

Death is a natural
process



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Abstract

Death is a natural process experienced by every being. Yet, society's attitude towards death and dying has become one of fear and avoidance. The intention of this essay was to consider factors that account for the gradual shift in social perceptions of death. The exploration of historical experiences of death identified the link between an increased awareness and fear of mortality, with the impact of medicalisation. It acknowledges how the radical improvements within healthcare have limited society's exposure to death by reducing the number of premature deaths. Adaptations to the care of the dying are also associated with the prevalence of the medical profession and the decline of religious influence. The essay highlights sociological concerns over the isolation of the dying, particularly when care provision is confined within the hospital environment, causing death to be hidden from society. The diverse rituals and traditions demonstrated by a variety of cultures were examined, along with the contrast in burial rites between the social classes. The psychological impact of death discussed the potential of creating a perpetual fear of dying, through childhood socialisation of death and grief.

Removal of such fear and misconception is associated with the vision of palliative care. Evaluation of its strategy identified its aim to improve quality of life by promoting informed choice and patient focused care. It also acknowledged the limitations of its resources and the restriction of services to specific conditions. The culmination of all factors expressed within the essay is fundamental to the changes in social attitudes. An increased awareness of mortality and the desire to prolong life wherever possible has

contributed to a fear and denial of death. Overall, social perceptions of death and dying are subjective to cultural diversity and are adaptive to the dynamics of society.

“ In this world nothing can be said to be certain, except death and taxes”
(Franklin, 1789, cited in The Phrase Finder, 2013).

The words of Benjamin Franklin signify the reality of death’s undeniable role in natural existence. Yet, the subject of death is more widely associated with morbidity than a universal biological process. Prior to the 19th century, very little research or literature featured such a taboo subject. This essay will explore changes in social attitudes to death and dying, with particular focus on changes in historical patterns, rituals and traditions and the progression of the hospice movement. Pre-modern society was well acquainted with death; the event, though tragic, was encountered with little surprise or overwhelming fear. The historical perspectives of death will outline the contrast between such awareness and acceptance of mortality during the Middle Ages, to modern society’s focus on prevention and cure.

The rituals and traditions surrounding death will consider the burial rites associated with social and economic status and present the symbolic interpretations of diverse cultures within society. The sociological impact of death will appraise the social disruptions caused by grief, and the positive social functions of death that contribute to equilibrium within society.

Additional analysis of the shift in attitudes towards death will discuss the notion that society is graduating towards further denial of death. It will examine the media’s portrayal of death in society, along with the desire to

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control and prevent death through medical science and technology. A brief review of the psychological perspective of dying will refer to socially constructed attitudes to grieving. In particular, parental socialisation and childhood experiences of grief that contributes to a perpetuated fear of death.

Finally, examination of the research into the growth of the hospice movement will reveal the history behind its evolution and review the pioneering work of Dame Cicely Saunders. Critical analysis of palliative care will attempt to identify limitations of the service, along with the efforts by palliative care councils and charities, to extend services and prevent social exclusions. These services, when implemented effectively, have the potential to change society's perception of death and the dying process.

Historically, the risk of death in western societies has reduced significantly over the last few centuries. Improvements within childcare, education and the discovery of antibiotics, has limited society's experience of infant mortality and contributed to an overall increased life expectancy. Premature death of children under the age of five was just 5% between 1990 and 2010, in comparison to the thousands that failed to thrive during the Middle Ages, due to poverty and diseases such as tuberculosis and the Black Death (WHO, 2012, p19).

Chronic and terminal illnesses such as cancers, cardiovascular disorders and respiratory diseases account for the majority of deaths among the middle aged in contemporary society. The younger generation tends to be associated with deaths resulting from suicide, Aids and illnesses related to

drug and alcohol abuse (Taylor and Field, 2003, p156). Medical technology has contributed to the eradication of many diseases within western countries but it is yet to take effect on a global level. Populations within Africa continue to be affected by cholera, leprosy and malaria. Survival rates are low due to extremes of poverty, unsanitary living conditions and limited access to medical treatment (WHO, 2012, p94).

