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The social process of dying: an ethnomethodological study of the mortification of the self during a terminal illness.

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THE SOCIAL PROCESS OF DYING: AN ETHNOMETHODOLOGICAL
STUDY OF THE MORTIFICATION OF THE SELF DURING
A TERMINAL ILLNESS

BY

TED W. ST. PIERRE

A Thesis
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through the Department of Sociology and
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of Master of Arts at the
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ABSTRACT

The focus of this research is the study of the social process of dying in general, and "mortification of the self" during the process of dying, in particular. The analysis is based on an ethnomethodological approach which views the effects of social activities of a phenomenon, i.e. of dying in this research.

The framework of the study is based on knowledge of dying "for sure". The fact that a person is dying is, from a sociological perspective, determined largely by those who routinely and rightfully engage in assessing those states and giving courses of action. These people who assess the "dying state" are the physicians as well as other medical personnel. Their decisions involve members of the family, friends, the hospital situation, medicolegal criteria and lastly, the patient who may not be aware of his state.

In respect to a dying situation, all those individuals who are involved with the situation, including the patient, are subject to "awareness contexts" in dying. The element of suspicion forms the basis of the awareness contexts in this research.

The focus of inquiry observes quantitatively the effects of social activities in dying and is analyzed through the theory of mortification of the self. As well, during the dying process, there are role adjustments undertaken by
the people involved with the one who is dying as well as the patient himself who must adapt his new role to his present status.

Finally, the social process of dying occurs in the perspective of a passage from multiple statuses, such as from health to illness, from social value to social worthlessness, from an awareness context to another, and passages within the dying process itself.
ACKNOWLEDGEMENTS

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CHAPTER I

INTRODUCTION AND REVIEW OF THE LITERATURE

Introduction

Death is Universal

Death is inevitable. But it does occur in different places, at different ages, and with different consequences for the family, medical practitioners, and the community. To the physician, the dying patient often represents failure (Glaser and Strauss, 1965); to the nurse, a futile depressing case (Quint, 1966); to the family, frequently a heavy financial burden, and his friends, even his clergyman, may avoid him whenever possible. (Glaser and Strauss, 1968).

Perspectives on Dying

North American perspectives on death seem paradoxical. Our newspapers confront the brutal fact of death directly, from front page headlines to the back page funeral announcements. We seem capable of accepting death as an everyday affair,-- frequently under the most unhappy circumstances. Preparations are made for death through some form of "life insurance, medical insurance, burial plots and elaborate funeral arrangements. It becomes ironical to see so much care given to the dead through the ten-Cadillac limousines with lights on, rushing through eight lane expressways at top speed to reach a cemetery some forty miles away
from the downtown area.

Death is one of the characteristic features of human existence, and the people of any society must find the means to deal with the recurring crisis. Presumably one way to deal with it is to talk about it. Curiously, however, we generally seem to prefer to talk about particular deaths rather than about death in the abstract. Death is something of a taboo topic, with very little abstract or philosophical discussion of death (Feifel, 1963). Moreover, we are characteristically unwilling to talk openly about the process of dying itself; and we are prone to avoid telling a dying person that he is dying.

Why Study Death and Dying?

So far little research has been done on death and dying, although North American society is continually confronted with this fact. It may appear paradoxical to concern ourselves with death and dying in a society as advanced as our own, in which human life is highly valued and warding off death is relatively good. The emphasis in recent years is seemingly to avoid talking about death and dying. The same stigma has been carried over to persons who represent death and dying, namely terminal patients (Spiegel, 1964). It may be asked why have death and dying recently emerged as important matters of concern in our society which prefers to repress rather than to examine these phenomena?

Today's advanced medical techniques have compounded
the process of dying by intensifying the moral, legal and social dilemmas faced by those concerned with the terminally ill (Manning, 1970). At the turn of the century, when death was a frequently recurrent household event, survivors lent a hand during the terminal illness of a family member or neighbour, curtailed their social engagements, felt the presence of dying in the home and mourned. Recently new dimensions have put a new outlook on dying. It may be that a successful society such as ours can engage in the luxury of focussing on dying—whereas less developed societies have greater infectious diseases, where hunger is rampant and mortality is high.

Another argument for studying the process of dying lies in the importance of organ transplants. Because of these new medical measures now practised, the medical profession is now beginning to focus on important concerns: Should the patient be told about his dying status? If so, what should be said? How long need he be kept alive? How should his psychological needs and those of his family be cared for? This sophistication dissipates the magical aura of the physician and makes the medical management of dying more difficult (Levine and Scotch, 1970). Because public scrutiny of the behaviour of professionals has grown, the public is now putting new demands in dying matters as well as living. The physician is obviously subject to an increasing system of social controls in respect to dying.

Today, the elements of medical expertise and choice as to where the dying will die present the survivors with
more complicated chores and much less codified means of achieving them with propriety and dignity (Lerner, Riley and Knutson, 1970). The **prolongation or termination of life** has made new demands on the family, medical and legal professions, as well as the hospital, other health agencies and to the dying patient. In this complicated process of dying, changes occur in the character and duration of the dying experience. This dying experience includes a variety of factors such as medical problems (physicians, hospitals, clinics) as well as social problems (the family, psychological and moral dilemmas). Without doubt, the social process of dying has become an important sociological concern (Levine and Scotch, 1970).

**Review of the Literature**

Concern: Death and Dying

Is the concept of death and dying so intertwined that one can be used to refer to the other? However intertwined they might be in our thought, nevertheless, the process of dying and the actual occurrence of death cannot be treated as a single phenomenon. In fact, the major significant difference between death and dying lies in the problems they pose for the patient, the family, the health professionals, and society. A true understanding of the problems requires that we unravel death and dying and attempt to ascertain their differential social impact. (Levine and Scotch, 1970:211)

A first point in distinguishing death from dying is to regard death as an event, and dying as a process. From
a linguistic point of view, dying is treated as a process since "to die" is an active verb:

This does not mean that a person is in the ordinary way active in his dying: but it implies that somehow the source of dying is in the person rather than outside him. (Smart, 1969:27)

A perfectly healthy man who is suddenly shot and killed in a bar is an example of an event, hence his death lies "outside" him. But if one can die quickly or slowly, perhaps painfully as well, this is a process predicated in the person himself. It should be noted here that the cause of this person's dying does not lie in him. To elaborate, if a perfectly healthy man is shot in a bar, brought to the hospital, but dies only much later, it is clear that the "cause" of his death was accidental and external from the shooting itself rather than through organic internal deficiency. From the time of the shooting to his actual death, it can only be said that he was in a state where he was going to die.

The point is that the events and processes of a person's existence are looked upon as a continually shifting perspective. The process of dying after the shooting of a man interferes with his normal ongoing life. The man's former perspective, that is, that of a perfectly healthy man, to that new state of dying, is a shifting perspective in this man's normal life. Such interferences which absolutely mean that a man will die is known as a process of dying. This concept of dying is hard to apply in medical institutions such as hospitals where dying is referred to as a
matter of symptoms:

Dying is not a matter of symptoms, but of actually being in a process of dying. (Smart, 1969:28)

The fact that a man has cancer or a tumor does not necessarily mean he will die. The point to be made here is that the concern is not with the symptoms of the patient which might be misleading and not resulting in death at all. Rather, if someone is dying, the concern is with his actual condition which will normally result in his death. This actual condition is the process of dying. Although the concern for this definition does not include the symptoms of the patient, normally, however, it is known both that a person is dying and that he is dying of something in particular.

"Dying, in this sense, is dying 'of'." (Smart, 1969: 29) This simply means, given a person's present condition, under normal expectations that this person is in a process which will eventually lead to his death.

A last point should clarify the fact that dying is a process and death is an event. The healthy man can die from an internal condition as well. A fragment enters his heart via his blood stream and he dies instantly. His sudden death was an event from an internal cause. One may ask: when did he die? The same man can die from an external cause by stepping off a fishing dock and drowning. A third example involves both the process of dying and the event of death. A boy dying of a malignant tumor is killed by a car while hitchhiking. This sudden death is "per accidens" since the
cause of death is not what the person was dying of. Lastly, a teenage boy dying as well from a malignant tumor jumps out of a ten-storey building. His sudden death is also not what this person was dying of, hence his "adventitious death" was an event. (Dublin, 1963 and Henry and Short, 1957)

**Diagram 1**

**DISTINCTION BETWEEN DEATH AND DYING**

- **DEATH** → *occur in a continuum* → **DYING**
  - **AN EVENT**
    - **A FAIT ACCOMPLI**
      - **EXTERNAL CAUSE**
        - **SUDDEN DEATH**
          - **DEATH "PER ACCIDENS"**
            - **DIED FROM**
  - **A PROCESS**
    - **INSIDE**
      - **INTERNAL CAUSE**
        - "GOING" TO DIE
          - **MALIGNANT TUMOR**
    - **OUTSIDE**
      - **changing perspectives**

**Interpretations of Death and Dying**

Quite generally, there are several assumptions to be made in an analysis of the concepts of death and dying. So far, in this paper, dying has been explained as a process,
death as an event or "fait accompli". While the individual is in the process of dying, he may or may not be aware of this process (Glaser and Strauss, 1965). Although not everyone is dying, everyone will die. Some people have to face death and make adjustments to this realistic fact, whereas others die suddenly without any adjustments necessary. These adjustments will determine what role a person chooses while in the process of dying. Although the main concern of this paper is based on the process of dying, it would be in a sense banal to omit other interpretations of death and dying in this analysis.

A. Myths and Spiritual Interpretations of Death and Dying

The realm of mythic and spiritual interpretations moves us to philosophical as well as theological approaches to the concept of death and dying. Definitions of a religious nature usually tend to primarily relate to non-empirical or non-scientific proofs which can neither be proved nor disproved. Why is it that religious definitions of death and dying tend to have so much impact on people? A common saying by those who are in a state of dying is that "I am dying because I have sinned." This saying is prompted by the religious concepts of sin and punishment. Religion is primarily involved in man's efforts to provide a motive language or a set of motive concepts which can be used, sometimes in vain, to provide answers to why certain events occur. This involvement of religion as well gets involved with what behaviour or decisions the individual should or should not undertake.
a. Christian Theological Interpretations of Death and Dying

A major attempt to provide answers to death is that religious definitions are basically rooted in Christ's own death. The belief that Christ rose from the dead involves the immortality promise made in the Bible to those faithful who would follow Christ's life. Despite the physical changes which accompany death, man is told that he lives on after death. Death like life, has been viewed as an act of divine will.

Religion provides man with a definition of death which, it is believed by those involved, helps man to adjust to death. (Vernon, 1970:56)

Since religious interpretations can hardly be tested empirically, it is difficult to test whether these spiritual interpretations are effective or not.

