**NHS Education for Scotland**

**Talking about Bereavement Podcast Series – Transcript of “Loved Ones” – An appropriate catch-all or a problematic phrase?’ Podcast**

**Presenter:** Lynne Innes, Senior Educator, NHS Education for Scotland / Lead for Spiritual Care and Wellbeing, NHS Fife (LI)

**Speakers**: Dr Kate Woodthorpe, Reader of Sociology, University of Bath / Co-director, Centre for Death and Society (KW) and Dr John MacArtney, Associate Professor of the Sociology of dying, palliative care and the aftermath (JM)

**LI:** Hello and welcome to the Talking About Bereavement podcast, which is brought to you by the Bereavement Education Programme in NHS Education for Scotland. I'm Lynne Innes, one of the educators in the team, and in these podcasts, I'm going to talk about bereavement with our guests, who will be sharing and reflecting some of the work and learning they're involved in as they talk about bereavement.

**LI:** Hi and welcome to this episode of the podcast. I'm delighted to introduce my guests today who are Dr Kate Woodthorpe and Dr John MacArtney. Kate is a Reader in Sociology at the University of Bath who she is Co-director of the Centre for Death and Society and internationally leading research centre specialising on the social context of death, dying and bereavement and John is an Associate Professor of the sociology of dying, palliative care and the aftermath. His research has been funded by Marie Curie, the National Institute for Health and Care Research, the UK Research and Innovation Economic and Social Research Council and the Australian Research Council. Dr MacArtney's research seeks to bring sociological insights into experiences of dying which can help to open up discussions about locations of care or attitudes to dying. And I know that you both sent me some other details of the work that you've done and the work you've been involved in. But I wonder if, if I could come to you to expand a bit on the introduction that I've just given and tell us a bit more about yourselves and, and how you've got to where you are in terms of your life and your work.

**KW**: I'll go first. So, hello everyone, I'm Kate. I am, as Lynne said, I'm a reader in sociology at the University of Bath where I'm involved in the and I currently Co-director of the Centre for Death and Society. I've been working on end of life and its aftermath for 20 years now. I can't quite believe that when I look back, but that was, I started my PhD in 2003 and I've done lots of work on mainly funerals and funeral practice and policy, but also on cemeteries, on the people who work in the provision of funerals and bereavement. I've done work also on education and I've recently just secured some funding looking at dying at home. So, I've been working in this field for a long time and actually my interest in it, I've always been working in sociology, but my interest in it, and I've written about this, came from actually quite significant bereavements when I was a teenager. And I think not to put you on the spot about this, John, you don't need to reveal anything, but I think people who often are academics working in this space are often inspired or something happens in their personal life that really opens their eyes to what goes on at the end of life. So, mine was from losing some teenage friends when I was a teenager in a car crash. So, and I think that's really important just to acknowledge because there is something about the personal profession in this space when you're talking about such evocative issues.

**LI:** Yeah, thanks, Kate. And I, I think that was kind of making me think about part of my role as well as being an educator I'm a healthcare chaplain and we talk about the person in their jobs a lot and, and how that impact, how that impacts them as they go about their kind of daily work. So, what you've just said there kind of, it was making me think how many of us do that move into jobs and professions that have had something's had an impact on us that motivates that. So, thank you for telling us a bit more about yourself. John, I wonder, come to you now.

**JM:** Thank you and thank you very much for the invite to come speak to you today. I as you say, I'm a sociologist. I'm, I'm a sociologist of health, illness, dying and palliative care and, and my research started with an interest in, in living well with cancer and that included cancers of terminal illness and I later went to look at cancer diagnosis, but I then came back to cancer in and, and other illnesses, terminal conditions and my and turn to Kate’s challenge there, which I was a little more expected about. My initial research was, was orientated around living with cancer because of, of a family member's experiences and what they'd gone through. And you hear stories [inaudible] about their engagement with the NHS back in the late mid-90s this would have been and the difficulties they had still sticks, sticks with me about just being kicked out onto the street you know, I was cut up, the cancer was removed, and I was kicked out onto the street. And then what to do, do I do? And, and the difficulties they had about living with still having cancer what does that mean and, and all that. And so, my PhD looked into, you know, self-health and ideas on that, which included talking to people who were there like I say who had late-stage cancers and my research moved, has moved on and, and the interests have moved on in that, in that direction. So that's, that's how I, I think how I got started in research in this area. And I think it's, it's just felt like, it probably looks more like a natural progression looking back than it actually is. But as academic careers lurch around from funding parts, funding parts and, and but yeah.

