The need for innovation in deathcare leadership

Rebecca M. Entress, Jenna Tyler, Staci M. Zavattaro and Abdul-Akeem Sadiq
School of Public Administration, University of Central Florida, Orlando, Florida, USA

Abstract

Purpose – The purpose of this viewpoint essay is to examine deathcare leadership during the COVID-19 pandemic and recommend innovations to employ a more human-centric approach.

Design/methodology/approach – This viewpoint essay uses scholarly and popular literature to explore deathcare practices during the ongoing COVID-19 pandemic and to identify limitations of existing mass fatality management policies.

Findings – Deathcare leadership in the USA lacks a human-centric approach. Rationalistic mass fatality management during COVID-19 left families struggling with grief and mourning because many burial rituals could not take place. This essay suggests a humanistic approach to death management through leadership innovations as a remedy to this problem. Such leadership innovations can improve responses to deathcare during this ongoing pandemic and future public health emergencies.

Originality/value – This essay offers practical improvements to make deathcare more human-centric.

Keywords Deathcare, Leadership, Innovation, Human-centric

In the USA, there are many images associated with COVID-19, but one that captured the country’s attention was drone footage of prisoners digging mass graves on Hart Island in New York City. The scale and level of death associated with this pandemic overwhelmed deathcare facilities in the USA, including hospitals, morgues, cemeteries and death certificate processing (Entress et al., 2020). Refrigeration trailers lined city streets and bodies were stacked in warehouses and processed by people in hazmat suits (Davies, 2020). As complex disasters such as the COVID-19 pandemic become more commonplace, deathcare practices need to move beyond the status quo to ensure mental, physical and emotional stresses of death are tended to (Tun et al., 2005). Communicating these elements during crises is critical to build trust among stakeholders (Baker and Hernandez, 2017).

In this viewpoint essay, we argue that mass fatality management (MFM) practices focusing largely or even solely on rationalistic approaches to deathcare exclude the crucial human element of death. This leaves families unable to properly mourn loved ones, especially during COVID-19, which necessitated social distancing rules with limited gatherings. The ongoing crisis and subsequent rising death count suggest that MFM planning can no longer be limited to existing rational best practices including setting up mobile morgues, managing inventory and cataloging remains and maintaining operational continuity. It is this technical approach that seems to be falling short when people cannot mourn and bury properly, resulting in an absence of closure for families and loved ones (Entress et al., 2020; Patterson, 2001; Zavattaro, 2020). We argue that MFM best practices should be supplemented with a human-centric approach to deathcare, which includes empathy and understanding toward families in mourning. MFM plans must address these issues, we argue, and also involve stakeholders, such as counselors and social workers who can provide needed assistance to devise equitable, care-centered plans.

Public sector deathcare leaders need to learn lessons from the COVID-19 pandemic and promote innovations in current and future mass fatality responses. Many US states are opening economies again, resulting in a spike of positive COVID-19 cases and deaths. As the
Government role in deathcare

The role of governments in deathcare is often limited and ignored in the administrative leadership literature. Before discussing how governments are and should be involved in deathcare, we address American federalism, which sets the backdrop of the debate over the appropriate role of government. The USA was developed through a system of federalism, where national, state and local governments share power and responsibility (Radin and Boase, 2000). This system has been debated starting with the founding fathers where Alexander Hamilton advocated for a strong centralized government and James Madison advocated for strong local control (Kettl, 2020). The US response to COVID-19 veers more on a Madisonian perspective, where the federal government admittedly is letting the states lead. For example, rather than implementing broad regulations to address the pandemic, the federal government relies on state and local governments to implement their own specific policies, such as stay-at-home orders (Rocco et al., 2020). The federal government can thus be viewed as a “backup” to state and local governments (Kettl, 2020).