A second aspect of spiritual interpretations of death and dying stems as well on the immortality concept based on reward and punishment. Primitive societies confronted the immortality of man by creating hypothetical 'upper' and 'lower' villages where the 'good' people would frequent the upper village and the 'bad' people would be cast into the lower village after their physical death (Cohen, 1968). Early modern man believed in a heaven and a hell in after-life, both places being determined by the 'goodness' or 'badness' of the person while in life. The main concept here is that of reward and punishment. On the perspective of goodness, man tends to view this reward in reverse. The goodness of God can be applied as well to the goodness of man, thus suggesting that man's life somehow 'deserves' the reward of immortality. However unempirical this belief may be, a favourable aspect of this interpreta-
tion would be that death could be treated as a natural phenomenon instead of a denial. This thought is summed up in Fulton's suggestion that:

Within such theological structure, man could stand secure in the knowledge that death was a personal matter between God and himself. The very purposefulness of his death placed him at the centre of existence and elevated him above all other creatures. As part of a divine plan, death was the brother to life, and as such could be confronted openly, spoken of freely, and treated as a natural phenomenon. (Fulton, 1964:359)

The third spiritual interpretation involves modern society's concept of death and dying. Erving Goffman, (1966) referring to the modern views of death and the afterlife, suggested:

The sense of contrast between what is living and what is dead has become attenuated, in large part because of the decline of exposure to death. (Goffman, 1966:140)

With dying occurring more frequently in institutions, and modern society's successful attempt to curtail infant mortality and to prolong life, modern man has increasingly had limited contact with the dying and the dead. Modern society had successfully diminished visibility of death and the reality of death and dying. Instead of adjusting to the natural phenomenon of death, modern man has learned to evade, fear, and deny dying and death. In sociological terms, Blauner suggests that:

When those who die are not important to the life of the society, the dead as a collective category will not be of major significance in the concerns of the living. (Blauner, 1966:381)

The common belief today is that the loss of some individuals
requires only minor adjustments (such as a death in a family). The loss of others requires extensive adjustment (such as the assassination of a political figure). Basically, it is not so much the dying person and the eventual death that man has learned to evade, but ritualistically the funeral has received the most attention.

b. Philosophical Interpretations of Death and Dying

The major philosophical work on death has been dealt with by existentialist philosophers and writers who are more or less opposed to dogmatic doctrines but consider a few extreme experiences the best starting point for philosophic thinking. On the topic of death, Heidegger discussed death in a crucial chapter *Being and Time* (1927). A criticism of Heidegger came in a section of Sartre's *Being and Nothingness* (1943). Finally, Albert Camus devoted two books to suicide [*The Myth of Sisyphus*, (1942)] and murder [*The Rebel*, (1951)] in which he discussed "existentialist atheism". Each man's philosophy on death will be briefly reviewed, primarily to see the philosophical evolution on death and dying until recent times.

What meaning and significance can be attached to the fact that man must die? Much more specifically, what meaning can man attach to his own death? An existentialist point of view is usually based on the homelessness of man. This philosophic mood of existentialism perceives man to be
thrown in a natural and social environment which oppresses him with its foreignness and, its unsuitability as a home for all that is specifically human about man as an individual. In order for man to better understand his natural and social environment, he must gain an interpretation of reality and human existence:

(The existentialists) assert emphatically that a proper understanding of, and right attitude toward, death, one's own death, is not only a 'sine qua non' of genuine experience, but also of gaining any illumination about the nature of the world. (Gray, 1967:46-47)

(1) The Being-Toward-Death:

All men come to realize that they are mortal as soon as they become self-conscious. Because of death's certainty and inevitability, thinkers tend to feel obliged to question the meaning of life. Heidegger's major work is in Being and Time, where he defines man as a "being-toward-death". Heidegger does not merely affirm a mere biological fact but insists upon the absolute vanity of everything man does. In reference to human existence Heidegger used the term "being-there". Although his main concern is with "the meaning of being", his main argument in his analysis of the "meaning of Being", can only be explored by way of an analysis of "Being-there". (Kaufmann, 1959)

The second and last section of Being and Time bears the title: "The Possible Being-Whole of Being-toward-Death". In simpler terms Heidegger attempts to conclude that it is the survivors who suffer the death of the one who died.
It is the one who died who 'suffers' the loss of Being which was taken away by death. In regard to the death, man must gain a vivid realization of death as making up part of life, not as a mere end of life. Death is a phenomenon within life. A major requirement for death to be a possibility of increasing the Being is for man to recognize that death is always his own, it is something that belongs to his very essence, as Nothingness belongs to Being. Not only must man face the reality of his own death, but more importantly his own death is personal:

No one can take my place in death, nor can I, in this sense, ever die for another. I always die alone and the very meaning of death to me, (according to Heidegger), is attained only in contemplation of my own death. (Gray, 1967:54)

(2) "Attitude toward my death":

Sartre repudiated Heidegger's conception of "Being-toward-Death" in a strict criticism in Being and Nothingness. Like other existentialists, Sartre lay claim to the discovery of important truth as the "raison d'être" of his philosophy. For Sartre, the truth was that we may anticipate that we ourselves must die, we never know when we shall die; but it is the timing of one's death that makes all the difference when it comes to the meaning of one's life. Unlike Heidegger who said that "dying is something which nobody can do for another", (see above quote), Sartre adopts the notion that it does matter whether or not something happens to a man or to another. Adopting this attitude that it does matter whether something happens to a man or not, then this
attitude can be adopted toward death. As Sartre states:

In short there is no personalizing virtue which is peculiar to my death. Quite the contrary, it becomes my death only if I place myself already in the perspective of subjectivity. (Kaufmann, 1959:52)

(3) Death, the "fundamental crime":

In his book, The Myth of Sisyphus, Camus is quite explicit in his vision of death:

Because of death, human existence has no meaning. All the crimes that men could commit are nothing in comparison with that fundamental crime which is death. (Lepp, 1968:132)

Christian tradition might accuse God the Creator for this fundamental crime, but Camus had no connection with Christian tradition. Hence Camus talks about the existentialist atheist. For Camus, his argument was that death became a crime with the emergence of self-consciousness, that is to say, with man. Death thus becomes a crime without a criminal. In conclusion, Camus states that the human condition is fragile and unhappy because it inevitably implies consciousness of death.

Although much thought and writing by existentialists has been done on the topic of death and dying, the awesome terminology of these thinkers (especially Heidegger) distracted attention from many important distinctions. First, the fact that Christianity has had a vast influence to make men dread death through the concepts of sin and punishment. Second, existentialists have not considered differences in attitudes toward death, say, between dying patients, suicidal
attempts, and the living healthy. Third, consideration
should have been made to allow for changes in attitudes
toward death. Finally, none of the existentialists has con-
sidered that man attains satisfaction within himself, which
is a most crucial distinction that makes all the difference
in facing death.

B. Biological Interpretations of Death and Dying

Criteria of Death

Man has always been in search for a sound defini-
tion that would act as a criteria of death, both scientific
and theological. Definitions of death are of considerable
significance for an understanding of attitudes about death.
Once an individual has been defined as dead, by whatever
definition employed, the attitudes toward the person may be
expected to change. By formal or by common law, and by
professional ethical standards, the treatment due living per-
sons differs markedly from that accorded the dead. Later we
will examine in depth the treatment due to living persons,
who are dying. We especially consider those who are termin-
ally ill, but past and present medical definitions of death
in particular.

(1) Internal Ambiguity:

If we look up the criteria of death in Smith's
Principles of Forensic Medicine (1821) we read:

If we are aware of what indicates life, which everyone
may be supposed to know, though perhaps no one can
say that he truly and clearly understands what
constitutes it, we at once arrive at the discrimination of death. It is the cessation of the phenomena with which we are so especially familiar -- the phenomena of life. (Smith, 1821:16)

Along with this definition are found several early writings listing cases which were erroneous due to vague definitions on the signs of death. The 18th and 19th centuries have many examples of errors in certification. Especially in wars, if local air raid wardens merely viewed heaps of corpses, more than often did some of these "corpses" struggle away for help or even walked away to safety!

In Medieval Europe, premature burials were very common, especially in times of cholera plagues, when bodies were immediately put into a coffin and bolted tight upon apparent death in order to make room for others. It was not uncommon to hear kicking and screaming from coffins as well as from fresh graves. DeFontenelle (1834) recorded forty-six such cases of persons who had been certified dead and had recovered while awaiting inhumation. It even became necessary for France to establish a law forbidding burial before twenty-four hours had elapsed after apparent death had occurred. Most European countries had adopted the law to preserve the corpse until signs of putrefaction began.

Several records are known of surgeons performing caesarean sections on women mistakenly considered to have died during labour. Before the days of modern surgery, many operations performed during life had invariably fatal implications. Several cases are known where premature caesarean sections were performed on women who had apparently died,
and where doctors were even charged with homicide. (Paris and Fonblangue, 1823:6)

(2) Medical Signs of Death:

Earlier medico-legists differ little in their acceptable signs of death listed in medico-legal textbooks. They are briefly:

cessation of respiration and heart beat, changes in the eye, insensibility to electrical stimuli, rigor mortis, pallor, hypostasis and relaxation of the sphincters. (Nysten, 1811)

Although these earlier medico-legists had similar definitions to present-day criteria of death, difficulties were greater because of lack of knowledge and improved techniques. Nevertheless, all these earlier medico-legists were agreed that the only incontrovertible sign of death was the onset of putrefaction.

(3) Somatic and Cellular Death:

It was only after 1836, that differences were made between what was known as personality death and molecular death. Ryan's profound statement is still pertinent today:

Individuals who are apparently destroyed in a sudden manner, by certain wounds, diseases or even decapitation, are not really dead, but only in conditions incompatible with the persistence of life. (Ryan, 1836:499)

For once, a recognition had been made, of differences between somatic death, the extinction of personality, and molecular death, the actual death of the cells which make up the body. Specifically, somatic death is the cessation of all vital functions such as the heart beat and respiration. Molecular
or cellular death follows. It seemed as though all one had to do was to retain the body until putrefaction began and rigor mortis, (which was due to cellular metabolism continuing after somatic death) had begun. The dilemma presented to doctors began with organ transplants when the organs have to be removed in a state which is incompatible with the persistence of life.

(4) Modern Criteria of Death

In our society the criteria usually employed for the termination of vital functioning include the cessation of breathing, heartbeat, pulse, or other automatic and voluntary responses; the onset of rigor mortis; or evidence of the beginning of decomposition. Brain death as a criterion is under test and may serve the purpose. There are still questions regarding its validity, since brain death may precede the cessation of breathing or heartbeat. (Knutson, 1968)

Other definitions of death and dying are employed by Sudnow:

A tentative distinction can be made between "clinical death": the appearance of 'death signs' upon physical examination; 'biological death': the cessation of cellular activity; and a third category 'social death' which, within the hospital setting, is marked by that point at which a patient is treated essentially as a corpse, though perhaps still 'clinically' and 'biologically' alive. (Sudnow, 1967:74)

"Social death" will be explained in detail later in this chapter under the Sociological definitions of death and dying. The above definition, widely used by medical
practitioners in modern days, emphasizes the degree to which the individual patient is treated by observers as human. As an individual becomes more or less human in the mind of the observer, attitudes toward this individual are expected to change. Hence, a completely comatose patient (social death) may be treated as a dead corpse while essentially he still is clinically and biologically alive. Does this not present new complications especially in crucial events of organ transplants? It is important to discuss this dilemma.