Death and disease was encountered during the Middle Ages with such regularity, it became less feared. Historian Ariès (1974, p7), referred to death in this era as “tamed death”. Death was experienced on a communal level as friends, family and even children visited the dying on their sick bed, “with no theatrics, with no great show of emotion”, (Ariès, 1974, p13).

Religious influence was prominent during the 11th and 12th century and great emphasis was placed on the judgment of the individual on the last day of their life. A strong allegiance with church was believed to determine resurrection. Thus, the process of “One’s own death”, (Ariès, 1974, p36) became more personal, indicating a greater awareness of existence and mortality.

The 18th century witnessed the most significant change in social attitude towards death. “Thy death”, as described by Ariès (1974, p66), intensified the emotional aspect of separation. This led to more pronounced displays of grief through a greater fear of loss. The emotional impact of death contributed to a new desire to withhold the prognosis of death and relocate the dying to the hospital environment. Ariès (1974, pp86-89), refers to this as the “Forbidden death” as traditional rituals of death were abandoned and replaced by clinical practices of the medical profession. The religious figures’

responsibility of overseeing the death process was relinquished to the physicians.

Sociologists such as Elias (1985, cited in Giddens, 2009, pp320-321), acknowledge that medicalisation has enabled greater management of symptom and pain control. However, in doing so, the dying are pushed behind closed doors through a societal need to civilise the death process. He argues the promise of death free from pain and distress may come at the emotional expense of patients; as dying in hospital is both isolating and lonely. Caring for the terminally ill in hospitals became the cultural ‘ norm’ and was the site of approximately three quarters of all deaths by the 1950’s. Ironically, many elderly people are more fearful of the institutionalisation of hospitals and nursing homes than death itself. They feel a loss of identity when removed from social circles and loved ones, to an unfamiliar environment where care is provided by strangers (Kearl, ND).

Conversely, many sociologists argue that medicalisation of death has established positive social functions. Kellehear (2000, cited in Howarth, 2007, p135) maintains that “ good death” is subject to a degree of social regulation, reliant on the collaboration of the patient, their family and the medical profession. He claims that if the responsibility of care is placed in medical hands, the patient and their family can be proactive with preparations and the organisation of personal matters. He argues, in certain circumstances the patient may continue to work, promoting self -worth and a valued contribution to society.

Continuation of social roles is dependent on the nature and progression of the condition. Illnesses that cause a gradual decline in health and an anticipated death, arguably, have less impact on society. Sudden and premature deaths can evoke more intense reactions within society and require lengthier periods of readjustment (Clark and Seymour, 1999, p11). Diseases such as AIDS can attract negative societal judgment, causing sufferer's to withdraw from social interaction. They may experience a loss of identity to the disease and choose to keep the stigma hidden from social view (Moon and Gillespie, 1995, p89).

Deaths caused by AIDS and suicide tend to receive less empathy due to the perception of personal responsibility. Yet, some cultures in Japan view suicide as an honourable act with no attachment of religious punishment. The high rates of suicide among Japanese women over the age of 75 are thought to relieve the burden of care and responsibility from loved ones. Although suicide is still perceived negatively by Western societies it does not reflect such extreme attitudes of the Middle Ages. The historical shame attached to suicidal death led to the denial of proper burial rites. Suicide victims were often buried in the same manner as criminals and the poor of society, in unmarked graves and ditches (Howarth, 2007, p65).

Burial within the confines of the church was the privilege of the wealthy. Those of high social status endeavoured to secure a burial plot under the flagstones, or within the walls of the church, believing this increased their chance of resurrection (Ariès, 1974, p18). The poor did not qualify for such opportunities. Their burial was of little significance to the churches entrusted with the care of the dead. The poor were buried in either, unmarked graves

or large communal ditches. As the pits became piled high with the deceased, older ditches were re-opened and the remaining bones were removed (Ariès, 1974, pp18-22). This was common practice until the 18th century when concerns were raised over the lack of respect shown towards the remains of the deceased. Tombs were introduced to accommodate the dead and reduce the risk of disease from the foul smelling ditches (Ariès, 1974, p70).