The appropriate role of the government in providing services is key to the federalism debate, where on one side there is concern of government overreach, while the other views federal intervention as necessary for making progress (Kettl, 2020). When the federal role is not strong, government responses can be fragmented and disjointed (Radin and Boase, 2000). Federal involvement is vital during emergencies, as the federal government typically supports overwhelmed state and local governments (Roberts, 2005). The work of medical examiners, coroners, emergency managers and municipal graveyard staff represents additional governmental involvement in the deathcare process in the USA (Entress et al., 2020; Zavattaro, 2020), though they are often left out of emergency planning and training exercises. A medical examiner is an “appointed medically qualified officer whose duty is to investigate deaths and bodily injuries that occur under unusual or suspicious circumstances, to perform post-mortems, and sometimes to initiate inquests” (New York State Homeland Security and Emergency Services, 2020, p. 20). A coroner is an “elected official whose statutory authorities include: pronouncement of death, identification of the body, signing the death certificate, notifying the next of kin, and collecting and returning personal belongings to the decedent’s family” (New York State Homeland Security and Emergency Services, 2020, p. 19). Medical examiners have traditionally assisted criminal justice investigations, although more recently they have been used for public health purposes (Hazlick, 2006). Both are of government interest and keeping the public safe whether being protected from crime or disease justifies government intervention under a federalist system.

A mass fatality incident (MFI) is a situation whereby the number of decedents overwhelms the response capability of a community. During an MFI, the community is unable to care for the dead and needs support from other entities, including the state and federal governments. In the USA, responding to MFIs necessitates collaboration among public (e.g. medical examiner and coroner), private (e.g. cemeteries and funeral homes) and nonprofit organizations (e.g. faith-based organizations). This collaboration mechanism is referred to as the mass fatality infrastructure (Merrill et al., 2016). The MFM process is complex and involves multiple stages, such as body recovery, body storage, body identification, the establishment of a family assistance center, body reunification with family members and body disposition – either by cremation or burial (McEntire et al., 2012; Vidal and Feinman, 2017). This complicated and multistage process necessitates coordination between multiple government agencies during emergencies, and the federal government can take a lead role to...
ensure that services are appropriately provided. Consistent with Van Wart (2003), coordinating such services is a leadership responsibility of the government, even when the government is not directly providing such services. Indeed, leaders are expected to make sure needed tasks and resources are in place and available, even if they are not doing the work themselves (Van Wart, 2003).

During the COVID-19 pandemic, there have been scenarios where the federal government provided guidance and assistance to improve state and local response efforts, albeit, these efforts were limited. For example, the Federal Emergency Management Agency (FEMA) worked with the US Department of Defense to procure 100,000 body bags to help respond to the massive number of deaths expected (Capaccio and Natter, 2020). Similarly, the Centers for Disease Control and Prevention (CDC) issued additional guidelines when conducting a postmortem procedure on a deceased individual with known or suspected COVID-19 due to the distinctive nature of the virus (CDC, 2020). When a deceased person is known or suspected to have contracted COVID-19, the individual conducting the procedure (e.g. coroner or medical examiner) must inform the local or state health department. In addition, the postmortem procedure should avoid aerosol generation and if not possible, personal protective equipment (PPE) should be worn (CDC, 2020). When transporting the body, those in charge of transportation should wear PPE if they expect body fluid to be splashed. Also, before putting the body in a body bag, those handling the body should wear nitrile gloves, and once the body is put into the body bag, they should disinfect the outside of the bag with disinfectants approved by the US Environmental Protection Agency (CDC, 2020).

Coordination between government agencies and different levels of government is even more important during emergencies as there can be death surges, which the local infrastructure that responds to emergencies cannot adequately address (Stanley, 2010). If the deathcare response following emergencies is poorly managed, it can reflect negatively on government agencies, as was the case with FEMA’s repose to Hurricane Katrina (Roberts, 2005). Poor deathcare planning during emergencies can have dire consequences. During the COVID-19 pandemic, countries with poor deathcare planning and an abundance of deaths have dehumanizing and wartime deathcare practices such as burials in mass graves, bodies stacked in hospital rooms and bodies stored in ice rinks when morgues reach capacity (Entress et al., 2020). Unfortunately, the federal government does not always take responsibility and provide needed services. This could be because the probability of catastrophic events is rare and there are few incentives for politicians to invest time and resources to prepare for deathcare during emergencies (Roberts, 2005).