**LI:** I suppose one question that came up for me, and I noticed you had both given me that in your bios and you talked about the aftermath. And I wondered, just for clarity, how you would describe, and I know this is not what the podcast is technically about, but if you would describe maybe for, for the listeners, what is aftermath.

**KW:** At the risk of sort of launching in again, this is something I actually feel very strongly about because as a sociologist, I think, I can't speak on behalf of you John so you please do just chip in or, or say, you know what you think about this. But I understand the end of life and dying as part of a, it's a social experience. It is profoundly shaped by the environments in which people live. And that includes their physical environment, but also culture, politics, economy, all these kind of things feed into that experience and how it's negotiated between people. Yet it has been incredibly psychologised in my view, and very much about the individual who's dying. And it's an individual experience. And as a result, grief and bereavement have, you know, what happens after someone has died has been really, most work and most theorising about it has been really focused on the inner world of the, the emotional world of the, of people who are impacted. And over the last few years, I’ve been talking a lot with Jane Ribbens McCarthy, who's, who's fantastic sociologist working in this space, and Kathryn Almack. And we wrote a paper about trying, trying to position bereavement more about in terms of what happens after death is an aftermath, because it is not a, you know bereavement has time period connotations and it is now becoming very medicalised as well, this idea of, you know, what goes on too long or is complex, is, is either complicated or pathological. Whereas we're saying, no, actually, it, it, it can be, it may be lifelong, this sense of loss and accommodation and responding and the, the whole identity in terms of the, it's almost like a deck of cards, isn't it? You take out one and then what happens to the rest? Or I can't think of a better metaphor, but it is, it is something that's constantly going to be worked on and it'll come back as well at particular times. It's not a thing, you know, two years, right that's it you're back to something and then that's not going to be rocket science to anyone listening to this. But I think it's really important to think actually the language of bereavement is quite limiting. Whereas actually aftermath, and this was Jane in the, in the article that we wrote, Jane, Kathryn and I, it's about thinking, you know, we need to think about this as a much bigger thing now. And actually, loss impacts on people in all sorts of different ways. And that depends on these kind of bigger contexts in which they're living.

**LI:** Thank you. John, is there anything you'd like to add into that?

**JM:** Well, I completely agree. It's a, it's a fantastic paper if you’ve not had a chance to look at it. I would recommend everybody goes and, and digs that out because it is a really important reminder that as, as Alan Kellehear has said, you know about dying and you know, it's a social event that healthcare sometimes gets involved with. And if we remember that that is the orientation for most people, most people who are experiencing dying and death will not, you know, the healthcare will be such a crucial and important resource and factor in that experience for most people, but it's not all of it. And in terms of the time spent and the social relations that are involved, who is involved and, and the networks of that, that extend beyond healthcare. Once you start to map those, you, and you look at it from the, the point of view of the family and the person who, who, you know, who's dying, you do start to see it from a quite a different point of view. But we have got used to looking at it from a, a healthcare medical point of view, because that is where the resources are. That’s where the money’s spent, that's where the specialism is, that's where the knowledge is. And, and, and these are the, the ways we come to know it, but it's not the only way. And we must remember the, the strengths of that and the limitation to that. And, and Kate and, and, and the paper that she’d mentioned there, it's a really good reminder of that.

**KW:** Can I just say also…

**LI:** Yeah.

**KW**: …I think you're absolutely right, John, about that it is where the resources are. And it's a cliff edge, the point then when someone, someone dies that's it. I mean, there is so, so little out there post death. And also, you're often thrust into a more commercial world at that point. And it's about access, you know, who's got the resources within their family to be able to pay for funerals or therapeutic support if you need it, or access to things that might make a, a difference to the, your quality of life as you're now going into this world without this person. It's, it's, it is quite astonishing that there is so much public, publicly funded and support or charitable, you know, support that's up to the point at which someone dies. And then you're into the wilderness, for most people.

