morass of feelings, that the coroner routinely

works, and where he experiences much of his work-related anxiety – both conscious and unconscious. The coroner often feels helpless to mitigate the anxiety of the people with whom he interacts at work. Owing to policy or by order of law coroners may be required to make decisions that are contrary to the demands of families. Though the coroners I spoke to understood that much of the family's anxiety was an unavoidable consequence of the loss of their family member, they all appeared especially concerned about situations in which they felt they had somehow added to the anxiety of the family.

Ultimately, a coroner is subject to his or her own anxiety as well as to vicarious anxiety that is the result of working in such emotionally charged environments. To understand why coroners continue the practice of communicating with families despite these problems, one must consider the possibility that there exist both explicit and unconscious reasons for doing so.

Explicit Reasons For Communicating With Families

When I asked coroners why they felt it important to communicate with families their responses varied. One coroner indicated that if medical records were unavailable or were likely to be difficult to obtain, it was sometimes necessary to request a medical history from family members. All of the coroners accepted that, as it is the family's legal right, they were responsible for speaking to family members who requested the results of an autopsy. When I asked coroners about communicating with families at scenes and on subsequent occasions about topics not related to the autopsy they responded with surprisingly ambiguous responses. One coroner claimed that it's just unusual to not speak with families, another simply told me that "you gotta talk to the families" and another told me "OK, your job, technically, is to go in and do the forensic aspects and walk out but, no, we expect the coroner to go and talk to the family". Clearly, beyond the rationale of very occasionally collecting medical history and of communicating autopsy results, coroners felt interacting with families to be an important

component of their job. Though they did not often justify this importance, none of the coroners seemed to be able to explain precisely why they felt it important to speak with families at scenes, in their offices, and on the telephone - it was simply something that they felt they had to do. None of the coroners told me that they were instructed to interact with families by superiors, by the police or by their colleagues. Though it is entirely possible that coroners were at some point informed that it was expected of them, none of the coroners seemed to resort to this rationale to explain why they communicated with families. None of the coroners hinted that they interacted with families out of some sort of social expectation or simply just to be polite. The fact that coroners seemed unable to provide me with an explicit reason for their practice of speaking with families led me to suspect that perhaps coroners are motivated by unconscious reasons for this practice.

Unconscious Reasons For Communicating With Families

My explanation of possible unconscious rationales for explaining why coroners habitually interact with families despite the potential for this interaction to result in considerable anxiety is informed by psychodynamic theory. Dartington (1994) and Roberts (1994) have suggested that different types of work tend to attract different personalities. They claim that people who work in 'helping professions' tend, according to Roberts (1994) to share certain unconscious desires: "An important aspect of becoming a helper may be a deep-seated fear of helplessness and loss of control and an attraction to omnipotent expectations of one's capacity to cure". (In Hinshelwood & Skogstad, 2002, p. 14). As all coroners in Ontario are required to be licensed medical doctors it is not unreasonable to expect that a certain homogeneity of unconscious experience exists among coroners. Additionally, all of the coroners interviewed claimed that much of their experience dealing with people had come from working as doctors, and that they had worked with patients and families frequently in their medical professions. It is reasonable to suggest that

the coroners I interviewed shared a concern for the mental health and well being of their patients and the families of their patients

I believe that coroners are involved in coroners' work, at least in part, because it involves dealing with the mental distress of others. It is entirely possible that the apparent job satisfaction among the coroners that I interviewed, and the low turnover of coroners within the organisation results from the fact that coroners are frequently successful in mitigating the emotional pain of the families with whom they interact in the course of their work. In doing so coroners assuage anxieties in themselves that may be vestiges of their own "emotional development and the particular emotional difficulties [they have] experienced" (Hinshelwood & Skogstad, 2002, p 14). This is not meant to imply that coroners have 'emotional difficulties' or that they have had some sort of problem with their 'emotional development'; rather, it supposes that human development is coloured by circumstances which cause anxiety, as we are not always able to assuage many of our anxieties, we carry them with us and attempt again, and again to control or to avoid them. Psychoanalytic theory suggests that many of the anxieties which haunt us throughout life are experienced during early childhood development, when we are most helpless to understand, control and avoid them. As such coroners, who are commonly hired because they have, as one coroner put it, "seen life in the raw", may share a common desire to alleviate distress in others and to play an active part in diminishing their suffering. I believe it likely that 'seeing life in the raw' requires that one see things that are frightening, disturbing and, ultimately, anxiety provoking. Whether for coroners these experiences occur early in the developmental stage or during a coroner's professional development is irrelevant. What is important is that at some point coroners made the unconscious decision to try again, and again to master their anxieties by engaging in situations which have the potential to cause the coroner great anxiety. By confronting situations that are similar to the ones that caused the coroner anxiety in his or her