**Mass fatality management leadership during COVID-19**

MFM requires government involvement, as discussed earlier, and planning for MFIs is crucial in achieving an effective response (French, 2011). This includes developing a MFM plan, which is typically housed in the health department of local, state and federal governments, or it can be housed in the medical examiner’s office or as an annex within an emergency management plan. For example, in Florida, the Mass Fatality Response Plan is a stand-alone plan maintained by the Florida Medical Examiners Commission, and in California, the Mass Fatality Management Guide is also a stand-alone plan (Florida Medical Examiners Commission, 2018; State of California Governor’s Office of Emergency Services, 2019). In Texas and New York, the MFM plan is annexed to the State of Texas Emergency Management Plan and the New York State Comprehensive Emergency Management Plan, respectively (New York State Disaster Preparedness Commission, 2020; Texas Department of State Health Services, 2015).

The components for effective MFM planning include effective leadership and personnel, availability of resources, incident management capabilities and training (McEntire et al., 2012;
Sadiq and McEntire, 2012; Vidal and Feinman, 2017). Planning can build trust and develop important relationships among relevant MFM stakeholders (New York State Homeland Security and Emergency Services, 2020). As a result of the sheer number of fatalities from, and unique nature of, COVID-19, MFM plans must be flexible, scalable and sensitive to cultural and religious practices (Entress et al., 2020; Florida Department of Health, 2020; World Health Organization, 2017).

Poor MFM can have negative impacts on the affected community for six key reasons. First, it can lead to psychological trauma and stress among first responders and survivors (Entress et al., 2020; Gupta and Sadiq, 2010). Second, it can damage public trust and the victims’ families’ trust in the medical examiner or coroner (Carroll et al., 2017). Third, it can result in ineffective response and delayed recovery (Morgan et al., 2006). Fourth, if an MFM plan does not include provisions for religious and cultural considerations, it can further deepen religious and cultural divides (New York State Homeland Security and Emergency Services, 2020). Fifth, it can lead to the violation of the human rights of the victims’ families if their loved ones are not identified before disposition by mass burial or cremation (Gupta and Sadiq, 2010). Sixth, it can exacerbate already existing racial inequalities if marginalized communities experiencing a disproportionate number of deaths from COVID-19 view the management of their dead as inadequate in comparison to death management in affluent communities.

The need for innovation

In the USA, the virus continues to spread, highlighting the importance of flexible MFM planning. Current barriers exist because, as previously stated, politicians are not incentivized to invest resources in preparing for catastrophic events because of their rarity (Roberts, 2005). Such barriers are not likely to be solved because, by nature, catastrophic events do not occur with regularity. Based on the existing literature and press coverage of the pandemic in theUSA, we identified several barriers to MFM and deathcare leadership. First, much MFM planning centers on singular events, such as a bombing or mass shooting. A pandemic, such as COVID-19 has laid bare these limitations. Second, “many countries across the globe do not have a policy, fatality infrastructure, and preparedness plans for the management and cremation of bodies” (Kumar and Nayar, 2020, p. 1). Third, when plans exist, they are often made without consulting partners, such as faith-based leaders, nonhospital health care workers and funeral home directors (Johnson, 2009).

Given the ongoing impacts of COVID-19, there is an immediate need for public leaders to be innovative in COVID-19 death management. Governmental leadership is not limited to elected officials and political leaders; it also includes organizational heads and even supervisors (Van Wart, 2003). This means that changes and innovations implemented by workers in the deathcare industry would indeed contribute to administrative leadership. Innovation generally refers to “the generation, acceptance, and implementation of a new idea or approach to an issue, among social actors, that challenges the prevailing wisdom as it advances the public good and creates public value” (Bland et al., 2010, p. 2). While the interest in public innovation emerged during the “reinventing government” movement, there is a sustained interest in determining how public leaders can better facilitate innovation (Sørenson and Torfing, 2011). Recognizing the need for innovation in managing this global pandemic, we offer three recommendations to improve current deathcare practices focusing specifically on the human side of death to supplement rationalistic best practices. These recommendations highlight the shift from a rationalistic deathcare approach to a humanistic approach. Table 1 highlights the differences between these two approaches. As noted, these are not incompatible but meant as a complement, especially in response to COVID-19. Although this framework was developed in response to experiences from COVID-19,
incorporating a humanistic deathcare approach would be beneficial during all MFIs. The humanistic elements are reflected on and further explained in the recommendations further.