**LI:** And that part, I think, and you know, when you're talking about arranging the funeral and, you know, looking at wills and all that kind of thing feels very transactional and, and that, you know, and it's almost to get it done as quickly as possible and all of that. I suppose I wonder if that is the, the right, the right approach that we've kind of developed or seems to be the way that we kind of manage it in in this country. So sorry, I was just thought that, you know, people might not have heard of the term aftermath, and I just wanted to kind of put that out there. I think the other thing that you said in your introduction, Kate, was about the work that you were doing on dying at home. And that was, I just had some kind of thoughts about that as you were talking about the, the resources are in healthcare and, and so but that's also a cliff edge and quite a lot of maybe movement away from dying at home because people are often in hospital. But there are actually quite a lot of people who do die, still die at home as well.

**KW:** Yeah. But actually, this probably is a good segway into what we're going to talk about because that study hasn't, is only just starting.

**LI:** Right.

**KW:** But one of the things that instigated it is that language around and the sort of moralising around dying at home, you know, peacefully surrounded by family. Which it which really led us as a team to start wondering where's that come from? And then critically, and who's critically evaluated that? Is that even achievable or realistic for a lot of people, either because they don't have that family or that their home is completely inappropriate for that to happen or actually, they don't want to because for whatever reason, the sort of tensions within a network of people where this isn't viable or wanted. And it's that kind of moralising language around dying that we were, that really instigated that project. And I guess that leads into, like I say with this nice segway about loved ones, because it is, it is partly to do with all this kind of, you know, very romantic language often used to try and soften it somehow. And I suppose that's how John and I got to this point. I don't know, John, if you want to say something about, a bit about how you contacted me.

**JM:** Well, well, it was listening to you, Kate, on another podcast, if that’s okay.

**KW:** We should plug that one as well. It's the Death Studies Podcast.

**JM**: So yes, I was listening to that podcast and Kate was talking and I think I, I don't know, Kate, you, was it an off the cuff, it felt like an off the cuff sort of getting something off your chest moment of oh, and also, you know, loved ones. I haven't listened to it now for a few years, so I may be misremembering this now. So, but, and, and you were saying that and, and it's, you know, this is problematic too, because we know about family relationships at the end of life and we, we, they don't transform. Families don't change from being these very difficult spaces. You know, you know that they, they, they can be all the things we know about other people's families, our own families, and the difficulties within don't transform necessarily because somebody's dying. And so, what are we doing when we use this term to just group all of those different relationships? It was a real light bulb moment. I said, gosh, yeah, yeah, that's a really good point. And the more I reflected on my own work that I've done on this and, and I've written about location of care and, and, and the home and, and, and the contrast to hospices and hospitals and, and work with carers that have done and, and families. Yeah, that's a really, really important point. And I just then kept raising in meetings with other people when I say I’m using this term and just discussing it because I work a lot with clinicians in palliative care and, and primary care. And they, they were like, yeah, that's a good point. It's a similar sort of light bulb moment for them. So, I then emailed Kate to say should we do, let's, let's formalise this in some way. What, what have we got time to do with this, this would be really great to, well to do something and we had, we just had enough time between us, I think to write a blog and, and that's how we've got to where we are I think.

**KW:** There's a couple of things to add to that is that you restored my faith, John in, in academic generosity, which was very, really nice because sometimes it can be quite a cutthroat sector to work in. So, to actually reach out and say, I heard you talking about this. Let's do you want to do something together rather than going off and doing it yourself. Thank you for that. But, but I think I need to acknowledge also that came from a fantastic PhD student that we had here in CDAS. CDAS is the Centre for Death and Society at Bath called Tara Bailey and she about 10 years ago and she was a former funeral director and a funeral arranger. And she felt that she was doing a PhD on funerals. And she made the comment to me that she felt that funeral directors and people working in funeral services felt very, very uncomfortable talking about money, very uncomfortable. And as a result of that, that they reverted to moralistic language about why you need a funeral, what's the purpose of a ritual, what the, sort of obligations that you might have to one another, either to the person who's died or to the wider social network around that person to, to put on this ritual and therefore spend money by paying for a funeral. And that really stuck with me, this moralising language that's used to, I don't know, it compel people to behave in particular ways or to shuffle them in a direction. I don't know, in the clinical setting, I don't think it's, it might be quite different about this language, but what it does is it sets expectations for people that they, they, and then you, you're creating. Sometimes I think you're creating a sense of performance that needs to happen because you have to live up to this idea that this person is a loved one. Even though you couldn't stand them, or you had a very difficult relationship with them, or you may have loved them very, very much, but there's something quite inauthentic about calling them a loved one because it feels artificial. You'd never have called them that in your lifetime, so why, in their lifetime, so why suddenly start reverting to it now when, when they're either dying or have died? So that's where it came from. But John, it was I really valued when we, when we wrote that blog, your view, because I've done most of my work on post death and, and to hear actually that it happens pre death. I, I just kind of assumed it didn't happen that much pre death, that there would be more sensitivity or, but maybe not.