(5) Modern Dilemmas on Determining Death:

The "Hippocratic Oath" taken by all physicians obliges them not only to help, but also "never to harm" a patient, "nor to give advice which may cause his death". This ancient pledge can best be described as contributing to the modern doctor's dilemma.

With today's transplantation of cadaver organs to living persons, it is of great importance to determine the exact moment of death. The sooner the organs are removed from the cadaver after somatic death, the better are the chances for the grafted organ to survive. Potential donors are usually young persons dying as the result of a serious accident. Their lives are usually artificially maintained by apparatus functioning as a heart and lung. The potential receiver is prepared for the organ transplant. Although the patient may be completely comatose in the state of 'social death', the dilemma occurs when the doctor has to decide when to turn off the apparatus which is maintaining life in order
that an organ may be removed for grafting purposes while it is still being circulated with oxygenated blood.

It thus becomes a matter of great urgency to define death in a way that:

(a) gives the 'dying patient' every possible protection in terms of his rights, (b) protects the cardiac surgeon from allegations of violating moral, civil, or criminal law; and (c) does not preclude a potentially life-saving operation for the patient desperately in need of a new heart. (Glaser, 1970:108)

Public scrutiny is creating anxiety in spite of this confusion. Doctors came under such attack that Dr. Barnard had to protest, "We are not vultures!" In the inquiry into the meaning of death, the major difference comes between cardiac death and brain death. Since death comes at different times to different organs and tissues, the technical question of death (as against the theological or philosophical definitions) has been resolved by popular consensus. It is now considered that the brain and not the heart is the criterion of human life. The brain is the master control; the heart is just a pump. In a dispute, brain death is determined by an electroencephalogram, when available.

C. Behavioural Interpretations of Death and Dying

1. Anthropological:

"Anthropological death', a term coined by Kalish (1968) is used to refer to one who, like a traitor, has been rejected and cut off from his community. As was mentioned above, attitudes toward an individual may be expected to
change as he becomes more or less human in the mind of the observer. Thus it would hold true that because of the terminal patient's new role in the community, attitudes toward him would change, even to the point where he would become an outcast, or traitor to his community.

Another aspect of the anthropological interpretation of death and dying is the ritual associated with the dying person as well as those rituals that follow the death of the individual in different societies. Numerous studies have been conducted in different societies on the analysis of death and funeral rituals, mainly to show that funeral services are usually seen as involving an effort somehow to benefit the deceased, whether out of kindness to him or out of fear of his displeasure. Whatever the motive may be, these studies are readily available with detailed aspects of death rituals.

Recently, Talcott Parsons developed an explanation for the ultimate meaning of death. We will include his explanation in this section since it is based on a kinship-religious nexus. Parsons views an integration of the biological mechanism of procreation and that of mortality of the individual with that of the sociocultural organization of action systems, such that:

In a complex society such as our own, the instrumentalities for effecting such integration must be highly ramified, because the means of facing death must articulate with a great variety of functionally distinct structural contexts and discrete concrete structures. (Parsons and Lidz, 1967:140)
Simpler forms of these instrumentalities is the fact that an ancestral cult is universal among primitive societies (as well as some more advanced societies). In primitive societies, the kinship status of the individual is integrated with the ultimate meaning of his life and his death. The greater the meaning of life with a kinship group, the greater the meaning of an individual's death. In such a society, both life and death are strongly "one possibility" things. The greater one's life, the greater will be the ritual rites when the individual takes on the new status of the dead. These societies thus conceive of life as an individual matter, but death becomes an affirmation of collective status.

There is relatively little institutional 'room' for more individualized social or personal reactions to the death. Above all, the death cannot stimulate responses that break through the kinship nexus level of social responsibilities or derive their meaning from transcendental references. (Parsons and Lidz, 1967:141)

Despite social evolution, kinship organization (including some religious commitments) remains the focus of the system of orientation toward death. Even in North American society, it is the concern of the next of kin in the first instance to take the responsible role for arrangements after a death. Although the rituals after death are a symbol somewhat of the deceased's identity, I believe Parson's main objective was to show that the deceased is an integral part of the nuclear family's continuance in the social structure:

Kinship is the structural context in which the individual is 'rooted' as a human social actor. It provides the interpersonal mechanisms for effecting the society's generational continuity and hence must be specially concerned with birth
and death. (Parsons and Lidz, 1967:142)
Perhaps many of the problems of transition and adjustment—at death—could become minimized if there were a better understanding of the importance of the kinship-religious nexus in social structure.

2. Psychological:

Intensive study of the behaviour of individuals, and their relationship to death and dying, has been made in the realm of social-psychology. There are many psychological studies on suicide, murder and attitudes towards death and dying. Recently, Daniel Cappon has studied attitudes towards the dying. He discussed the positive correlation between acceptance of death and religiosity (Cappon, 1961) and the effects of conscious, public attitudes toward death and dying (Cappon, 1962). Several studies have been conducted on attitudes of the dying in specific illnesses such as leukemia, cancer and heart diseases (Orbach, et al, 1955, and Henderson, 1965).

Shneidman (1967) deals with sociological, psychological and psychiatric aspects of death, and suicide in particular. The dominant theme is the attitudes and motivations of the individual which lead him to adventitious death, and the social impact of the individual's death in the social structure.

Since most psychological definitions of death and dying are related to studies of behaviour, it would be well to orient this paper to sociological definitions which
are the main focus of this thesis.

3. Sociological:

1) Dying is a social fact.

It is obvious, then, the notion that a person is dying is by no means straightforward. Although people have a continual awareness of the fact of death, North Americans are prone to empty "dying" with respect to a very delimited class of states and persons. It is simple to confront the fact that "he is dying", yet to face the unavoidable conflict that we must ourselves die seems to be another matter. The fact that a person is dying leading to his eventual death is, from a sociological perspective, determined largely by those who routinely and rightfully engage in assessing those states and giving courses of action. These people who assess the "dying state" are the physicians as well as other medical personnel. Their decisions involve members of the family, friends, the hospital situation, medicolegal criteria in cases of organ transplants, and lastly, the patient who may not be aware of his state.

During the dying process there are role adjustments undertaken by the people involved with the one who is dying as well as the patient himself who must adapt his new role to his present status. Dying is a social fact because it need not be a noticeable process insofar as it serves to provide others, as well as the patient, with a way to orient to the future, to organize activities around his inevitable death, to prepare for it.

Deaths occur in a social order as well:
The thoughts, concerns, activities, projects, prospects, and the fate of others are more or less linked to the one who dies and the fact of his death. (Sudnow, 1967:62)

This linkage involves a variety of social structures such as the family, the hospital, the society, and the programming of courses of action on the forthcoming death. It also involves the medical order of diagnosis of treatment. The medical professionals can recognize that a person is terminally ill and diagnose a treatment for the disease. Special treatment is given moreover when the patient is actually dying. This prediction that a patient will die places a frame of interpretation around the person. This frame usually has severe consequences for the social activities of the patient. These consequences will be further elaborated in an analysis of the process of humiliations, degradations and abasements in dying.

2) Social Death:

Dying, then, is a social fact because of the processes required of the people involved with the dying patient, as well as because of the adjustment needed on the part of the patient himself. Dying was also seen as occurring in a social order involving a linkage with a variety of social structures. The crucial point occurs when physicians have to determine whether the dying person is actually dead or not. Does the fact that a person is socially dead warrant the medical profession to give up all attempts to save him? Sudnow brought this problem into question when he studied dying patients in the hospitals. He discusses "clinical
death", the appearance of death signs upon psychical examination, "biological death", the cessation of cellular activity and a third category, 'social death; which within the hospital setting, is marked by that point at which a patient is treated essentially as a corpse, though perhaps still 'clinically' and 'biologically' alive. (Sudnow, 1967:74)

"Social death" or "dying as a form of treatment" (Sudnow, 1967:75) becomes a type of non-person treatment. Nurses and physicians usually talk openly about the patient in his presence, as though he were actually a corpse; his family often deserts him, insurance companies are usually pre-informed, funeral arrangements are completed, and in certain cases, remarrying, grieving, and announcements of one's will have been very often known to be completed. This social death treatment has become even more complicated with organ transplants where the patient is essentially socially dead, although clinically and biologically alive. Can his organs be removed at this uncertain state?

3) Roles in Dying:

In the section titled "Anthropological definitions of dying", Talcott Parsons stresses the importance of kinship as the structural context in which the individual is 'rooted' as a human social actor. Because of his interaction and integration with other social actors, each individual has influence on other human beings. These influences effect the society's generational continuity depending on the influence of the individual. Thus the death of an individual has its
most effect on the segment of society in which he has the most integration, namely the family.

When a patient learns that he has a terminal illness, certain stages of denial and bargaining occur before he finally accepts his inevitable fate. He must learn the difficult task of reorienting his roles to adjust to his present status. Although this adjustment presents problems to the patient, this is usually temporary depending on the length of the illness. If the individual's death effects the family, would the family roles not be effected as well by his death? Depending on the status of the individual, his death is unlikely to raise critical problems for the system. This is not so in cases of death in the family. Parsons comments, saying that:

as societies become more modern, kinship structures cover a diminishing proportion of the individual's role involvements. In very primitive societies, questions of 'who' a person is can be answered almost exclusively in kinship (and ascribed religious) terms. In modern societies, differentiated elements pertaining to occupational and community roles are generally more important components of an individual's identity. (Parsons and Lidz, 1967:142-143)

The way an individual acquires his identity is through his participation in each sector of the society, as well as his involvement in a role which is independent from any other roles. This role participation is a very unique 'personal' complex. The unique personal complex in role participation is further complicated in that:

a society having such a complex role structure can manage to 'place' its people in roles that fulfil
their aspirations and its operational requirements only by developing very considerable mobility.
(Parsons and Lidz, 1967:143)

The intense mobility offered to the individual also requires him to 'pluralize' his role. The role-pluralism and mobility offers unlimited roles to the individual in institutions, political power, status and influence. How then, can the family members adjust to all the unlimited commitments left behind by their deceased kin? In primitive societies, funeral rituals and mourning were all prescribed. But modern societies are faced with personal problematic decisions which may seem very strange to inhabitants of primitive society. The commitments that the family must engage in after the death of one of its members are determined only through private consciences. The private consciences involve the family's decisions as to the type of funeral service, whether or not to have organ transplants, when can life-preserving equipment be turned off, what to do with the deceased's belongings, and furthermore, will freezing processes of the 'body' be undertaken.

Conclusions on Definitions of Death and Dying:

In the analysis on definitions of death and dying, interpretations moved from mythic and spiritual approaches to the more complicated medical and behavioural interpretations. Although philosophical and theological interpretations are non-empirical proofs, they did prove to be very influential in providing symbols of death and dying. The Christian view of the after-life provides a dread and denial of death.
The biological interpretation stressed the former and modern dilemmas in determining death. Formerly, the problem was that of premature burial, whereas now the major criteria for determining exact death is debatable both by social and medical scientists in terms of scientific, medical and philosophical definitions.