**Recommendation 1: focus on human-centric deathcare practices**

As the pandemic continues, FEMA released additional MFM guidance (FEMA, 2008). FEMA officials acknowledged states’ role in MFM and recommended coordination among death-affiliated agencies. Officials also recommended including cultural and religious leaders in burial practices (FEMA, 2008), but that is the only point that focuses on the human side of death. This seems strange to suggest as an innovation, but Patterson (2001) argues that public administrators play a formidable role in giving families closure, so recognizing the empathy required for deathcare is vital especially during crises.

Our recommendation has grounding in the literature, as Sadiq and McEntire (2012) found the aftermath of the 2010 Haiti earthquake involved not only processes to find and catalog bodies, but also the need for psychological stresses on survivors, deathcare managers and body handlers. In that case, a shortage of coffins led to additional stress (Sadiq and McEntire, 2012), and we see a clear parallel to the current response to burials during the COVID-19 pandemic in the USA. Given that the death count continues to increase, coupled with physical distancing rules that make proper mourning and burial nearly impossible, we recommend leaders consider the human-centric approach to supplement technical MFM plans.

Existing MFM best practices provided from the US federal government, we argue, are not enough and we recommend innovation in deathcare based upon a human-centric approach that favors those responding to the MFI and the victims. At the core of this is public leadership with an ethic of care, which flips traditional administrative approaches grounded in technical rationality to include empathy, sympathy and understanding (Burnier, 2003). We are not advocating for removing the needed technical approaches to MFM. We suggest an innovation that would rework and revise plans with a human-centric approach that ensures care for all deathcare workers and victims. This is consistent with Van Wart’s (2003) assertion that leaders have a responsibility to consider environmental factors when leading. Indeed, a human-centric approach would inevitably consider the cultural and environmental factors with deathcare planning.

**Recommendation 2: develop and/or expand current networks to include deathcare facilities and critical stakeholders**

In many cases, critical stakeholders to the deathcare community are excluded from the MFM planning process. For example, past surveys found that of those surveyed, only
approximately 50% of health departments included access to spiritual counseling as part of their MFM plans, and only slightly more than half of faith-based organizations were assigned support functions in MFM plans (Merrill et al., 2017; Zhi et al., 2017). This means there is a need to incorporate these services into the MFM planning process.

Developing and/or expanding current disaster management and health care networks to include deathcare facilities and the public can facilitate innovation as more voices and opinions are represented and considered in decision-making (Bland et al., 2010). Having representation from citizens can provide public leaders with a better understanding of social, cultural and religious practices and norms within the community. Excluding critical cultural and religious leaders from deathcare and burial practices removes a vital space for connection during mourning (Crawford, 2004). While existing MFM plans might mention or include cultural and religious aspects, we argue that a human-centric approach can bring these elements more clearly into the plans and training.

While deathcare networks might be strong and interdependent (Gershon et al., 2011), we recommend expanding the networks to meaningfully include relevant deathcare actors in local and federal disaster training exercises. MFM response happens in logical stages, but the scale of the disaster could alter those efforts and require decision-making on the fly, meaning prior training and scenario planning could help (Phillips et al., 2008). We contend that including religious and community leaders in immediate and after-action reviews can help make future deathcare planning and training more human-centered and recommendations more effective (Stark and Taylor, 2014). Johnson et al. (2015) found that involving religious organizations in emergency response contributed to greater collaboration and enhanced community resilience. By including religious and community leaders in deathcare, religious and community leaders (such as those well connected to community nonprofit groups related to vulnerable populations) can have a seat at the table to innovate MFM planning and training, as these elements are missing from COVID-19 deathcare response.