**JM:** No and, and this is my experience and, and one of the things we, we may want to do in the future is it's more in-depth research into its use potentially. But certainly in, in palliative care spaces and, and hospice spaces where I do a lot of my work, it's just a category I've done a lot of work in, in discourse analysis and sort of it's a category that is used to group people. It's a shortcut. It's, it's, it's done unthinkingly, and I don't mean that pejoratively necessarily. I mean, it's just something that we, it's a turn of phrase that's used and it's become a sort of common language. And as part of when we were, when we were preparing our blog, I, I did put into Google trends and see loved ones, you know, and it has increased in, in its term, in its use in the last 10, 15 years, which I think, I think we're the three of us between us probably reflect on that. Yeah. When did it really kick in? But it's definitely very common now as a, as a turn of phrase. And, and that was just something, well, what are we doing, I say we, what are, what are clinicians, what are people doing when they do this? It's a sort of social science question we ask when, when we see things like this happening is what does it mean to, to work in this way, to use this sort of language? And it's more than just a term and language. What it, what is it representing? Is there something else happening here? You know a lot of people will just be thinking, well, it's just the way I, it's just a term I use. I don't mean anything more or less than I'm, I, I think I'm using it for. But that doesn't mean that's, as Kate was saying, that's how it's received. And that doesn't mean there isn't a history to this. And I think that's one of the great things that social scientists are able to do is to take those common be, you know, common sense understandings and say it might feel like common sense to you, but there's a lot going on here. There's a history to why we're, why we think this is just everyday sort of language. And there's and there's repercussions beyond the ones you're thinking about that you might not be aware of. But here, let's show you some of this research about how people relate to each other in illness and at the end of life and how those relationships can be really varied and, and why people care for each other isn't just because of love. It could be duty and obligation, fear. You know, there's lots of reasons and lots of really good research on to why, to why someone might be attending to someone who, someone else who's ill and or dying. And if we just pop a label of loved one on that, what are we doing? You know, we often talk about in, in healthcare, being sensitive and, and, and aware to the, you know, the diversity of cultures and, and lives that, that, that you the people you're caring for and you're supporting. Well, are we eradicating, are we silencing certain experiences by just saying we only understand that relationship in one way love, loved one and a particular type of love as well.

**LI:** Got your blog here and I think you, you talk about loved ones as a general catch all for family, friends or other close people. Since reading your blog earlier, last year now, I've been really conscious of the word loved ones or the two words loved ones since then. And very intentionally, you know, not using it, inappropriate, or not using it at all not, not even inappropriately, just not using it. I don't, I don't think I used it a lot, but I, I, I don't really know if I did or not. And I hear people, because I work in a, a hospital, I hear people using it and, and I don't even know if they know they're using it. I think there's, you know, I wonder if how much thought is going into the language that is being used. And I suppose that's, that's maybe what you were just saying there, John, is actually that kind of, it's become an automatic way of speaking rather than something that we've, we've reflected on and thought about deeply.

**JM:** Absolutely. And there's two things I just want to follow up on there, you know, yes, it sort of a linguistical twitch, if you like. Some people, I just did one there, if you like. And other people use, if you know what I mean and, and they feel that and until you point it out to them, they won't be aware that they're saying it. And the other thing to point out is, is my, certainly my concern was more this general categorisation. If, if you're a clinician and you know, the relationships that you know of the people you're supporting and you know that that is a modern western understanding of love, that this, this person is caring for this person out of that. And, and, and it feels appropriate then that you, you, you know, you know these people and you can describe it. Oh, this is your loved one. Then there's, I don't see a problem with that necessarily. It's if you, you know, who are you to make that judgement is I guess is the question. And how well do you know the people you're talking about to ascribe this particular relationship to them? And as Kate says that, you know, then you start to think about the moralising that happens and, and the normative aspects to that and how, how you expect people to value and relate to each other that come, that comes from that. That's when it starts to become problematic. And you know, we can get rid of loved ones and bring in a new term and that, that structure underneath that doesn't change. And so final thing to say is what, what we turn to at the end of the blog is this isn't a language police thing. This isn't stop saying it and carry on. It's, it's a what are you, how do you see the relationships between people? What are you thinking about them in that space? And then use your language to reflect that and be a little bit more aware of how you're viewing those relationships and that, be a little bit more reflective about that there are diversity of ways that people care for each other and it's not always happy families. And, and that's the that's more the point than don't use these this word or this phrase from my point of view anyways, because there were lots of things we're being told. Don't say this, don't say that. But if we don't change the underlying structures of, of or attend to the things that, that is the problem, then we're not really changing anything by just not using those terms really…