Behavioural interpretations began with the anthropological meaning that the dying person becomes an outcast or traitor so-to-say to his community. Psychological interpretations reviewed studies on attitudes and behaviour toward death and dying. Finally, the sociological perspectives presented dying as a social fact, occurring in a social order. "Social death", or "dying as a form of treatment" discussed the treatment given to socially dead patients although they were clinically and biologically alive. Discussion also centered on the new roles of the dying patient as well as the family and hospital staff roles undertaken during his process of dying. What is still lacking in our definitions on death and dying is precisely that:

When is the person dead? Who can determine whether the life-machines can be turned off or not. Finally in case of organ transplants, when can these organs be taken from the body? (Morrison and Kass, 1971:694-702)

The only statute of its kind which states a precise definition for determining death is from Kansas. This bold and initiative statute supports brain death as the main criterion, saying that a person is dead if in the opinion of a physician ... there is
the absence of spontaneous respiratory and cardiac function or the absence of spontaneous brain function. Death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purpose of transplantation. (editorial, 1971:40)

Although this definition seems to favour the potential recipient of an organ transplantation and against the interests of the moribund donor, it does set the most precise criteria for determining death. It could no doubt be improved by having death certification by at least two other psychiatrists with no interests in that particular transplant. Personally, this writer does not subscribe to the current dictum that the medical profession alone, or even primarily, should determine death. Yet complications could certainly arise if dying became a continual court matter. Nevertheless the medical profession must be aware that there is public disquiet about definitions of death. In this age of medico-legal uncertainty, brain death as the major criterion is quite an accomplishment.
DIAGRAM 2

INTERPRETATION OF DEATH AND DYING

A) MYTHIC AND SPIRITUAL
   - Philosophical (existentialist)
   - Theological (Christian)

B) BIOLOGICAL INTERPRETATION
   - MEDICAL
     - Physical
       - biological death
       - clinical death
       - dilemmas in organ transplants

C) BEHAVIOURAL INTERPRETATION
   - ANTHROPOLOGICAL
     - ritual
     - kinship-religious nexus
   - PSYCHOLOGICAL
     - behavioural
     - Attitudes
   - SOCIOLOGICAL
     - social context
     - social crisis
     - social death
     - roles
     - brain death
CHAPTER II

ETHNO-METHODOLOGY IN THE STUDY OF DYING

Sociological Perspectives of Dying

Sociology concerns itself with social phenomena and its relationship with social structures and social systems. Biological aspects of death and dying have received the most attention, leaving the social interactions during dying in the background. The social side of dying is evidenced by the fact that dying comes to individuals who are members of interaction systems. These interaction systems include the involvement of man in social structures which he has built. It is only obvious to conclude that dying and death have an impact on these structures.

Dying is one of the most personal and unique things one individual can "do". Unless man is alone, he does not die "behind the scenes". His interactions with all those whom he is associated, and the social orders that occur in his process during dying cause dying to be a very definite social phenomenon.

Dying has many social dimensions. Some of these dimensions or social conditions contribute to, or hinder dying. Furthermore, aspects of dying involve very strongly dying-related behaviour, which include roles, norms, values and motives, definitions of the situation, fears and joys.
of the social fact of dying. A most important aspect of dying is that it occurs while the individual is living! Reactions to dying differ with other individuals, depending on their adjustments to dying and death. Behaviour towards dying will then be influenced by:

the knowledge which individuals have about death (and dying which) is taken into account by them in many aspects of living. Dying itself is in fact a social process, one in which identifiable steps or stages occur. The dying process involves many individuals and may involve experiences occurring from childhood on... Death and dying, then, are social phenomena and are woven into all social systems. (Vernon, 1970:8)

If dying then is a social phenomenon woven into all social systems, occurring as a social process and integrated into dying-related behaviour, -the related patterns of inter-action,- then it can be concluded that dying is very definitely a sociological topic.

**Experiencing the Social Process of Dying**

Above, I mentioned how dying was a unique and personal type of death-related behaviour. I also pointed out that dying was a social phenomenon interrelated with patterns of interaction which made it researchable. For a fact, "I" cannot experience my own dying and then write about it. Nor can "I" interview dead bodies so that they can tell me their feelings about their own dying. Because death and dying are considered taboo topics in North American society, the concern of this topic extends not only to dying persons but also to doctors, nurses, families and religious groups. Need-
less to say, research may also be concerned with economic and political concerns as well.

I propose to discuss my own ethno-methodological experiencing of another individual's process of dying. Is this possible? First, our experience of death and dying can only be indirect. We are aware that all men are mortal and so, as a conclusion, we too must die. By seeing others die, we can become convinced of our own mortality. Yet, as long as we are "alive", then it is always someone else who dies. The important fact here is how to experience another person's dying. This is possible through communication and identification. A person can communicate-- be it verbally or indirectly-- with a dying person, then it is possible to identify with the dying experience of a dying person. The "closer" the dying person can be to me, the better my experiencing his dying.²

Heidegger is not so optimistic on this score. He believes a person can only communicate the more banal experiences. Deeper experiences of life are by nature incommunicable. This would mean that since death and dying are basic experiences in life, it does not matter how close a person may be to us, his dying could not constitute a genuine psychological experience. In philosophical words, Heidegger states that:

the authentic Being-come-to-an-end of the deceased is precisely the sort of thing which we do not experience. Death does indeed reveal itself as a loss, but a loss such as is experienced by those
who remain. In suffering this loss, however, we have no way of access to the loss-of-Being as such which the dying man 'suffers'. The dying of Others is not something which we experience in a genuine sense; at most we are always just 'there alongside'. (Heidegger, 1962:282)

I agree that I cannot experience the dying of another person in a genuine sense as I would literally be dying as well, or I would have to be dying the other person's dying. Admittedly, this is impossible. But, my own "experience", both direct and indirect, of interhuman relations can reach a communication, although difficult, of another person's "dying experience". The closer the emotional bonds, the greater the communication. The greater the communication, the better the experience. The converse, that the lesser the emotional bonds, then lesser the communication leading to lesser the experience with an individual, should follow true with strangers:

The death of strangers is impersonal and tells us nothing essential about our own death. (Lepp, 1969:27)

Diagram 3 illustrates the difference in experiencing the dying of a personal friend and that of a stranger. Man's self-consciousness leads him to become aware that he is going to die from an early age. The child learns of it through mention that grandmother died. Death becomes more realistic when a pet cat is found dying after being hit by a car. It is man's consciousness then that makes him aware of another's dying and death, as well as his own. I refer to this as a psychological experience of dying. The problem
is, that although man's consciousness tells him that he, too,
existentially will die, it may not tell him when and whether
he is dying. Dying in terms of NOW begins a process of
anxiety, fear, pretension and alienation. This problem leads
to the next section which deals with the fact of awareness
of dying, or stated in simpler terms:

Doctor, doctor, will I die?
Yes my child, and so will I. (Powers, 1971:73)

DIAGRAM 3

EXPERIENCING ANOTHER INDIVIDUAL’S DYING

EXPERIENCING DYING

stranger
little or none
psychological
experience

through
consciousness

no communication

impersonal -- no experience

close friend

strong communication through identity

personal experience

Knowledge of Dying "For Sure"

When an individual begins to die, his main suffering
is not limited only to biological pains as dying is not
necessarily related with suffering only. What he suffers most
is the result of the fear of his own death and the loss of
those around him:

He reminds people that they, too, are going to die,
which they naturally are not eager to consider. As a
result, the first problem faced by the dying
individual is to discover the truth about his
condition. (Powers, 1971:74)

People who have interaction with the patient and knowledge of his condition are the doctors. Only in rare instances do modern day medical practitioners tell their patients the truth. Thus the patient has to find out by himself. Clues are given by doctors, nurses and relatives, but these are so vague and "two-faced", that the patient may only view them as conspirators against him.

The topic of death and the dying patient's fate are subjects which doctors shy away from. Death is representation of failure and defeat in the medical profession. Doctors may "cover-up" this mentality by withholding the truth, using the reasoning that the patient would "give-up", "lose hope", and besides patients do not really want to know. Contrary to this, studies show, however, that:

80 percent (more or less, depending on the study) of doctors oppose telling dying patients the truth, while 80 percent of their patients want to be told. (Powers, 1971:74)

Barney G. Glaser and Anselm L. Strauss (1965) used in their book Awareness of Dying, a theory of "awareness" in their examination of the dying patient and those about him in social condition. On the topic of truth and pretense, they state that:

In American hospitals, frequently the patient does not recognize his impending death even though the hospital personnel have the information. This situation can be described as a "closed awareness" context. Providing the physician decides to keep the patient from realizing, or even seriously suspecting, what his true status is, the problem is to maintain the context as a closed one. (Glaser and
A justification used to "play the game" of keeping this "closed awareness" is to suppress the truth and to assume that eventually the patient will realize what is happening. However, this mutual pretense usually goes on until the very death of the patient, even when all parties know the truth, and know the others know it too. It is through this mutual pretense, and withholding of the truth that I have chosen the variable of "suspicion" in my discussion of the concept of "knowledge for sure".

**Suspicion In Dying**

The element of "suspicion" in dying will be studied from the perspective of the individual's suspicion (in terms of others), as well as the others' suspicion. The reverse point-of-view will be studied as well, that is, no suspicion from the individual as well as no suspicion from others. The concept of "suspicion in dying" is stated in Diagram 4 on the typology of suspicion and dying.
### Diagram 4

"Knowledge for Sure" in Dying

<table>
<thead>
<tr>
<th>Individual's Suspicion</th>
<th>Others' Suspicion</th>
<th>Others' Non-Suspicion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual Pretense Awareness</td>
<td>Suspected Awareness</td>
<td>O.S. (others do not suspect that the patient is aware of his status).</td>
</tr>
<tr>
<td>O.S. (both parties suspect the individual's dying)</td>
<td>I.S. (the individual &quot;covers up&quot; his suspicion that others know)</td>
<td></td>
</tr>
<tr>
<td>I.S. but both pretend that none suspects it)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

| Individual's Non-Suspicion |  |
|----------------------------|  |
| Closed Awareness | No Awareness |
| O.S. (others suspect that he is dying but the individual has no awareness of his own death). | O.S. (neither party suspects a sudden death). |
| I.S. | 3 |
| 4 |

5. (at any stage, open awareness can occur): both staff, (family) and patient know that he is dying and acknowledge it in their actions.

### A Typology of Suspicion and Dying

"Knowledge for sure" in dying will be analyzed from a typology of suspicion and dying based on Glaser and Strauss' "awareness contexts" (1964:669-79). Briefly, the typology is based on suspicion, both of the individual and of the others as well, suspicion in dying refers to the lack of suspicion from both parties.
1. Mutual Pretense Awareness:

All parties pretend that the patient is going to live. Interaction is in the form of a "make-believe" game with future-oriented topics; the patient is usually ignored and abandoned leading to withdrawal and loneliness for the patient.