The evolution of undertaking as a recognised profession and business replaced the primitive role adopted by carpenters and grave diggers. The management of death and burial came at a high price as funeral processions developed into a spectacle of wealth and social status. Little consideration was given to the poor, who, in extreme circumstances would store bodies of their loved ones until able to pay the funeral costs. The poor were also at the mercy of thieves involved in stealing recently expired corpses and selling them to the medical profession for analysis. They could not afford to pay for reinforced coffins or graves that offered protection within the confines of the cemetery. Such was the stigma of a 'pauper's burial', people began to take out burial insurance and often went without food to maintain contributions to their policy (Howarth, pp222-242).

The increasing cost and unsanitary nature of burial motivated an influential figure, Sir Henry Thompson, surgeon to Queen Victoria, to propose an alternative method of dealing with deceased. In 1874 he founded the Cremation Society of England and began the lengthy campaign for the legalisation of cremation. Despite continued opposition from the Home Office, it was eventually pronounced legal in 1884 during the trial of Dr William Price in a South Glamorgan courtroom. Price was an 83 year old man

who was arrested for attempting to cremate the body of his five month old son. The judge, Mr Justice Stephen, declared cremation would be permitted as long as the process did not impact negatively on others. This gave rise to the construction of crematoriums and the realisation of the cremation movement on a global scale. During the 19th century “ The Cremation Society of England” became “ The Cremation Society”, forcing the Home Office to recognise this as a legal alternative to burial and issue cremation regulations that remain present to date. The Roman Catholic faith was also forced to acknowledge the shift in public opinion towards cremation. This led to the Pope lifting the ban that previously forbade catholic priests from conducting services in crematoriums (Cremation Society of great Britain, 1974).

Although cremation has become increasingly popular in contemporary society, many continue to uphold the traditional ritual of burial. The expansion of cemeteries within close proximity of museums and parks has created more accessible environments and a society inclusive of the deceased (Kearl ND). Decorative memorial statues and headstones are more prevalently adorned by floral displays and traditional flower wreaths, symbolising continuity and eternity.

Symbolism associated with the rites of passage reflects the varied cultural traditions within society. Colour is a universal symbol of death and grief, yet there are such variations of colour worn by different cultures. Black has been the traditional colour to mark the period of mourning within Britain. A torn black ribbon worn on clothing is also significant to Jewish culture and is worn for the first seven days of their mourning period. Conversely, white is worn

by Sikh, Buddhist and some Hindu cultures, symbolising purity and eternal life. (Everplans, ND). Mourning periods are also subject to cultural diversity and social regulation, as “ normal” routines and social interactions adapt to the beliefs and traditions of the individual.

The sociological impact of death and its associated mourning period are socially disruptive on a variety of levels. From a functionalist perspective, the societal roles of those close to the deceased may be compromised by extensive grieving periods that can negatively impact upon the equilibrium of society. Whilst the customary ritual of mourning is acknowledged by society, there is a limit to its tolerance. There is an underlying necessity for the individuals to resume their roles and re-integrate with their social groups (Howarth, 2007, p235). The depth of disruption to social order is dependent on the number and circumstances of death and the re-distribution of roles within social groups. Historically, the effects of the Black Death on the working class community were experienced on a far greater scale through the loss of so many lives. Yet, the social groups of the upper class were able to function to some degree. They utilised their wealth and status, retreating to sanctuaries to protect themselves, whilst continuing their positions and roles from a safe distance. Re-establishment of roles is essential, not only to maintain society’s ability to function, but also to limit the financial cost of death (Kearl, ND).

As Marx (1964, pp71-73) argued, a capitalist society has little sympathy for the workers, who, in their attempts to meet the demands of the ruling class put themselves at greater risk of death. The focus remains on the potential disruption to work and its threat to capitalism. Working hours lost to grief

and mourning reduces production and profits. Death also provides opportunities for financial gain within a capitalist society; insurance policies, funeral and burial costs undoubtedly contribute to capitalist economic wealth.