**LI:** Yeah.

**JM:** …or, or substantially certainly in this case maybe in other terms but.

**LI:** So, it's really, it's really thinking about the relationships. Kate, I wonder if you wanted to add anything in there.

**KW:** I think also we're going to, we're entering into a period of quite significant change, generational change, so that there have been a lot of assumptions in the last say 50 years as, as health, you know, modern healthcare has developed about people's expectations and obligations, what they will do for one another. A lot of it's been based on the war generation, you know, the, the kind of values that were established sort of 1920s to 1940s almost. And what we're going to start seeing is some of the values that have really taken become very deeply embedded since the 1960s, which is rampant individualism and much more diversity in opinion and identity. And we can see it, you can see it already in politics, this idea that you, you can no longer assume or trust that people will do the right thing, whatever the right thing is. But so much of policy and practise is based on the fact that you can assume that people relationally will step up for one another. And I think what we're starting to see is you can't assume that anymore because this is a different generation of people. They've, they've lived in a different time, a different period. They're going to have very different expectations of one another and what they're prepared to do. And, and you can see that in the funeral world in terms of who is actually taking on funeral organisation, who, you know, because some of the, the arguments or contestations that happen about people's responsibilities to one another and concerns about the state having to step in because families will just go, well, I'm not going to do it. You can't make me. I haven't seen it, oh, I haven't seen this man for 30 years. He was estranged. And that kind of level of estrangement has become easier in many ways because of, you know, divorce laws changing, having multiple children by different partners, re-partnering, your families have become much more complicated in the last, within the last generation or two. And the result of that is you can't make these assumptions anymore. So, he may well, this man may well be your father, but he might, you might have not had any kind of relationship with him, but biologically you're connected to him. So, we're starting to see that in funerals, definitely with people just saying, well, I'm just not going to do it, and you can't make me.

And there's big concerns about what, what then happens? The state has to step in. And I think this is what we're going to start seeing in healthcare. You know, you can't, you can't assume that people, well you're seeing in care already, aren't you? But you can't assume that people will take this on. Oh, and it's not that they don't necessarily want to. It’s they might not be able to. They might, they might, you know, life is so complex now and you might live at a distance and you don't have the resources or disposable income to be chasing up and down the motorway or on trains to be visiting someone to take care of them. You may not be able to actually sustain a very close relationship with someone and, and that's not a, that's not a judgement about people in terms of their efforts. It's more about though I think for professionals, it's about recognising that you're going to get a much more complicated group of people coming, well population now accessing services, at least relationally and their relationships. You cannot make assumptions about, you know, that parents will, will do stuff for their children, adult children at least or and children will do stuff for their parents at the most simple level, let alone, let alone gosh, siblings, aunts and uncles, cousins, ex-partners, stepchildren. You know, it's a very, it's a much more complex picture now.

**LI:** Yeah. I think, I hadn't really thought about, about that and…

**KW:** Sorry Lynne.

**LI**: No, it's okay. No not at all. I was thinking, I was, what I was thinking about as you were speaking was my own kind of family dynamic as, as you were speaking. And I'm probably in what is it they call the sandwich generation. You know, I've got elderly parents and, and grown up children and grandchildren and my aunt died recently, well about a year and a half ago. And I was, I organised all of the funeral and I, I couldn't have not, you know, that wouldn't have been right for me not to do that. And then I started to think, as you were talking, what if my children, don't want to organise my funeral. And, and, and is that because I'm the very end of the baby boomers generation, that kind of inbred in me that I would obviously do my aunt's funeral and my mother's and whatnot, not that she's died, but, you know, when the time comes and I wouldn't even contemplate not doing it, but will my children contemplate? And I'm not suggesting they will. I've just got me thinking about all of that. And that complexity.