past, the coroner works to resolve these situations in a manner that does not cause the coroner anxiety and, in doing so, he gains control over the pre-existing, unconscious anxieties.

Though much of the conscious anxiety experienced by coroners was clearly the result of having interacted 'unsuccessfully' with family members, coroners indicated that the majority of their interaction with family members was successful. Coroners frequently felt that there was not much they could do to alleviate people's distress yet they all reported having frequently tried to do so. When I asked coroners if they thought that they had helped people, if they thought that people felt 'better' having spoken to them, they all responded that they believed that their 'system', their technique of dealing with people, put people at ease and, at the very least, alleviated the family's sense of uncertainty and confusion. One coroner referred to people as "amazing" and claimed that families tended to like him. Another coroner claimed that 99% of the people he had dealt with were 'reasonable', he also felt that he often helped people. The remaining coroners also felt that they helped people and they believed that by the time they left scenes people felt informed and comforted despite the coroner's belief that families initially felt animosity toward them.

All of the coroners told me that they enjoyed their work as coroners, one coroner saying, "Well, in terms of does [the job] affect you? Sure it must affect you in some way, but it's affected me in an extremely positive way." I believe coroners' enjoyment of their jobs to be evident in the extremely low turnover of coroners in the organisation. As one of the senior coroners made a point of telling me, rather mordantly, "you're not [doing this job] to make a fortune". It seems likely that, despite the fact that such interaction is not required by the organisation's mandate, coroners continue to communicate with families in order to, through the process of transference, master their own anxieties. As coroners are frequently successful in mastering their own anxieties

– by controlling them in others – they find their work as coroners not only possible but enjoyable.

The Organisation and its Defences

If it is true that coroners remain coroners, and happily so, because they are meeting their own unconscious needs by helping to control the anxieties of others, and if it is also true that coroners are able to control the anxieties in others frequently enough to meet their own unconscious needs, then the question becomes, exactly how is it that coroners are able to resolve these emotional charged interactions with families frequently enough and with sufficient regularly to make their job tolerable and to satisfy their own unconscious needs? And, what is the role of the organisation in enabling and/or supporting this process?

It became clear during the interviews that the organisation, the policy and practice of the Office of the Chief Coroner for Ontario, make it possible for coroners to succeed in interacting with families in a manner which satisfies the coroner and the families that he must deal with. The organisation functions to ensure that coroners are able to undertake the difficult task of resolving situations which are often so fraught with emotion and anxiety that it is difficult to imagine that the coroner could routinely function in this environment let alone benefit from it.

There are five main ways in which the organisation functions to increase the success of coroners when dealing with families and, in doing so, to effectively provide for the mental and occupational health of its coroners.

Requiring Coroners to Be Physicians

First, the organisation's formal policy, as stipulated in the Coroner's Act (Revised Statutes of Ontario, 2003), of hiring physicians, as well as the informal policy of hiring physicians with training and experience in emergency medicine, increases the likelihood that coroners come into

the organisation already in possession of the skills to communicate effectively with families. Coroners all reported having worked in environments where dealing with families was necessary. Coroners with experience in emergency medicine had years of experience dealing with life and death situations and with families under considerable stress. Coroners with experience in emergency medicine also reported having dealt extensively with emergency personnel including the fire service, emergency medical services (ambulance) and police.