Social mechanisms have evolved throughout history to reduce the disruption of death to society. During the Middle Ages, when childhood mortality was commonplace, people were socialised to refrain from forming a deep attachment to their children. Many did not refer to their children by their names until they reached a certain age, as survival rates were low. Women often gave birth many times to increase the likelihood of the survival of at least one child. Through the effects of medicalisation, premature deaths have been significantly reduced. Medical institutions have increased the promotion of health awareness to minimise the risk of death and its disruption to society. Death itself has become less visible as social systems of modern society have contributed to the institutionalisation of the dying. Funeral arrangements have become a more discrete process through delegation of matters to businesses specialise in the management of death (Kearl, ND).

Death, though disruptive, has evident positive social functions. Society's rules of succession allow the social roles of the deceased to be surrendered to family members or the wider community, creating the potential of social mobility. Death also functions to control an ever increasing population, whilst its fear induces a greater level of social control and conformity (Kearl, ND). An increased awareness of mortality can promote reflection on the values of a society. When death is experienced on a large scale, communities

demonstrate a collective approach to morals and values. Social bonds are formed as they attempt to cope with tragic circumstances and are united in grief (Howarth, 2007, p112).

Tragedies and natural disasters that lead to mass death receive extensive global media coverage. Televised news reports provide visual access to scenes such as the gunfire during the Gulf War and the terrorist attacks on the World Trade Center. Despite the morbid aspect of death, television shows such as 'ER', 'Six Feet Under' and 'House', depict scenes of death and dying that have become a part of popular culture. Film productions incorporating death as the underlying theme are presented across a variety of genres such as westerns, horrors and comedy. References to death do not escape the music industry, expressly within the lyrics of rap and heavy metal songs. The description of violent acts, coupled with the murders of well-known musicians within the rap culture, no doubt contribute to the dark and morbid image of death (Durkin, 2003, p44). Sensationalising media reports on the deaths of public figures and celebrities heighten the curiosity of the public and instigate outpouring displays of grief. The term "dark tourism" outlined by Marchant and Middleton (2007, p2) highlights the increasing phenomenon of visiting scenes of tragic death like the Nazi concentration camps and Ground Zero. It suggests that such behaviour may not simply occur out of grief and sympathy, rather, curiosity and a desire to connect with the event. Fundamentally, the suggestion is that society may be more open to face death than deny or hide from it.

Contemporary western societies have been described by some sociologists as 'death denying', a result of the medicalisation of death. The dynamics of

society have become focused on finding cures for illness, disease and the prevention of death wherever possible. Advancements within the medical and pharmaceutical fields have made significant progress in prolonging life. However, the involvement of such specialised medical technology is often limited to clinical environments. Arguably, this contributes to social isolation of the sick. The invisibility of death not only shields the death process, it protects the family members and social groups within society. If medical technologies and tools were not utilised in the management of death, it may be deemed as a capitalist attempt to limit costs within healthcare provision. Many social scientists argue that medicalisation has, in fact, enabled a degree of acceptance towards death. They maintain that the active scientific approach to healthcare increases the acceptance of death when it is beyond the control of science (Zimmerman and Rodin, 2004, p125).

Scientific analysis and discoveries have provided western societies with a greater awareness of environmental risks. Natural disasters, often referred to as “ Acts of God”, may not be controlled by science; however, modern technology has increased the accuracy of predicting such events (Howarth, 2007, p77). Whilst, prediction can facilitate a greater level of preparation and reduce the risk of death, it is essentially beyond all control.

The nature of death can itself be shaped by society in relation to the cultural, social and economic environment. Durkheim’s exploration of societal influence on death was examined during his suicide study (Appendix 1). His investigation highlighted the correlation between economic instability during periods of both depression and prosperity and an increase in suicide rates. He maintained that societal forces were of greater influence than an

individual's state of mind. The conclusions of Durkheim's study were based on official statistics, therefore, it is reasonable to question their true reflection of society (Giddens, 2009, pp16-17). However, his argument that death is a social problem is plausible. It is society's response to death that is reflected in the unique rituals and symbolic meanings established to provide a coping mechanism for death and dying (Howarth, 2007, p15).