**KW:** In terms of sociology that is the, the big thing that sociology can add to healthcare that, that I think is really missing a lot of the time, which is this understanding of the bonds and the ties that hold people together and a very highly individualistic way. And, you know, often more psychological and clinical way of thinking about individuals operating within a network. Well, it doesn't work like that. There's, there’s all these kind of unspoken rules. And David Morgan wrote about this and I think he's just terrific. He was a sociologist writing about family practices. He called it family practice. Family isn't a thing that is. It's a thing that's done and it's repeatedly and continuously negotiated between people. But underpinning a lot of that, are these unspoken rules about who will do what for who and on what grounds and on what terms. And I don't see that reflected in policy at all. And I don't see it particularly reflected in a lot of the clinical literature either that I see all the research studies for that this is often talked about in terms of variables and things I actually know. These are really powerful and often not really talked about until you get these moments of crisis that suddenly or, or, or people partner up and they go hang on, your family's really different. You do, you do something really different to our family, even though you might think that very broadly you were from the same background, same social, cultural, ethnic, educational, geographical background. Actually, you're really different because the way you do things and the way you do things for other people is very different. And that sociology has a really important role in showing that and illuminating it and making people aware of it. And I think that's thank you for asking us to do this podcast because this is one of our ways of being able to do that.

**JM:** If I may just jump in and plug something, I have a piece of work coming out in a couple of months time. It's a report into the role of social sciences and humanities into research of death, dying and the aftermath. And we've done a, we've, we’ve I won't go into too much detail but keep an eye on it. Please follow me on, on, on Bluesky and I'll be plugging it there. I'm working with Marie Curie with this as well. And with the James Lind Alliance. It's coming out of the new James Lind Alliance priority setting partnership that's been done on palliative care. We've done some work on that to look at the social science and humanities priorities and identify those. And, and it's, it's because of the things that Kate and I have just been talking about, is that as important as those clinical questions are, they often build in assumptions about the social world and not really recognise the implications of those. And, and, and beyond, what you said there Kate, beyond variables, these are not variables in the much too complex to be understood in, in, in that sense, there's a lot of history and, and, and, and social diversity to be taken into account and these things. And the value that of working with social scientists to develop these research questions. There's a lot of good evidence, I would say, of, of the benefits of that. I'm, something I do a lot of the time and try and bring it to the clinical studies I do. But yeah, so a small plug for a piece of work that will be coming out in, in mid, I think, mid-February, early March.

**LI:** And can you remind us what it's called…or do you not know that yet?

**JM**: Off the top of my head, I can't remember the full title. The, the report is called Kowing Dying.

**LI**: Okay, okay.

**JM:** To Know Dying.

**LI:** So, I'm aware we've talked about quite a lot of different things and that's great. It's been really, it's been so interesting for me actually. I really enjoyed talking about this. I suppose I'm just going to go back to your blog for a moment and, and I suppose I was kind of interested to know how your blog was received, what the impact of it was and all of that kind of stuff.

**JM:** Well, a lot like your response there actually Lynne I've had, because I do work daily, daily interactions with clinicians and, and other researchers in my field. And it's interesting that the term loved ones goes well beyond dying, palliative care. It's, it seems to be across healthcare. I certainly know it in mental health services it's used a lot. And I've worked with colleagues in, in cardiac services and when I've seen people who are aware of my blog and they're in meetings and people apologise, they’ll go ‘I'm working with the…sorry, John’. And so, there's, there's that moment and but it's done well. And I think it's because those people understand that actually there's a point that is, is worth making and, and, and resonates. And I think that was why I wanted to work with Kate to, to write the blog was because actually it was when pointed out it is something that clinicians go ‘Yeah that's a good point’ because they, they do know the diversity of the families they're working with. It's a daily occurrence to have the difficulties of negotiating the strange family dynamics that they meet every day. And then when you point out that dissonance, that incongruence between this term and their experiences they go ‘yeah, that, you're right, that doesn't work.’ So that, it's been mostly I haven't had any critique and, and, and it was my most popular back in the days of X and Twitter with my most popular tweets. And yeah, so I'd say mostly, mostly taken well and, and as intended, it was not, we're not here to, to tell, oh, you're doing it all wrong. You know, it was an observation of literally look at what you're doing and the people you're working with and then look at the terms you're using. And then that doesn't seem to match just on that basic level. And, and also here's a lot of, you know, social science and health science research on the roles of caring and how much we know about why people care. And let's draw on that a little bit more to when we think about what's happening here. How about you, Kate, in the world of funerals?