Scheduling

The organisation of the work itself, most notably the practice of having coroners work only 24 hours at a time (with the exception of weekends) and only for a few days out of the month, ensures that coroners do not become overwhelmed by the anxiety to which they are exposed. Although they must complete reports, communicate with the police and families, and attend meetings at the Coroners' Office for some time after their shift, they are not, in this time, taking on any new cases and are not 'accumulating anxiety' such that their work becomes unmanageable or unbearable.

Splitting

Coroners frequently resort to the defence mechanism described by Melanie Klein (1959) as 'splitting'. Two types of splitting were used by coroners: coroners 'split-up' responsibility for families with the other organisations with which they work, and coroners split their own contact with families by maintaining contact with them for the duration of the investigation.

All of the coroners indicated to me the importance of having good working relationships with other organisations (particularly the Toronto Police and the Victim Service Unit) who, in turn, assume responsibility for interacting with families. All of the coroners interviewed felt comfortable asking the police for assistance with families. Additionally, all but one of the

coroners had attended scenes where a Victim Service Unit had been called in to help deal with the family of a deceased person. Coroners felt that the Victim Services Units were an important service for assisting families and for helping to explain the process of death investigation to families who may feel uncomfortable speaking to people in authority – namely the coroner or the police. This 'sharing of responsibility' for reducing the anxiety of family members allows the coroner to avoid taking on the full emotional burden of an anxious family. These 'good working relationships' make it easier for coroners to ask other organisations for assistance, as well as increasing the likelihood that they will be provided with such assistance.

All of the coroners I interviewed indicated that though they frequently spent time speaking to families at scene they always invited families to contact them by telephone once they had time to think of any questions or concerns that they might have about the death of their family member. In this manner coroners 'split-up' contact with the family such that the coroner is not forced to confront the full emotional burden of the family at one point in time. Coming into contact with the family is partitioned into several sessions in order to make the experience manageable for the coroner.

Attending Deaths Due to Natural Causes

Coroners are not obligated to accept all reported deaths and will, under certain circumstances decline a case which meets certain criteria and which is evidently the result of natural causes. That having been said, coroners still accept many deaths which are ultimately deemed to have been the result of natural causes. It is the practice of the Coroners' Office to have coroners attend scenes of death if they have chosen to accept the case.[10] The vast majority

[10] Attending natural deaths is not a universal requirement. Some coroner and medical examiner jurisdictions permit coroners and medical investigators to decline attendance at deaths which they believe are likely to have been the result of natural causes.

of the scenes that a coroner attends involve natural deaths.[11] Coroners indicated that families were often in attendance at natural deaths and that natural deaths were often the cause of a great deal of anxiety for both the family and for the coroner. Given that the majority of a coroner's calls are likely to be 'naturals' and that these types of calls are thought to be particularly distressing it stands to reason that a large part of a coroners 'net anxiety' results from attending natural deaths. The practice of attending natural deaths requires that coroners confront, contain and master anxieties in others and, by extension, in themselves. Coroners indicated that most of the time these cases were manageable, that they were able to help families by reducing their anxiety. It would seem that natural deaths are, thus, the locus for much of a coroner's 'success' in mastering his own unconscious anxieties. I have already mentioned that physicians have perhaps chosen to become coroners in order to overcome their own unconscious anxieties. I have also postulated that perhaps having 'successful' interactions with families - helping alleviate their anxieties and reduce their suffering - may be a means of mastering the coroner's own anxieties. As such, I believe that the practice of requiring a coroner to attend a large number of natural deaths frequently places them in a situation through which they are likely to successfully control their own anxieties.

Occupational Support

Finally - and perhaps most importantly - the support of the supervising coroners is integral to successful interaction between coroners and families. Coroners told me that they frequently called their supervisors to ask for advice about the investigation and about dealing with families. All of the coroners in non-supervisory positions claimed that they felt comfortable referring families to their supervisors when they felt unable to resolve situations in which there was disagreement between themselves and the family, or between family members. None of the

[11] Data for scene attendance by coroner was unavailable at the time of writing. Based on the summary of deaths statistics (Appendix B) it would appear that approximately 4 out of 5 cases (80%) accepted are determined to have been the result of natural causes.

coroners indicated the least apprehension about turning over cases to their supervisors and the supervisors, for their part, indicated their willingness to provide assistance and support to their coroners whenever and however often it was required. The senior staff, thus, provide what might be considered a 'safety-net' to duty coroners who, in effect, only deal with families which they feel they can handle.