2. Suspected Awareness:

The patient suspects that others think he is dying. He must confirm his suspicions through cues and try to interpret them by himself. The "runaround" answers given to his questions can eventually result in strain since the patient is stripped of honesty.

3. Closed Awareness:

This context refers to physicians, family, hospital staff, and interested others in keeping the patient from realizing what his true status may be. However successful others are in not disclosing the patient's true nature of his illness, the 'closed context' does not exclude the fact that the individual may be suspecting his true status. Although closed awareness is a strong moral support for the family and hospital staff, it creates strong anxieties for the patient.

4. No Awareness:

This refers to victims of sudden, unexpected death. There is no suspicion involved since both parties are unaware that the individual was to die.
5. Open Awareness:

The state whenever both staff, family and patient know that the individual is dying, and acknowledge it in their action. Open awareness can occur at any time in the suspicion context of dying. Positive results can occur from this awareness as the patient can prepare more appropriately for his death, or adverse effects may result, such as "giving up", deep depression, or anger.

Framework of the Study

I pointed out above that patients, relatives, doctors, nurses, (even dispensers of research funds) are not willing to introduce the subject of dying. This fact leads mostly everyone to withhold the truth, creating suspicion in dying and an obstacle for interaction. This obstacle, known as fear of death, creates a multitude of experiences and reactions from every one. The most single fear of death, though, is the fear that a person will lose his "self":

Since no one can say convincingly what death is, it is not easy to say why people fear it. In general, the fear of death has been broken down into the specific fears of pain, loneliness, abandonment, mutilation and somewhat more difficult to define, fear of the loss of the self. This is not just another way of saying fear of death, but a kind of disassociation of the self as a conscious entity (the sense of me-ness one feels) from the self as a particular individual, with his particular history in the everyday world. That individual is one's closest associate and one fears his loss. (Powers, 1971:74)

The fear of the loss of self is associated with the
dying patient's experiences with pain, loneliness, abandonment, mutilation, humiliations, and degradations while he is dying. The self thus begins a process of being mortified in an individual's experience of dying. A concept known as "mortification of the self" has been thoroughly developed by Erving Goffman. In his book, *Asylums*, (1961) Goffman develops this concept of "mortification of the self" by arguing that in the accurate language of some of our oldest total institutions, the inmate begins:

a series of abasements, degradations, humiliations, and profanations of the self. His self is systematically if often unintentionally, mortified. He begins some radical shifts in his moral career, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others. (Goffman, 1961:14)

I propose to take Goffman's theory of "mortification of the self" in total institutions and to apply them to the experiences of mortification of the self during the process of dying. An analysis of these series of mortification of a person's self during the process of dying can surely present to others, who must interact with the dying person, the realistic situations which confront a dying person, either in institutions or civilian life. The concepts which will be used in this study are developed from Goffman's theory of "mortification of the self" from his study on *Asylums* and other institutions.

**Concepts to be Studied in "Mortification of the Self"**

*In the Social Process of Dying*

1. "presenting culture": (p.12) the way of life
and a round of activities taken for granted until the point of admission to an institution (here the ordinary life of a terminal patient before his admission to a hospital will be examined).

2. "disculturation": (p. 13) the "untraining" which renders him temporarily incapable of managing certain features of daily life on the outside, if and when he gets back to it (this refers to a terminal patient's return home after a long stay in a hospital or clinic).

3. "role dispossession": (p. 15) in civil life, the sequential scheduling of the individual's roles, both in the life cycle and in the repeated daily round, ensures that no one role he plays will block his performance and ties in another. But in the process of dying, is this membership lasting, and does the role of the patient as terminally ill prevent educational or job advancement or courting?

4. "civil deaths": (p. 16) a temporary loss of rights, to the extent that sometimes they are permanently abrogated, (an analysis of what rights does a dying person lose in comparison to "normal" others).

5. "deference obligations": (p. 17) what he is told to do and act in a structural manner may force him to balk or hold his peace forever, (especially immediately following the news that he will die).

6. "personal defacement": (p. 21) stripping of one's "identity kit" (e.g.: clothing, personal things are removed.)
7. "personal disfigurement": (p. 21) direct and permanent mutilations of the body (hair removal, scars from operations, loss of limbs).

8. "fear of physical integrity": (p. 21) anxieties concerning shock therapy, surgery, painful tests. Also, certain movements, postures and stances will convey lowly image of the individual and be avoided as demeaning (e.g. loss of equilibrium leads to inebriated walking movements). Any regulation, command, or task that forces the individual to adopt these movements or postures may mortify his self (in this case surgery of his illness forced these movements).

9. "contaminative exposure": (p. 31)
   a. violation of one's informational preserve regarding self: collection of patient's social statuses and past behaviour are collected and recorded in a dossier. New facts are exposed to a new kind of audience.
   
   b. physical contamination and interpersonal relationship: e.g. patch over eye as a humiliating circumstance, -- exposure to both sexes for medical and security examinations.
   
   c. experimental mortification: a witnessing of physical assault upon someone to whom one has ties and suffering the permanent mortification of having taken no action (in this case the parents not being able to help the patient during treatment).

10. " a disruption of the usual relationship
between the individual actor and his acts": (p. 35)
a. 'looping effect'-- the individual finds that
his protective response to an assault upon himself is collapsed into the situation; he cannot defend himself in the usual way by establishing distance between the mortifying situation and himself.

**Situational Adaptation in Dying**

In total institutions, inmates have solidarizing tendencies such as fraternalization and clique formation. Constraints which place inmates in a position to sympathize and communicate with each other do not necessarily lead to high group morale and solidarity. The area to be explored is the solidarizing tendencies which a dying patient experiences; (does he speak to anyone about his condition? If so, to whom does he speak to? If not, how does he adapt to his role of dying?)

The mortifying process . . . represent the conditions to which the (dying) inmate must adapt. These conditions allow for different individualistic ways of meeting them, apart from any effort at collective subversive action. The same inmate will employ different personal lines of adaptation at different phases in his moral career and may even alternate among different tasks at the same time. (Goffman, 1961:61)

Some of the adaptations to be explored during the process of dying will be those of:

a. situational withdrawal: (p. 61) the fact that the inmate withdraws apparent attention from everything except events immediately around his body and sees these in
a perspective not employed by others present. (types of regression in behaviour exemplified by the patient will be observed).

b. intransigent line: (p. 62) challenging the institution by flagrantly refusing to co-operate with staff. (observation of challenges which patient shows as apparent rebellion. Also the manner in which people and hospital staff react to the rebellion).

c. "colonization": (p. 62) experience from the outside world (i.e. experience of former life when previously well) is used as a point of reference (i.e. the present status of dying).

d. "conversion": (p. 63) inmate appears to take over the official or staff view of himself and tries to act out the role of the perfect inmate. (here will be observed the different stages of dying).

e. "proactive status": (p. 72) the inmate's social position on the outside will never again be quite what it was prior to entrance. When proactive status is a favourable one, jubilant reunions are made (e.g. priesthood). When proactive status is unfavourable, we can employ "stigmatization", we can expect the ex-inmate to make an effort to conceal his past and try to pass. But what happens when released from hospital knowing that death will surely occur soon?

Focus of Inquiry
As has been mentioned previously, it is often unclear where dying actually begins, either biologically or socially, except for the existentialist philosophy of dying-from-birth. This research deals with the social process of dying in general, and "mortification of the self" in dying in particular. The main focus is to develop a sociological version of the structure of "mortification of the self" during the process of dying. The central issue to be presented will be the terminal person's situation during the process of dying.

If dying is to be studied as a social aspect, sociological perspectives should include a variety of linkages of those surrounding the dying person to the one who actually is dying and eventually to the fact of his death. The study of the phenomenon of dying will then refer to a specific terminal patient for clarity of the concepts. It is hypothesized that in the social process of dying, a terminal patient will undergo experiences known as "mortification of the self", either while in institutional or in civilian life.

These experiences of "mortification of the self" in dying will be analyzed through qualitative and quantitative aspects as observed through such social structures as:

1. the family;
2. hospital;
3. public places;
4. education;
5. religion.

In summary, the terminal patient will be seen in a variety of different settings such as the family, hospital, public places, education and religion. Observations will focus on the above-mentioned settings and what they are intended to do with the patient (qualitative, such as in affection, treatment, efficiency, grades and spiritual comfort), as well as how settings actually affect the patient in terms of abasements, humiliations, degradations of the self in the process of dying (quantitative).

Finally, several aspects will be analyzed in each setting in reference to the patient and process of mortification of the self. These aspects will include such elements as:

1. secrecy: in hospitals (clinical); public places (closed awareness); family and friends (ethical or effective secrecy): public institutions (particularistic).

2. concern: a. with friends and kin . . . maximized
   b. for hospitals . . . . . statistical
   c. in public places . . . minimal
   d. education . . . preparation for societal usefulness
   e. religion . . . spiritual comfort

3. linguistics: in each setting, reference will include any particular linguistic usage in interaction with or about the dying person.

Diagram 4A will set down the qualitative and
DIAGRAM 4A

OUTLINE OF FOCUS OF INQUIRY

DYING

as seen from:

institutions to be analyzed

Patient

Mortification of the Self

qualitative
1. affection
2. treatment
3. efficiency
4. grades
5. spiritual comfort

quantitative
what can be observed in terms of what produces abasements, degradations and humiliations of the self in the process of dying.

family
friends
peer group

hospital
clinical nurses
doctors

restaur't
public places
services

educat'l
knowledge

relig.
spiritual
clergy

secrecy
meaninglessness
concern
linguistics

--avoidance, --awareness
Method of Procedure

The scientific studies to date on dying include several approaches by noted researchers: Glaser and Strauss analyzed the "awareness of dying" (1965); the interaction between staff and patient (1965 and 1968). The phenomenon of dying as troublesome (Sudnow, 1967); the avoidance of topics on dying by the medically trained (Jeanne Quint, 1966 and 1967); Brim et al. (1970) included several studies on the "dying patient", such as what people think about death (John Riley Jr.); the dying patient's point of view (Elizabeth K. Ross); dying in a public hospital (David Sudnow); dying as an emerging social problem (Sol Levine and Norman A. Scotch) and dying and its dilemmas as a field research (Dianne Crane). The purpose of this particular study is to focus intensively on dying as a social process and to view the effects on the patient of "treatment" by others. The introduction explains this fully. The method chosen to analyze this study is that of intensive observation:

Sociologists usually use this method especially interested in understanding a particular . . . problem rather than demonstrating relations between abstractly defined variables. (Becker, 1970:26)

Although I will be unable to participate in dying itself, I will engage in a number of different activities in the life of a dying person. Thus my method as observer will make use of the case study approach.
The case study usually has a double purpose. On the one hand, it attempts to arrive at a comprehensive understanding of the study: . . . its members: . . . it also attempts to develop more general theoretical statements about regularities in social structure and process. (Becker, 1970:76)  

**Description of the Population**  

Since dying involves interaction with other persons, I have decided to study dying by observing the activities of a terminal patient. He is eighteen years of age, and is dying from a tumor of the brain. I have personally known "J.P." for eighteen years, thus making familiarity and friendship a strong basis in my methodology. Close association and interaction has been going on for three years already, especially since he was first admitted to the hospital. He was dismissed as a terminal patient, (although he has never been told by anyone that he is dying), and subsequently readmitted to hospital (January, 1971) and especially close frequentation in the past six months. At present, he is not in a hospital (February, 1972).  