**KW:** I think it was very well received, but it was very well, well read. And it was an absolute pleasure to write. So, it's and it's well, you know, Lynne, you got in touch about it. So, it's, it's clearly, you know, it's reached some corners of the country that, that we wouldn't have otherwise reached. So that's really good.

**LI:** And I'm planning, we have a, a, a journal club with the, the team that I'm in here in Fife. And I'm going to put it forward for one of our monthly journal clubs because obviously as chaplains, they're often out and about hearing and, and possibly using the term loved ones. And it would be good to kind of talk about that with them. So, I’ll certainly be kind of spreading it a bit further as well.

**JM:** I’dbe interested to know if it has an international resonance, you know, how far the term has gone and if it, I suspect in, in some and countries it is used USA, Australia, maybe, but I'd be, if it translates or if a similar sort of term is being used in, in non-English speaking countries and if there's any, any resonance. So, if anyone wants to get in touch and let me know, I'll be just, just interested to know.

**LI:** That, that sounds good. I wonder, I’m aware we're kinda coming to the end of the, and there, there's my linguistic twitch. I don't know if you've noticed it. It's kinda, I say kinda all the time. And I know that I say it and I try not to say it. And when I hear things back, I'm really giving myself a hard time for it. And I just noticed I did it there. So, yeah, we're coming to the end of the podcast and, but before we finish off, I wondered if there was anything else that you wanted to say that you haven't already been able to, to articulate.

**JM:** I, I would just say, please do have a read of the blog. We, we put links in, in the blog to other papers that, you know, just for some examples. And I think that might be of interest. It's something you read whilst sipping a cup of tea in a, in a 10-minute break. And that's as it was intended just to, to get people to, to have a think, yeah and share and get in touch if, if there's anything you want to talk about it.

**LI:** Okay.

**KW:** And I would add, have a listen to the Death Studies Podcast, which instigated the blog, which then led to this podcast recording. Because the Death Studies Podcast is, it's, it's some academics talking to other academics, but they're from lots of different backgrounds. And it's really interesting to get a sense of different work and perspectives, you know, from photography, from film and television, from social sciences, from psychology, from creative writing. It's a really varied and very insightful podcast that I think it's very listenable. So, I'd recommend that as well.

**LI:** So that's called the Death Studies Podcast.

**KW:** Yeah.

**LI:** Just when you were speaking there about photography, I, I think I found your blog on the University of Glasgow website and I noticed it was linked to a kinda series of photographs that they had done. I can't remember what that was called now, but I did see the exhibition at a conference.

**KW:** So, there's Naomi Richards who works at Glasgow and she's just done a, a terrific study on dying in poverty.

**LI:** Yes, that what it was.

**KW**: And she, and part of that study was taking photographs. And that's…

**LI:** Yeah.

**KW:** … actually it was that, part of that study inspired our dying at home one because she did look at homes and what, you know, homes for people who are living in poverty. What does that actually mean? And we're now taking that further. So, she, she's also involved in an end of life studies group…

**LI:** Yes that’s right.

**KW:** …there at Glasgow. And they are, they're a very active bunch of people as well to look up.

**LI:** Yeah. And that was a really interesting exhibition. I think it was at the Palliative Care Congress a couple of years ago that I saw that. Yeah, yeah. It's quite kind of fascinating and, and maybe something that folks haven't considered either, you know, particularly when people are dying in hospital where the home context is not really visible. I just remembered that there that that's where I had kind of seen it as well. I think that's where I read it. Anyway, it's been so wonderful to speak to you both and, and hear more about this and also about your other work as well. I've kind of learned loads in this, this session and I'm certainly going to look up the Death Studies Podcast. So, thank you so much for, for taking part and being very generous with your time and, and offering us this podcast. We're really grateful for your help. Thank you so much.

**KW:** Thank you.

**JM:** Thank you very much for inviting us.

**LI:** Bye, bye.

**KW:** Bye.

The podcast was recorded in January 2025 and can be found at <https://www.sad.scot.nhs.uk/podcast/> or <https://open.spotify.com/show/11AORpjHqbsYwgg1DJUtLk?si=687dba351d1f45d4>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk) or contact supportarounddeath@nes.scot.nhs.uk

© NHS Education for Scotland 2025. You can copy or reproduce the information in this document for use within NHS Scotland and for non-commercial purposes. Use of this document for commercial purposes is permitted only with the written permission of NES.