The Loneliness of the Dying

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In the pandemic situation, there is a care deficit both in public and private life. In private life, the care deficit is most palpable where elderly parents and their multigenerational families must keep each other on a distance socially and spatially. Many elderly grandmothers and grandfathers feel isolated and lonely even if they can keep in touch with their families using cell phones and other digital devices. Digital intimacy may be a substitute for physical closeness for a while but can be disturbing when lasting too long.

In public life, the care deficit can be seen in governments' policies and strategies to control the epidemic and keep hospitals and health care services going and offer enough supplies and resources to take care of infected patients and organize an effective infection control.

The Covid-19 body a health worker attends to is infected and medical staff are obliged to protect themselves against the infected body, simultaneously they must treat and care for the ill person. Bodily contact the care health workers must provide in relation to the ill and contaminated patients are amputated by "social distancing" and the protection equipment adds an aspect of emotional coolness in interaction between the patient in the bed and the health worker at the bedside.

Dying with dignity

Dying with dignity is related to images and ideals of being a part of a family that cares for you and respect you as a special and precious person. In Norbert Elias' book 'The Loneliness of the Dying.' (2001) he writes: 'In the intensive care unit of a modern hospital, dying people can be cared for in accordance with the latest bio-physical specialist knowledge, but often neutrally as regards feelings: they may die in total isolation.' (Elias: 2001: 88). The fact that elderly in institutions needs so much social contact, express an existential longing for confirmation of being part of the social and

emotional lives of their close relatives. They need identity-affirming communication that strengthens the experience of being loved and seen. A dignified death in individualized societies is about dying as a person who has lived and been loved by someone.

Here Elias draws on a warm-cold care dichotomy where family care is 'warm' and care in a modern hospital is the opposite, it is 'cold' and sometimes makes you feel invisible and isolated. Like Norbert Elias, the American sociologist Arlie Hochschild, discuss 'warm' and 'cold' care. She investigates how gender relations are an important part of cultures of care. Traditional and 'warm' family care is closely linked to images of femininity, homeworking mothers, wives, and grandmothers. 'Cold care' is represented by impersonal institutional care in large hospitals and nursing homes.

Each ideal of care implies an idea about who gives it, and how much of what kind of care is 'good enough'. Images of care can be a part of explanations of some social dynamics to a disease like Covid-19 that is new, unexpected, and devastating. People respond with fear, moralization and explanation, and action. For many, a Covid-19 related scenario is a fear of dying in a place perceived as cold and impersonal, like the high-tech intensive care units for dying Covid-19 patients. Rituals we use when saying farewell to dying loved ones are not as usual. The same applies to social ceremonies since ordinary funeral rites are put on hold. Families suffer when having to accept that the last parents/ grandfather / grandmother saw was a nurse in a cool and scary outfit.

Medical staff wears protection outfits that is scary and give many patients a feeling that they are being treated by astronauts stripped for human feelings and warmth. Astronauts are, as we know, humans who have been trained by governments to be crews on spacecrafts. That is why the image of astronauts taking control in a context where people are suffering and need urgent help is an image that fills most of us with emotional ambivalence.

Black or white?

But is care for Covid-19 patients either 'warm' or 'cold'? Is the picture only black or white? During the pandemic we have witnessed new and unexpected ways to protect the personal integrity of the dying. Hospital staff communicates with face expressions, gaze, touch, voice, and gestures. Infection control equipment restricts but does not remove all kinds of human expressions. Eyes may be used for contact, the voice may be warm and caring, and a touch by a hand with a surgical glove on signals compassion and empathy, even if it is not as intimate as skin-to skin- contact.

Medical staff and families with hospitalized Covid-19 infected relatives have been very entrepreneurial, and creative in the use of digital devices. Dressed in protection equipment, nurses and doctors stand next to the patient's bed and are the intermediary who facilitates face-to-face

communication between close family members in a context where physical meetings are prohibited. Love, care, and empathy is digitally expressed. Even within the most advanced high tech intensive care units there have been heartwarming moments of human compassion and care.