In order to check my observations both within a hospital context and outside a medical institution, I have informally interviewed twenty-four nurses from various hospitals who have had experiences with dying patients. All nurses were anxious to discuss their feelings about terminally ill individuals and their obvious shortcomings in "treating" these persons socially.  

No medical physicians were interviewed based on the assumption that this population has very few social contacts
with dying persons.

A third group of persons who were informally inter-
viewed were J. P.'s parents, relatives and close friends. The
topic of dying was always introduced informally in a conver-
sation in order to obtain the most honest answers with a
minimum of bias.

The justification for studying a dying person in
a variety of different settings is that dying is a personal
experience. Indeed, one of the major causes of "mortification
of the self" in dying is that dying has become very imperson-
al. It was stressed earlier that deaths occurring to strangers
are quite impersonal to us. Therefore, my main argument is
that if I really want to authenticate the experience of the
dying process of another individual, this experience must
be genuinely personal for me. Thus my reasoning for using
only one personal friend in this study. It is hoped that I
will be forced to consider the multiple interrelations of
the phenomenon of dying which I am observing. These multiple
interrelations, I believe, could not be observed intensively
nor objectively without my personally experiencing a dying
person's process of dying.

Techniques to be Used

J. P. does not know that I am studying his dying
experiences. My role is that of a respected friend, that is,
by J. P., his parents, family and relatives. I have placed
myself as an observer as well, as J. P. goes about his daily
round of activity. Observations are recorded as soon as possible after encounters. I note the kinds of people who interact with him, the content and consequences of the interactions, and how it is talked about by the participants and others. As much as possible, verbatim accounts are kept.

**Bias: Distortion of the Theoretical Perspective**

The observer has the problem of trying to avoid seeing only those things which accord with his explicit or implicit hypothesis. (Zelditch, 1962: 566)

During the course of the study, such feelings as loyalty and obligation may make me wish to protect J.P. by not seeing those events which could be rendered to criticism. Some people, including J.P., may keep back some information from me. I propose to take the role of J.P. and recreate in my own imagination and experience the thoughts and feelings which are in the mind of the one I am studying. Herbert Blumer points out this importance of describing a process in research by gaining accurate knowledge of the process:

To catch the process, the student must take the role of the acting unit whose behaviour he is studying. Since the interpretation is being made by the acting unit in terms of objects designated and appraised, meaning acquired and decisions made, the process has to be seen from the standpoint of the acting unit. . . . To try to catch the interpretive process by remaining aloof as a so-called "objective" observer and refusing to take the role of the acting unit is to risk the most kind of subjectivism--the objective observer is likely to fill in the process of interpretation with his own surmises in place of catching the process as it occurs in the experience of the acting unit which uses it. (Bruyn, 1966:13-13)
In summary, my intent is to "catch the process of dying as it occurs in the experience" of the one whom I am observing. This can only be done through my role as actually "experiencing" the social process of dying of a terminal person. Although I am not dying myself, nor can I actually feel the physical pains of dying, interpretations of a dying process can only be said to be based on my own personal knowledge which I gained during the research.

Conclusions on Ethno-methodology in the Study of Dying

The focus of this research is to study the social process of dying in general, with particular focus on the "mortification of the self" during this process. Analysis of this research is based on the effects of social activities of the phenomenon of dying. These effects will be observed by the researcher through frequent and close interactions with a terminally ill patient. Interviews are also conducted with nurses, family and interested others to check the observations.

The framework of the study is based on knowledge of dying "for sure", i.e. in respect to a dying situation, all those individuals who are involved with this situation, including the patient, are subject to "awareness contexts" in dying. The element of suspicion will form the basis of the awareness contexts.

The focus of inquiry is to observe quantitatively, effects of social activities in dying which will be analyzed through the theory of "mortification of the self". As well,
situational adaptations in dying will be viewed from the perspective of all involved with the dying process.

Finally, the social process of dying is seen in the perspective of a passage from multiple statuses, such as from health to illness, from social value to social worthlessness, from an awareness context to another, and passages within the dying process itself.
FOOTNOTES

1. The "I" not only refers to the writer as an individual, but this reference applies to other individuals as well.

2. "Closeness" to a person does not necessarily involve physical proximity alone. It includes as well emotional proximity involving such aspects as knowing how the person thinks, reacts, or feels about a certain issue. Knowledge about another individual is not only communicable, but observable.

3. Note: the verb 'dabeisein' literally means "to be at that place"; "to be at it". Maybe Heidegger did mean that the Other's dying is experienced by being in that place i.e. to be at dying although our own actual dying does not take place. Heidegger's main argument for this statement is in his search for the "meaning of Being". To gain an approach to Being, we must study not things but a mode of Being; and the mode of Being most open to us is our own Being which he calls "being-there".

4. The notion of experiencing another person's dying does not refer here to persons who have temporarily 'died' from cardiac arrests.

5. Note: This indifference of the death of strangers is evidenced by our indifferent reaction to week-end traffic fatalities. For Hitler it was the impersonal 'other' who died in the crematory ovens of Dachau. The American outlook on the victims of Hiroshima was impersonal. The
attitude of Frenchmen toward the atrocities committed in Algeria was indifferent. The mass murders in Bangladesh are looked upon impersonally by nations.

Note: Heidegger, on consciousness of death, sees death as the ultimate coronation of the nothingness that constitutes our being. He further states that it is desirable and inevitable for man to always be conscious of his being-toward-death, (i.e. annihilation of life), because life has no other end but death. He does feel though that we should face death and dying courageously. Pascal argues that man has an unconscious idea of dying death. Man seeks pleasure, sensual and intellectual, in order to relieve himself "unconsciously" so to say from the anxiety and fear of dying and death. Camus sees consciousness of death as a continual "combat" against a "plague". Sartre believes man's consciousness of his dying destiny leads him to deny all seriousness of life or death. Glaser and Strauss find "awareness of dying" to be a struggle for the truth which is sometimes Byzantine in its complexity.

"Treatment" not only refers to medical care of the patient, but for purposes of this study, "treatment" refers especially to social care of the terminally ill person.

Although the case study is frequently used by anthropologists to study directly a certain phenomenon, it is to be noted that my ethnomethodology employs the case study of a terminal patient not to study dying "per se", but the effects of treatment of the dying individual
which produce mortification of the self.

Impersonal in the sense that the layman has very little involvement with another person's dying, let alone his own. Care is provided for in an institution, communication with the patient's physician and nurses is very brief and vague.

cf. Heidegger on this topic.
CHAPTER III

THEORETICAL PERSPECTIVES IN THE SOCIAL PROCESS OF DYING

The Theoretical Framework

"Every healthy person must have a goal in life and that life must have content." (Hesse, 1968:162) Having goals in life must involve the future. However if a person does not have a future, such as in the case of a terminal patient, it follows that there are no goals in this individual's life. Once hope is lost that the patient will have any chance of recovering, attitudes from relatives and medical personnel toward the person change. The patient is no longer socially rewarding since he cannot be made the object of heroic life-saving efforts. Because of prescribed norms regarding appropriate behaviour toward the dying, communication between the patient and both the staff and relatives becomes very poor.

This lack of communication can be explained through studies which show the fact that interaction with persons who have no future is frustrating in our culture. Such individuals suffer a sharp loss in social value. . . . If dying patients were still perceived as having social value, it seems probably that medical personnel and relatives would wish to interact with them and that norms regarding appropriate behaviour in such situations could be located. Such norms still exist in other cultures. (Crane, 1970:313)

Instead of feeling a sense in dignity in dying, by

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having the relatives gather around until death occurs, the patient faces a trauma involving not only the loss of his social value, but the loss of interaction and communication with medical professionals and his relatives. The most important fact relating to this loss in communication and interaction is due to the knowledge of the imminent death which makes all references to the distant future very difficult.

It is not easy to carry on a future-oriented conversation without revealing one's knowledge that the conversation is, in some sense, fraudulent, especially if the speaker is relatively inexperienced. (Glaser and Strauss, 1965:38)

The most common reaction of hospital staff and the family to this difficulty in future-oriented conversations is very simply to avoid the patient. Soon, the patient finds himself abandoned, facing a sense of loneliness and helplessness, avoidance and isolation from others. The situations were demonstrated with J.P., when first admitted to the I.O.D.E. hospital. He became a central focus at the hospital, as doctors attempted to demonstrate their heroic life-saving techniques. After six months of futile attempts, the doctors "gave up", telling the parents that J.P. would not live more than six months. Soon afterwards, visits from relatives and friends became fewer, conversations were limited and short, and nurses began to avoid J. P.'s room. Not knowing what the real nature of his condition was, J.P. thought that the people were avoiding him because "I must be getting better so I don't need their help anymore."
Carol Knesl (1968) explains abandonment of the patient by means of isolation. He is transferred into a private room to allow him more privacy, only to find himself completely isolated, abandoned by friends on his ward, his family and his favourite nurses. The longer he exists in a state of dying, the greater the abandonment. In her study, Knesl concludes that

Loneliness, abandonment and isolation are encouraged and a full encounter between the nurse and patient discouraged by the practice of assigning part-time or 'float' nurses to care for these patients, or by rotating patient assignments among staff nurses. (Knesl, 1968:553)

Although all patients experience abandonment, isolation and loneliness, this experience is determined by the patient's degree of social value. I now turn to the dying patient's social value and the impact of social loss on his imminent death.

**Social Value and Social Loss in Dying**

Society places values on people, based on such social characteristics as age, education, social class, status, occupation, character, beauty and accomplishments. Even in dying, social values are inevitably placed on patients. These social values influence the care and reactions given to the patient from nurses, doctors and relatives. The influence is largely determined by the total of the valued social characteristics which each dying patient embodies, each to a different degree. Plainly, the more "valuable" the dying patient may be to society, the greater the reaction from
staff in treating the individual. Glaser and Strauss (1964) noted that the influence which

the total of the valued social characteristics which the dying patient embodies indicates the social loss to family, occupation, and society on his death. (1964:119)

Most studies on the dying in hospitals show that the single most important characteristic for basing social loss is age. The premature baby (or preemie) is expected to die within forty-eight hours. There is little or no social loss when he dies, since he influences the family very little. A rationale would follow that "He probably would have been sick all his life." The young teenager is a potential asset to the family, thus his dying presents a greater social loss. In the case of J.P., he is the oldest son in a family of nine children. His imminent death would bring a loss of much-needed help on the parents' farm, a loss in potential income, as well as the loss of the father's pride in his oldest son.