Chapter VII: Conclusion

Menzies-Lyth (1988) believed that the anxiety which nurses in her study faced was so extreme as to force them to abandon their mature methods of dealing with anxiety in favour of more regressive and primitive defences against anxiety. These regressive defences became entrenched in the nursing system - it's rules, regulations, it's policies and procedures – in a manner which, though it protected nurses from a certain degree of anxiety, inhibited the "true mastery of anxiety by deep working through and modification" (Menzies-Lyth, 1988, p. 64). The organisation, ultimately, through it's operational culture prevented nurses from confronting their experiences of anxiety, guilt, doubt and uncertainty by, "…eliminating situations, events, tasks, activities and relationships that cause anxiety" (Menzies-Lyth 1988, p. 63). In doing this, "little attempt is made positively to help the individual confront the anxiety-evoking experiences and, by doing so, to develop [the nurse's] capacity to tolerate and deal more effectively with the anxiety" (p. 63). Menzies-Lyth claimed that, as a result, nurses in that particular organisation persistently experienced higher degrees of anxiety, "than was justified by the objective situation alone." (p. 64). This feeling of persistent anxiety ultimately led to low job satisfaction and high employee turnover. The occupational and mental health within this particular nursing organisation was perhaps unusually poor, yet this case study provides an important contrast to the functioning of a healthy organisation. A healthy organisation is one which achieves its primary task while providing its members with the means to effectively avoid anxiety by functioning in such a manner as to ensure that employees do not regress into primitive defences - which in the long term merely compound and exacerbate the overall anxiety – but utilise other more mature and effective mechanisms of dealing with their anxiety:

> Notably, these other methods include the ability to confront the anxiety situations in their original or symbolic forms and to work them over, to approach and tolerate psychic and objective reality, to differentiate between them and to perform constructive and objectively successful activities in relation to them. (Menzies-Lyth, 1988, p. 64).

It was clear from the interviews that the primary source of anxiety to which coroners were exposed arose from having to deal with families. I found it compelling that the aspect of their job that they found the most stressful was something that they were, technically, not responsible for. In many instances exposing themselves to anxiety would appear to be, for the most part, their own choice rather than a necessary aspect of their work. The coroners chose to confront the anxiety of their work in a way that Menzies (1970, 1988) describes as characteristic of a person working as part of a healthy organisation. In many ways, the Office of the Chief Coroner for Ontario is an excellent context in which to explore the psychodynamics of the work environment. Coroners working with this organisation performed duties which many would consider horrible or gruesome and did so in a manner that exposed them to minimal anxiety. The anxiety to which coroners were exposed was of their own choosing and, ultimately, allowed them to successfully work through their own unconscious anxieties. The organisation, thus, enables coroners to provide for their own occupational and mental health while minimising their exposure to the types of anxiety that they are unable to deal with constructively.

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Appendix A

Section 10 of the Coroners Act

Duty to give information

10. (1) Every person who has reason to believe that a deceased person died,

(a) as a result of,

(i) violence,

(ii) misadventure,

(iii) negligence,

(iv) misconduct, or

(v) malpractice;

(b) by unfair means;

(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;

(d) suddenly and unexpectedly;

(e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;

(f) from any cause other than disease; or

(g) under such circumstances as may require investigation, shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances. R.S.O. 1990, c. C.37, s. 10 (1).

Deaths to be reported

(2) Where a person dies while resident or an in-patient in,

(a) a charitable institution as defined in the *Charitable Institutions Act*;

(b) a children's residence under Part IX (Licensing) of the *Child and Family Services Act* or premises approved under subsection 9 (1) of Part I (Flexible Services) of that Act;

(c) Repealed: 1994, c. 27, s. 136 (1).

(d) a facility as defined in the *Developmental Services Act*;

(e) a psychiatric facility designated under the *Mental Health Act*;

(f) an institution under the *Mental Hospitals Act*;

(g) Repealed: 1994, c. 27, s. 136 (1).