The high rate of suicide among young males is one of the more significant statistics in modern society. The general perception of the male as the provider may cause increased pressure to compete successfully for social and economic resources. Failure to meet such expectations can make suicide seem like a viable solution to the problem. The pressure to maintain the masculine role and the reluctance to seek assistance is instrumental to the male approach when faced with death and grief (Howarth, 2007, pp64-65).

Grief is considered by some social scientists as a universal reaction to the loss of human life. Yet, the subjective nature and extent of grief can vary between culture, social class and gender. During the late 19th century, unlike men, middle class women were encouraged to grieve openly as greater emphasis was placed on the caring and sympathetic disposition of their role. Functionalists, in their perception of the natural division of gender roles, would argue that exhibitions of male grief are a sign weakness and damaging to the masculine role (Howarth, 2007, pp223-231). Prior to medical advancements many women, particularly in the working class, died during childbirth. Husbands often remarried swiftly after the death of their spouse to re-establish the female role of housewife and mother.

In modern day society, there have been numerous studies that indicate higher levels of mortality occur within close proximity of the death of a spouse. Objective analysis of these circumstances may identify other contributing factors that have a causal link such as; lack of appetite, a change in lifestyle and the increased emotional and financial stress that accompanies death and loss (Gross and Kinnison, 2007, p372). As mourning has become less of a public display within society, Ariès (1974, p91) suggests that such discretion may influence the high rates of mortality among surviving spouses. He argues that society has become less accepting of grief, causing the bereaved to withhold emotion through fear of judgement.

Grief does not always follow death, it can precede it by those facing death. Psychologist Kübler-Ross developed a framework classifying the five stages of grief; " Denial", " Anger", " Bargaining", " Depression" and " Acceptance", all relating to the anticipation and process of dying (Kübler-Ross, 1970, pp34-99). Whilst these stages provide an insight and explanation to the emotions experienced, generalisations should not be made concerning the grieving process. The five stage theory (Appendix 2) is to some degree a ' one size fits all' approach and may not reflect the multi-cultural society of today. However, there is room for variation and flexibility within each stage of the Kübler-Ross framework that may be applicable to certain cultures.

Gross and Kinnison (2007, pp378-379) maintain that childhood grief is also subjective to culture and socialisation, rather than a generalised stage process. They argue that children of modern society are often shielded from the realities of death, resulting from parental fear and denial of death.

Feelings and emotions expressed by those surrounding them have the potential to shape the child's outlook and ability to contend with death. Kübler-Ross (1970, p6) argues that children who are present in an environment where death has occurred and are given the opportunity to talk rather than being removed from the environment, can share in the grieving and mourning process. Death then has the potential to be less feared and more accepted as a natural part of life.

Nurses and medical staff involved in the care of the dying are far more exposed to all aspects of death and grief than most. Communication with dying patients and sensing the appropriate time to discuss issues of terminal illness is a fundamental, yet challenging part of the role. Consequently, many healthcare professionals utilise a form of behaviour referred to by psychologists as "blocking". This enables them to avoid confrontation of such issues by changing the subject and re-directing the focus onto less pessimistic issues. Although the predominant focus of medicine is to cure, the dynamics of nursing terminally ill patients have progressed allowing greater emphasis to be placed on care. This has been motivated by the increasing growth of the hospice movement (Gross and Kinnison, 2007, pp377-378).

Evolution of the hospice can be traced back to the Middle Ages when its function was to provide shelter and care for the sick, elderly, orphans and the poor. The progression of medicalisation during the 19th century, led to the establishment of new hospitals that focused on the management and cure of financially profitable illnesses, such as scurvy and leg ulcers. The chronically ill and dying were deemed as undesirable and non-profitable

patients. Subsequently, medical and spiritual care was provided in sanctuaries by religious orders (Clark and Seymour, 1999, pp66-67).

The 20th century witnessed the greatest change in the provision of care for the terminally ill. In 1967, St. Christopher's Hospice was founded by Dame Cicely Saunders. It was the first of its kind, offering management of symptom control and care alongside clinical research. Saunders trained as a nurse, a medical social worker and eventually a physician. She was motivated to work within the care of the terminally ill as the general consensus among clinicians was that little could be offered to these patients. Her pioneering work within the hospice inspired charitable organisations to fund the construction of many more hospices. St. Christopher's hospice eventually extended its services to the wider community in 1969 (St. Christopher's. org, ND).