Another age-group which suffers great social loss is the children of dying mothers or fathers. The father's dying creates the future loss of a paycheck and the possible loss of family status. The dying mother presents a future loss in the family's emotional support, both for the children and the father. A rationale of loss here would be to the effect that "She is happier now; she was suffering so much." Lastly, the social loss exemplified in old age shows how age is a major determinant in a dying individual's social value. The aged patient is expected to die since he has
fully lived his life. The social loss of the dying aged is very much that of the preemie, and rationalized by "He had nothing to live for anymore."

Sudnow (1968) states that, when a person comes to the hospital by ambulance, one can observe "a direct relationship between the loudness and length of the siren alarm and the considered 'social value' of the person being transported." (Sudnow, 1968:104) Social value of emergency patients is even determined by the manner in which the ambulance driver wheels the stretcher and the excitement in his voice.

A second important characteristic for indicating dying patient's social worth is his social class. Social values determine the hierarchy of social classes which in turn strongly affects who in a hospital will receive the precious few life-prolonging or revival techniques. Social class very often has more value than age in dying. Thus one sees the only kidney machine in a hospital given to the aged resident of an influential business instead of to a young man. The shocking reality of social class in dying was shown when Doctor X simply stated to J.P.'s parents, "You poor people. We could continue treatment, but at an unbelievable expense to you." Soon J.P. was discharged from the hospital.

Glaser and Strauss (1968) noticed that the "quick-dying trajectory" (1968:97) receives more medical attention than any regard for social characteristics of the dying person. The staff doctor may attempt to save the patient even when he is not expected ultimately to live. The reason for this is
that saving life in a heroic fashion is part of a mandate as doctors and nurses react to

Quick dying (which) generates quick efforts to save, and everyone expects it; lingering dying allows staff more time for decision and more subtle, more covert ways of letting a patient die. (Glaser and Strauss, 1968:107)

A third determinant is assessing the dying patient's social value in his "moral character" (Sudnow, 1968:104). Sudnow (1968) states that in his study, alcoholics, sexual deviants such as prostitutes, gang members, wife-beaters, suicide victims and dope addicts all would have received more intensive care had the nature of their moral character not been previously known. If one anticipates having to be admitted to a hospital, it is suggested that he be well-dressed and possess a breath clean from alcohol. Interns have been heard saying that they couldn't see any sense in pumping it (blood) into him because even if we can stop the bleeding, he'll turn around and start drinking again and next week he'll be back needing more blood. (Sudnow, 1968:105)

In recapitulation, the dying patient has no goals because he has no future. Since he has no future, the patient has no social value. The social value of the individual is determined by social characteristics such as age, personality, character, social class and accomplishments. Attitudes toward the dying person make it difficult for people to interact and communicate with them primarily because people with no orientations toward the future are not expected to have future-oriented goals. Prescribed norms for proper behaviour in in-
teracting with dying patients suggest limited encounters with them. A common norm is to isolate the patient, thus abandoning him while he is dying.

The totality of valued characteristics of a dying person determines the social loss of that individual. As a result, the impact of the social loss of the patient will influence the reactions from his family, the medical personnel and, to some extent, the society. Social loss in terms of the dying individual is shown in Diagram 5.

It is in the following section that I will discuss: 1) the reactions of hospital staff and the family to the dying patient; 2) the norms which prescribe behaviour toward the dying; 3) the effects of treatment and care on the dying person in terms of the humiliations, degradations and abasements produced in the process of dying.
DIAGRAM 5

CALCULATING SOCIAL LOSS IN DYING

SOCIAL VALUE

based on

SOCIAL CHARACTERISTICS

age education talent accomplishments family status beauty moral character

determines amount of

SOCIAL LOSS

in terms of

others

family society hospital

paycheck occupation failure

dying individual

no social value no goals no future

loss of self
Situational Adaptations in Dying

The aspect which most strongly determines the social loss of an individual takes its meaning from the anticipated future. The social loss of the dying person is calculated in terms of what characteristics will be lost after his death. Although the dying patient is said to have no social value, his death will present a loss for his family members, his occupation and society—all of which have to go on without the dying person. Since social loss derives meaning from the anticipated future, it is while the dying person is living that the attitudes toward the degree of the loss of the individual are based on "social differentiation" (Crane, 1970:308) of the person.

"social differentiation" prescribes ways for society to react to individuals, according to whether they are more important or valuable than others. These prescribed ways in reacting to dying individuals are indeed norms which dictate the attitudes one should have toward the dying and their death. On this topic of appropriateness in dying, Parsons and Lidz (1967) point out that

attitudes toward the dying in our society differ, depending upon whether the process occurs at the end or as a break in the life cycle. The first type of event is considered normal; the second is the object of vigorous intervention. Efforts to minimize this type of death are highly valued. Thus we react to a threat to the life of an individual with apathy or activism depending upon our assessment of the appropriateness of death for him. (in Crane, 1970:308)

It would follow then, that a young man would pro-
bably receive more medical attention than would an eighty-year-old man, for example. The young man will receive a more active reaction, since it would be considered more inappropriate for him to die. Thus it was with J.P. who became the focus in the I.O.D.E. hospitals because of his brain surgery. It was considered a great accomplishment for Dr. X if his delicate surgery was to be a success. He not only would have performed a dangerous surgery, but would have minimized the chances for J.P.'s death. Medical science had thus failed to save a valuable life, i.e. of a young man. The hospital staff was quick to label J.P. as a "hopeless case". It was then that hospital personnel, family and relatives began the process of reacting to J.P.'s situation. These reactions I will call situational adjustments or adaptations to dying, both by family, hospital staff and J.P. himself.

Reactions to the Dying Situation

When a person is labelled as dying, what the future holds is usually the criterion which becomes a main focus for him. A dying person may have no "future" because he is "not expected to have any goals". The problem arises in whether or not to tell the person what the future holds for him. This, in turn, implicates the reactions of medical staff and family, and the patient when he is not told. What are the different chains of events which could result if and when the patient becomes openly aware of his future?

Two major aspects in adjustment to a dying situa-
tion involve both intellectual and emotional consideration. First, from the standpoint of significant others, consideration is based on the uncertainty about a person's adjusting to the knowledge that he is dying. Moreover the emotional effects from this knowledge are also feared. Second, in terms of the point of view of the dying person, he may view his experiences as being unknown to others, since others may appear to be emotionally reacting in an impersonal way towards him. The norms which govern behaviour and communication with all those involved in the dying situation may unintentionally produce effects on the dying person which are known as the "mortification of the self" in dying. These are analyzed in the following three sections: I suspicion, II secrecy, and III meaninglessness.

I. Suspicion in Dying

When a person's status becomes one of dying, he finds himself in a different realm of interaction with others. Since suspicion in dying involves uncertainty in the knowledge of whether or not the person is dying, interaction takes the form of a multitude of combinations of "who knows what". These combinations of "who knows what" have been called types of "awareness contexts" by Glaser and Strauss (1964: 669-79). Awareness contexts refer to the relationship between patient and the hospital staff. I will extend this concept of awareness context to include the family, friends and others outside the hospital environment.
The types of awareness context to be used in studying suspicion in dying will be those of "1. mutual pretense awareness, 2. suspected awareness, 3. closed awareness, 4. no awareness, and 5. open awareness". (Glaser and Strauss, 1965:11) Each type of awareness context in suspicion will include the observed patterns of each awareness context and the interaction, or lack of it, based on:

a) the formal institutions involved, as well as the informal group of family, friends and other concerned members of society:

b) the various reactions between the dying individual and others in each context;

c) the consequences of the interactions in each context. Which of the different interactions produce "mortification of the self" in dying?
DIAGRAM 6

AWARENESS CONTEXTS IN THE PROCESS OF DYING:
A TYPOLOGY OF SUSPICION IN DYING

<table>
<thead>
<tr>
<th>INDIVIDUAL'S SUSPICION</th>
<th>OTHERS' SUSPICION</th>
<th>OTHERS' NON-SUSPICION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual Pretense Awareness</td>
<td>O.S. both others and individual pretend that the other party does not suspect</td>
<td>Suspected Awareness</td>
</tr>
<tr>
<td></td>
<td>I.S.</td>
<td>0.S. others do not suspect that the patient knows</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.S. individual suspects that others know</td>
</tr>
<tr>
<td>Closed Awareness</td>
<td>O.S. others suspect his death</td>
<td>No Awareness</td>
</tr>
<tr>
<td></td>
<td>I.S. individual does suspect his own death</td>
<td>0.S. neither others nor individual suspected sudden death</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.S.</td>
</tr>
</tbody>
</table>

At any stage, open awareness can occur.
A. Mutual Pretense Awareness

When a patient and staff (and family) both know that the patient is dying but pretend otherwise—when both agree to act as if he were going to live—then a context of mutual pretense exists. Either party can initiate his share of the context; it ends when one side cannot, or will not, sustain the pretense any longer. (Glaser and Strauss, 1965:64)

The interesting aspect of mutual pretense awareness lies in the fact that all parties pretend to act as though the patient were going to live. The most difficult interaction here is the make-believe game in conversations. Conversations usually involve future-oriented topics, as though the patient had a real future. Such statements as "Where are you and your girlfriend going on your first date out of here?" from nurses, or safely discussing the disease without reference to its fatal significance, were tactics used in discussions with J.P. Both parties pretend that the other party does not suspect. This situation can lead to several consequences for the patient. First, conversations are limited and short. Nurses begin to avoid the patient, only stopping at the door to look in and possibly say, "Hi, how are you?" and leave. Abandonment from nurses who were once very friendly to the patient, as well as from family and relatives can force the individual to withdraw by means of keeping silent. In J.P.'s case, this silence became very noticeable after his discharge from the hospital. Since others prefer to avoid J.P. rather than face any future-oriented conversations with him, he once remarked, "My friends look at me like I was a
ghost and walk away, even without saying hello." A common reaction to abandonment in dying leads to the patient keeping a strict silence.

Goffman considers such silence as a "situational withdrawal" (1961:61) in an inmate culture. Here the person withdraws attention from everything except what he sees in a perspective meaningful to him. Where patients are referred to as "difficult" or as patients exemplifying "regression", I would argue that such a withdrawal is often indicative of situational adaptation. Staff and family expectations of the dying patient lead them to consider adjustment to dying only when the patient fulfills staff expectations of dying behaviour. Adjustment would also presumably include what may seem to be negative reactions to dying, since the dying person has not likely had previous experience in dying behaviour. In this example, strict silence on the part of J.P. would be a situational adaptation of his dying experience.