(h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g), the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (2); 1994, c. 27, s. 136 (1); 2001, c. 13, s. 10.

Deaths in nursing homes and homes for the aged

(2.1) Where a person dies while resident in a home for the aged to which the *Homes for the Aged and Rest Homes Act* or the *Charitable Institutions Act* applies or a nursing home to which the *Nursing Homes Act* applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body. 1994, c. 27, s. 136 (2).

Inmate off premises

(3) Where a person dies while,

(a) a patient of a psychiatric facility;

(b) committed to a correctional institution; or

(c) committed to secure custody or open custody under the *Young Offenders Act* (Canada), but while not on the premises or in actual custody of the facility, institution or place of custody, as the case may be, subsections (1) and (2) apply as if the person were a resident of an institution named therein. R.S.O. 1990, c. C.37, s. 10 (3).

Persons in custody

(4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada), the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (4).

Notice of death resulting from accident at or in construction project, mining plant or mine

(5) Where a worker dies as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry, the person in charge of such project, mining plant or mine shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (5).

Certificate as evidence

(6) A statement as to the notification or non-notification of a coroner under this section, purporting to be certified by the coroner is without proof of the appointment or signature of the coroner, receivable in evidence as proof, in the absence of evidence to the contrary of the facts stated therein for all purposes in any action, proceeding or prosecution. R.S.O. 1990, c. C.37, s. 10 (6).

Appendix B

Summary of Deaths by Death Factor for Toronto (2000)

2000 Summary of Deaths by Death Factor for Toronto

Death Factor	Natural	Accident	Suicide	Homicide	Undetermined	Total
Abuse - Child	0	0	0	3	0	3
Alcohol Toxicity (Acute)	0	10	0	0	1	11
Alcohol Toxicity (other alcohols)	0	0	3	0	0	3
Alcohol, Chronic Use/Abuse	68	0	0	0	0	68
Allergic Reaction - Insect	0	1	0	0	0	1
Allergic Reaction - Meds, x-ray contrast, etc	0	2	0	0	0	2
Asphyxia - Airway Obstruction	0	4	0	0	1	5
Asphyxia - Environmental - CO, vehicle exhaust, furnace fumes	0	1	10	0	1	12
Asphyxia - Environmental - other anoxic environment	0	1	8	0	1	10
Asphyxia - Food Bolus	0	11	0	0	0	11
Asphyxia - Hanging	0	1	67	0	0	68
Asphyxia - Positional / Restraint	0	2	0	0	0	2
Asphyxia - Strangulation (ligature, manual)	0	0	0	3	0	3
Burns - Chemical	0	0	0	0	1	1
Burns - Heat	0	14	5	1	1	21
Category Not Ascertained	0	0	0	0	44	44
Complications of Operation/Procedure/Treatment	2	15	0	0	0	17
Crushed and/or Buried	0	2	0	0	1	3
Drowning - Bathtub	0	7	1	0	3	11
Drowning - Open Water	0	6	4	0	2	12
Drowning - Pond/Quarry/Casual Water	0	0	2	0	0	2
Drowning - Private Pool	0	3	0	0	0	3
Drowning - Public Pool	0	0	0	0	1	1
Drug & Alcohol Toxicity (Acute)	0	15	3	0	3	21
Drug Toxicity (Acute)	0	39	47	1	26	113
Electrocution	0	0	3	0	0	3