The expansion of community based care led to an increase in funding from charitable organisations for the provision of specialist cancer nurses. As the hospice movement gathered momentum, there was an alteration in the terminology of this division of care, from 'terminal' to 'palliative care'. Distancing the association of 'terminal' with imminent death aimed to address the misconception that patients qualifying for palliative services were at the end stages of life. Although hospices were initially reliant on charitable funds, the elevating costs of clinical treatments and increased life expectancy forced many to apply for NHS state funding. The involvement of the NHS not only induced financial support but also an element of regulation (Clark and Seymour, 1999, pp74-78). The influence of government funding within hospices has generated concern among some sociologists, who fear <https://assignbuster.com/death-is-a-natural-process/>

the hospice movement is in danger of losing sight of its original vision. The focus on professionalism and quality audits has led to comparisons of hospices with large organisational institutions, guilty of “routinisation” (James and Field, 1992, pp1363-1375). Palliative care services are difficult to measure as the nature of the service is to manage care and symptom control rather than to cure. Palliative care focuses on the value of quality of life rather than the medical model of quantity of life (Appendix 2).

Palliative care and the hospice movement have predominantly been associated with terminal diseases such as cancer, AIDS and motor neurone disease. Yet, there has been an increasing demand for services to be inclusive of other lesser known conditions (Seymour, 2007). Many organisations are now actively working towards the provision of services across a wider spectrum, through data analysis and interaction with government agencies and politicians (National Council for Palliative Care, 2012). A key issue is the limitation of available resources and funds to meet the increased demand. Support and guidance extends to the family affected by the illness, exerting further pressure on the service to adapt the delivery of care in accordance to the family structure and dynamics. Consideration of varying traditions within a multi-cultural society is fundamental to the success of the service (Becker, 2009).

The demographic changes to society and increased life expectancy have intensified the expectation of services to be available for extended periods. Access to palliative care in a modern capitalist society has led to a ‘postcode lottery’. The poor of society are at greater risk of being deprived of services if they reside in damp, cold and lower quality housing, deemed an unsuitable

environment for community based care (Seymour, 2007). Less affluent areas of society with a high proportion of ethnic minorities are also significantly under-represented as palliative care service users. The language barrier and lack of information is a significant issue as patients and families are not fully aware of the referral procedure. For many cultures accepting a provision of care from outside agencies removes the responsibility from the extended family (Beresford, Adshead, Croft, 2006, pp146-151).

Palliative care services are not easily accessible to the homeless of society. They are often reluctant to attend appointments in an unfamiliar environment, for fear of judgment or isolation. New initiatives such as “ St. Mungo’s Palliative Care Project”, aim to tackle this issue by offering support and guidance to homeless sufferer’s and the professionals who work alongside them (National Council for Palliative Care, 2012). St. Christopher’s have also collaborated with the University of Bath’s “ Centre for Death and Society”, to promote services. Through the utilisation of media resources and technology they are able to extend services to non-resident patients and prevent social exclusions (Centre for Death and Society, 2012).

Professor Ilora Finlay has become a modern day pioneer of the hospice movement. Her role as the first consultant in Palliative Medicine at Cardiff University and work within parliament has led to the implementation of her palliative care strategy. This strategy has facilitated the enhancement of patient-focused services across Wales. Finlay is also responsible for the establishment of distance learning courses in palliative care, achieving international recognition and contributing to the increasing number of palliative care clinicians (Finlay, 2009, pp349-351). There is a recognised

need for re-investment in palliative care to develop professional skills across a wide range of services. The benefits will not only improve patients' quality of life but also reduce unnecessary NHS hospital admissions and the financial cost to the economy (Association for Palliative Medicine, 2010). Arguably, there would be less expectation of society to change its attitude towards dying, if, the focus remained on the provision of resources to prevent anxiety and facilitate a “ good death” (Zimm