Another group to consider including in MFM planning and training is social workers. Typically, social workers help families with death management in hospitals or hospice facilities, but the focus is largely on the legal aspects of death rather than the psychological ones (Hobart, 2002). Social workers specifically trained in the empathetic aspects of death can lend that expertise to MFM planning (Hobart, 2002). This expertise is needed especially in the current situation whereby COVID-19 patients died alone in hospitals because families were not allowed to be by their sides for safety reasons. Given the success of involving such critical stakeholders in past emergencies, we contend that this would also be beneficial in deathcare management.

**Recommendation 3: address mental health issues related to deathcare professionals involved in MFM**

Administrative leaders have a responsibility to ensure that necessary “tools, resources, and competence” are available (Orazi et al., 2013, p. 491). Mental health services provided to deathcare professionals are insufficient to meet the needs during an MFI. In fact, a study found that less than half of medical examiners/coroners surveyed in the USA (sample size was 122) had plans in place to provide mental health counseling to their staff (Gershon et al., 2014). This suggests a need for greater mental health services for deathcare professionals who are at the forefront of the COVID-19 MFI response.

In line with our human-centric approach to deathcare innovation, we recommend local, state and federal officials include mental health and well-being in MFM planning and training. Such services are resources and tools needed for MFM responders to perform their duties and administrative leaders have a responsibility to ensure these are available (Orazi et al., 2013). After the Pulse tragedy, City of Orlando officials offered free mental health
services to employees, and the police department does annual mental health checks for officers who responded to the scene (Bryer et al., 2018). Such practices can be institutionalized given COVID-19 is tasking not only the deathcare systems but also the people involved, as the pandemic has heightened an already tense profession (Center for the Study of Traumatic Stress, 2020).

For example, guidance from the Indiana State Department of Health for coroners managing COVID-19 victims focuses, again necessarily, on the process (Indiana State Department of Health, 2020). There is no visible section on this guidance for the mental health and well-being of coroners. In normal operations, deathcare workers can experience compassion fatigue, whereby people in caring professions can experience physical, emotional and mental stress and burnout (Adams et al., 2006). Incorporating this in future MFM planning could be easily achieved since there is guidance available from the National Response Coordination Center (NRCC) on mental well-being for deathcare professionals (NRCC, 2020).

Conclusion
In this viewpoint essay, we explore how deathcare is managed in the USA and offer recommendations to encourage innovation. The COVID-19 pandemic highlights the lack of leadership on deathcare and the need to innovate. This essay offers recommendations to improve deathcare management during COVID-19. By implementing the human-centric recommendations suggested in this essay, governments can improve deathcare management practices through innovative deathcare management ideas, and in doing so, increase community resilience during future pandemics or other disasters.

Future research on deathcare management is needed to study the effectiveness of the innovations proposed and explore community resilience through proper deathcare management. Specifically, there is a need to gather qualitative and quantitative data on communities that use a human-centric approach to MFM and conduct longitudinal studies to examine the impact of a human-centric approach on community well-being after COVID-19. In addition, research is needed to examine how a human-centric approach impacts the ability of deathcare professions to do their job during an MFI, as well as how the approach affects their own well-being and job satisfaction. Finally, research is needed to examine MFM models in other countries.

References


Further reading


About the authors

Rebecca M. Entress is a PhD student in the Public Affairs Program at the University of Central Florida. Her research focuses on health care policy, community flood risk management and evidence-informed decision-making. Rebecca M. Entress is the corresponding author and can be contacted at: rmentress@knights.ucf.edu

Jenna Tyler is a PhD candidate in the Public Affairs Program at the University of Central Florida. Her research focuses on evidence-informed decision-making, community flood risk management and organizational disaster preparedness and recovery.

Staci M. Zavattaro, PhD, is associate professor of public administration at the University of Central Florida. Her latest book examines city cemetery management. She serves as editor-in-chief of Administrative Theory and Praxis.

Abdul-Akeem Sadiq is associate professor in the School of Public Administration at the University of Central Florida. His research focuses on community flood risk management, organizational disaster preparedness, mass fatality management and collaborative governance.

For instructions on how to order reprints of this article, please visit our website: www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com