Not only hospital workers must manage feelings of fear, stress, isolation, and insecurity. Those who work every day in local health services and service-industries, most of them are women, face an increased level of frustration and anxiety. When customers and clients express anger and helplessness, service workers must keep smiling and show a professional attitude. Their jobs require a good deal of what Arlie Hochschild defines as 'emotional labor'- a concept that sheds light on the harsh stresses so many essential care- and service workers experience. First line workers in hospitals and other medical institutions must suppress their own feelings and even if they look like astronauts, they work hard to express human warmth in the care for the dying.

Complex Care work

Even if the pandemic has brought about an outpouring of gratitude toward frontline workers, it has created an intense amount of stressful work. Nurses must keep their own feelings under control when telling people, they cannot see a dying family member. Every day, doctors, nurses, and nurses' aides- especially those working in the intensive care units, must do a lot of complex emotional labor. Seeing patients die, taking care of mourning families, stay alerted to patients' breathing patterns and more is demanding and energy consuming. In addition, they must deal with their own anxiety, sadness, and panic in response to the care for needs among intubated patients at the same time as they for instance worry about their own partner's bad cough in the morning. These worries do not arise from the job itself, but from a hope to protect their own family from the virus.

So, what is disturbing with all the gratification of care work we witness these days? Several things, first among them is that care work is being low paid, female dominated and has low social recognition and respect. It is impressive that hospital workers after years with cuts in public budgets and austerity politics, have worked so hard, dressed like astronauts, to give infected patients a touch of human warmth and care as well on the medical as on the digital level.

Even if the hospital, the nursing home, the intensive unit is humanely run, a care system can be broken in a hidden place - in the home. Home-schooling, lockdown, and social isolation is not shift-work from nine to five. Nurses, care-workers, service-workers are generally mothers, wives, sisters, and daughters. A second and a third shift waits after the first shift at the paid job. The second shift is the housework in need to be done. The third shift is to support and comfort children and partners and keep the family together.

Despite home-schooling and strict mobility regulations, we have witnessed a lot of creative social, artistic, and digital communicative forms between family members isolated in institutions and friends, neighbors, and family on the outside. Musicians, jugglers, and other artists have streamed concerts, and some have even set up performances outside hospitals and elderly care homes to encourage, please and entertain lonely and isolated residents missing ordinary social life.

So far, the pandemic picture is more colorful than black and white only. Hospital care for the dying now include digitalizing proximity and face-to-face contacts with families. Even if it is heart breaking when couples who have been married for 40 or 50 years must say a final goodbye to each other through Facetime or Skype, it is better than nothing. Digital contact cannot fully replace close and warm bodily contact, still we may anticipate that digital media produce moments of experiences of emotional closeness and mental presence.

Vaccines can take us back to the usual interactional forms and rituals we practiced before 2020. Social life in post-pandemic societies may learn much from the experiences from Covid-19 related digitalization. Before the next pandemic occur, we may for example have developed more advanced welfare technologies to be used to relive health workers' burdens. Humanlike robots will not be infected by virus even though they in principle may be carriers of infection. But they might serve coffee and food and be of practical help. They may probably also do some cleaning and disinfect places and materials.

Norbert Elias envisioned that modern institutions where patients are seriously ill and dying are marked by emotional neutrality and a cool biomedical atmosphere. Will digitalization and welfare technology support or change his perceptions? Welfare technology or robots may change the division of labor between people and technology. On the one side we may expect that the technology will release the work force that may be used in other ways. On the other hand, robots, digital devices, and mobile phones are still things or objects; they do not answer to humans' need for a hug, a hand to hold and identity conforming communication. Despite of this, warmth and closeness that are communicated and experienced by help of digital tools in a situation where infection control demands that we are isolated from each other, may at least give some form of emotional comfort and relief for the dying and the family. For medical staff, digital communication and more advanced technology can remove parts of the practical work and free up time for more care and work for patients.

Seen from our point of view, there is no optimal solution to the social dilemmas produced by needs for infection control and people dying without their loved and dear ones by their side. The comfort

in this situation is that we do have mobile phones and “astronauts” - so at least most dying persons are not totally alone.