Explosion	0	2	0	0	0	2
Fall / Jump - Different Level/Height	0	79	58	0	5	142
Fall / Jump - Same Level	0	162	0	0	0	162
Fire - Smoke Inhalation	0	11	0	0	1	12
Hypothermia	0	6	0	0	1	7
Infectious Disease - Other reportable illness	15	0	0	0	0	15
Live Birth, < 1 Day	13	0	0	0	0	13
Maternal Death - Pregnancy, Abortion	2	0	0	0	0	2
Medication Error	0	1	0	0	0	1
Natural Disease - CNS/Neurologic - Epilepsy/SUDEP	15	0	0	0	0	15
Natural Disease - Gastrointestinal	7	0	0	0	0	7
Natural Disease - Pulmonary - Asthma	10	0	0	0	0	10
Natural Disease - Unspecified / Other	3590	0	0	0	0	3590
Shooting - Handgun	0	0	5	24	1	30
Shooting - Rifle	0	0	7	0	0	7
Shooting - Shotgun	0	0	3	1	0	4
Stillbirth	20	0	0	0	0	20
Sudden Infant Death Syndrome (SIDS)	4	0	0	0	0	4
Sudden Unexpected Death Syndrome (SUDS)	0	0	0	0	4	4
Trauma - Airplane Crash	0	0	1	0	0	1
Trauma - Beating / Assault	0	0	0	12	1	13
Trauma - Blunt Force	0	13	0	0	9	22
Trauma - Cuts, Stabs	0	1	9	17	0	27
Trauma - Motor Vehicle Collision	0	139	28	1	1	169
	3746	**548**	**264**	**63**	**109**	**4730**

Prepared by the Office of the Chief Coroner May 25, 2005

Appendix C

UNIVERSITY OF CAPE TOWN

Department of Public Health & Primary Health Care

LETTER OF INFORMATION

Dear Sir or Madame, (date)

I am a Master's student at the University of Cape Town and am requesting your participation in the research that I am currently conducting for the purpose of completing my Master's degree in Public Health. You have been chosen specifically to participate in this study due to your lengthy experience as a coroner in the employ of the Office of the Chief Coroner for Ontario.

My Master's thesis involves the psychodynamics and psychoanalysis of death investigation units. I am requesting a single interview with you which is likely to last approximately one hour. This research is based upon qualitative data collection and, as such, there will be very little structure in this interview. You may discuss whatever you feel is relevant to the research topic. There are no right or wrong answers to any questions I might pose, though I do request that you respond to questions thoughtfully and honestly.

The nature of the information that I wish to elicit from you is meant to inform a psychodynamic and psychoanalytical assessment of your work and, as such, will concentrate on the types of anxiety inherent to your position. As it is entirely possible that you have not previously been asked to comment on your work in this manner, this interview may inspire ideas or feelings that you generally avoid or have not been aware of. If you begin to feel uncomfortable at any point during the interview, please understand that you do not need to continue and that you may, at any time, stop the interview.

Your participation is voluntary *– if you choose not to take part, you will not be effected in any way. If, however, you do agree to participate, please understand that you may stop the interview at any time or decline to respond to any question. If you answer a question, or make a comment that you do not wish to appear on the transcript of your interview, you may let me know and I will omit this portion of the interview from the transcript – I will not make reference to any omitted material in my thesis.*

The interview will be conducted privately and will be confidential. I will be making an audio recording of the interview; this recording will be deleted as soon as your interview has been transcribed. I will be the only person to hear the recording and the transcription will be conducted solely by me. Your name will not appear anywhere on the transcript, nor will you be identified in my thesis or in any subsequent publications of this research. The information you give will not be disclosed to any of your colleagues. This study has been reviewed by, and has received ethical clearance from the Research Ethics Committee that the University of Cape Town.

I would very much appreciate your participation in this study. If you wish to participate please complete the following consent form.

CONSENT

I _____ hereby agree to participate in research regarding the psychodynamics of the Office of the Chief Coroner of Ontario. I understand that I am participating freely. I also understand that I may stop this interview at any point should I not wish to continue and that this decision will in no way affect me negatively. I am also aware that I may decline to answer specific questions, or that I may request the omission of any of my answers.

I am aware that this is a research project, the purpose of which is not necessarily to benefit me personally.

I understand that this consent form will not be linked to the transcript of my interview and that my interview will be confidential.

I understand that my interview will be audio recorded and that this recording will be deleted following the transcription of my interview. I am aware that the primary researcher for this study will be the only individual to listen to the audio recording of my interview. I understand that other members of the research team may review the transcript of this interview.

I am aware that, upon request, I am entitled to a copy of the master's thesis of which this research is a part.

_____ _____

Signature of Participant ***Date***