Another form of reaction to the dying patient in the mutual pretense context is the extensive use of props for avoiding topics related to the patient's future. These props can be used by the hospital staff, the family and the patient as well. This pretense role favours the staff since they are accustomed to playing it with other patients. But the patient has had no previous experience with this type of role. He is moreover handicapped because he is put into the part of the "not-dying patient". (Glaser and Strauss, 1965:72) Nurses react by hiding facial expressions. The stereotyped
smiling nurse seemingly has no sympathy for the patient. Contrary to this idea, nurses are affected deeply by their patients. As a consequence, nurses must "build up a barrier" with patients so that it "protects the nurse from facing her own feelings, which may be deeply disturbing." (Quint, 1966:159) The consensus among the twenty-four nurses with whom I had informal talks about the dying in their hospitals, was that the best defense against openly showing their feelings toward the patient was to treat him impersonally. This defense may then take the form of ignoring the patient. Ignoring the patient is observed usually through the routine "spot check" of the patient from a quick glance at the door, or a simple "Hi, how are 'we' today?", or even a small wave of the hand (ignoring not only the patient physically and emotionally, but avoiding any communication as well.) But to ignore the patient is to increase the loneliness in dying. Such loneliness creates the "stripping of one's identity kit" (Goffman, 1961:19-20), i.e. the loss of the feeling of belonging to a group. This loss of "belonging" became particularly evident after J.P.'s dismissal from the hospital. After a year's stay, he found that his usual friends visited him once and were never to be seen around him again. J.P. particularly missed previous invitations to go camping, going to drive-ins with his friends and the usual adolescent "kicks" that he formerly used to engage in with his friends. His frequent comment was "They're afraid of me." The situational adjustment observed here represents the creation of an "island of the self" by J.P. Since there are few people or situations
to which a dying patient can turn when he feels ignored by others, his main defense is simply to turn to himself for security.

A second use of props by hospital staff in order to keep a defense between the nurse and patient is to emphasize the medical equipment or the treatment routine of the latter. Such "material defense" is observed when concentration is focused on hypodermic needles, medication, meals on time, thermometers and baths. These props are used both by the nurse and the patient to avoid personal topics. Even the family uses props to avoid the patient's real future, as was observed when J.P.'s parents bought him a gun so he could hunt after his dismissal. (J.P. was eventually dismissed and was able to use it.) On the subject of material defense, Kneisl (1968) explains that

whatever the object, 'it' becomes the focus of attention, serving to screen the patient and his feelings and making it possible for the nurse to focus on manual tasks. The ritualized activities and routines of entering the room, feeling the pulse, taking the blood pressure, and giving the bath, subtly strip the patient of his dignity as well as his individuality. Frequent sedation takes the patient and his unacceptable behaviour (dying) even further away. (1968:552)

The stripping of the patient's identity can be related to Goffman's concept of "loss of identity equipment" (Goffman, 1961:19). The dying person is 'stripped' emotionally (and at times physically) of the suggestion of being treated as a human being. His worth may then well become less than that of the hypodermic needle. It should be of no
surprise to hospital staff that patients react with unacceptable behaviour. The patient is humiliated (probably unintentionally) and his lack of cooperation evidenced as a refusal to let the hospital use its props.

B. Suspected Awareness

The patient does not know, but only suspects with varying degrees of certainty, that the hospital personnel (and significant others) believe him to be dying. (Glaser and Strauss, 1965:47)

The hallmark of this concept is the patient's attempt to 'detect or elicit' signs which will confirm his suspicions that he is dying. These signs come in the form of cues, and the patient must learn how to "manipulate social cues" (Castaneda, 1971:35). In other words, how is the patient able to notice what cues are given about his terminality? The problem arises in his 'interpretation' of these cues: can it be that the patient is unnecessarily alarmed because of false interpretation?

The patient is alone in detecting and interpreting cues. He has no 'team' on his side. Rather the team is the hospital personnel, the staff and the family, all of whom keep informational control away from the patient. This 'team' must preserve its audience (the dying patient), as Goffman describes, from "acquiring destructive information about the situation that is being defined for them . . . a team must be able to keep its secrets and have its secrets kept." (Goffman, 1961:87ff) An important factor in interpreting cues is the patient's attempt to find out if he is in the
ICU (intensive care unit). In January, 1971, J.P. contacted pneumonia and was admitted to the ICU. Realizing his own nearness to death, he stayed awake all night and the following day for fear of dying, should he close his eyes. Even in this critical situation the real nature of his illness was never revealed to him. His query "Am I going to die?" was answered by "Have you asked your doctor?" This answer is apparently typical in many hospitals. Nurses are more often confronted with this direct question than the physicians. Since physicians say little about the patient's condition either to the nurse or to the patient, presumably it is the nurses who carry the brunt of stressful verbal interaction during which dying and death talk must be avoided. The physicians escape much of this stress since only brief visits are required for patients seemingly on the mend, hence talk is held to a minimum. (Quint, 1966:1569)

This 'runaround' that a patient is given when he makes oblique references to his dubious future is well exemplified in an anonymous quote from Glaser and Strauss (1965: 552)

Once upon a time a patient died and went to heaven, but was not certain where he was. Puzzled he asked a nurse who was standing nearby: 'Nurse, am I dead?' The answer she gave him was: 'Have you asked your doctor?'

The question that could be asked here concerns the 'rights' of withholding the truth from the patient. Should the patient be forced to accept the claim of not being told of his eventual death? Such a withholding of the truth produces a process known as "civil death" (Goffman, 1961:16) to the patient.
The loss of the right to know the truth about a patient's own future really "strips the individual from honesty" (Goffman, 1961:19). Once the patient sees that he is not being treated with honesty, it may result in a loss of winning over his trust. A personal experience occurred when I was reading Glaser and Strauss' (1968) book, "Time for Dying" and had carelessly left the book on the table. J.P. picked up the book and asked why I was reading such a book. My own reaction was to say that I was interested in ways in which people treated patients in hospitals (which I was, yet avoiding the real reasons, i.e. J.P.'s future).

The final point that should be made on the loss of rights in dying, is not only the fact that the patient is stripped of honesty, but he is "stripped of the right to live" (Goffman, 1961:19ff). Although the stripping of one's right to live may be internal and not caused by anyone, the ongoing mortifying process is that the individual is not supposed to have any idea of his sick status—i.e. he is not supposed to know when he will actually face the complete "loss of his self" (Powers, 1971:74). A reaction to this rebellion from loss of the self in dying was J.P.'s attempt to reinforce his suspicion by remarking, "Well, 'I'm' not afraid to die!"

The final part of suspected awareness lies in the psychological strain experienced both by nurses and family, and the patient. The nurses carry the stressful strain of keeping the patient unaware while he is in the hospital. This awareness is increased by making reference to a "future
biography" (Glaser and Strauss, 1965:34) as though to con-
vince the patient that he has a real future. But this strain
is even increased if the terminal illness is prolonged. In
J.P.'s situation, the strain has been in effect for over two
years. After a year of tests and operations in the hospital,
he has been discharged on the pretense that the operation
will help him to recover. On discharge there was real joy
among the younger family members who had not seen J.P. for
a year, since they were too "underaged" to enter the hospital.

The parents had been told by the physician that J.P.
would only live for six more months, but this information was
kept secret. Soon after the discharge, family members and
J.P. became aware that he was not getting better. J.P.'s
"proactive status" (Goffman, 1961:72) was much lower now than
it had formerly been. It was now clear that J.P.'s social
position on the outside was not the same as that prior to
entrance in the hospital. Although he would try to conceal
his past, the true situation would dominate. For example,
J.P. had once been an expert in canoeing. On a canoe trip
in August, 1971, he insisted on wanting to do the canoeing.
Contrary to his expectations, the skill was a thing of the
past. The reaction to this situation was one of anger for
J.P., who thought he had made a liar of himself. J.P. then
accused me of thinking he was a liar. The experience of con-
cealing one's past and trying to "pass" is known as stigmas-
tization" (Goffman, 1961:72). As a result, J.P. could not
conceal his past or his present. Only after several hours of
listening and offering suggestions as to reasons why people reacted negatively to J.P., did he attempt to show a cooling down of his bitterness against people (especially against his 'friends').

C. Closed Awareness

The situation . . . of 'closed awareness' context (allows) . . . the physician . . . to keep the patient from realizing or even seriously suspecting . . . his true status, (and) the problem is to maintain the context as a closed one. (Glaser and Strauss, 1965:29)

Since the physician has much power in a hospital situation, his reaction to the patient will most likely be followed by the staff and family. So if he chooses not to reveal the true nature of the patient's condition, others will follow likewise. The physician's major problem then lies in his explaining the "real truth" about administering more tests and treatments to the dying patient. During his year-long stay in the hospital, J.P. was continually subjected to painful treatments. It was never explained to him why these tests were being given. The usual stereotyped response to his queries was "We give these tests to everyone.", which J.P. came to believe was true.

The multitude of therapy, painful tests, and surgery soon created anxieties which I will refer to as "fear of physical integrity." (Goffman, 1961:21) It is interesting to note that, in a hospital situation, the patient has little say concerning the tests he has to take, nor is he given true explanations for them. The patient is mortified particularly
in terms of the lack of any solid guarantee from the staff that his physical integrity is being preserved. At any time, he can be subjected to a whole battery of tests and therapy.

Hospitals are very successful in "contaminative exposure. . . (through) . . . violation of one's informational preserve regarding the self" (Goffman, 1961:31). The self can be mortified when supposedly confidential information about the person's past is brought up in conversation. Mortification occurs when the patient knows that information about his condition can be observed from dossiers by physicians, nurses, secretaries and his family, but is continually withheld from him. The individual can also be mortified by "physical contamination and interpersonal relationship" (Goffman, 1961:28). When J.P. was subject to exposure for medical and security examinations, he seemed to react with the mortification of embarrassment from 'physical contamination'. A third "contaminative exposure" known as "experiential mortification" (Goffman, 1961:35) refers to the witnessing of physical assault upon someone to whom one has ties. Although this mortifying situation usually refers to one patient witnessing shock therapy to another patient, this concept of experiential mortification may be applied to parents and nurses. Here the parents know their child's eventual future, yet they feel unable to do anything about it. Nurses experience this "experiential mortification" in as much as they are unable to help the patient by revealing the truth or by providing the necessary emotional comfort. This
process of mortification is greatly intensified in the case of a young patient whose dying may be seen as a great loss, because of potential asset to the family.

A final effect of closed awareness in terms of suspicion is the fact that the patient is highly motivated to recover, but in reality will not. Although J.P. knew that his brain surgery would be painful and dangerous, he was inspired to recover. This high motivation even helped to cheer up those relatives and friends who knew that J.P. might not even recover from the surgery. Thus a dying patient, by being kept in a closed awareness context, can help reinforce the significant others. This fact does not, however, excuse the other processes of mortification of the patient's self while dying.

D. No Awareness in Dying

This happens in the case of sudden, unexpected death. The person involved might be an accident victim, or a patient who was expected to recover but dies suddenly, e.g. on the operating table, or from a sudden heart attack. The main problem in the "no awareness" context is when the family of a recovering patient comes into the hospital to visit the patient and finds that he has suddenly died. This knowledge can be quite upsetting for a family and a scene in the hospital usually follows. Some doctors have noted that such patients who died suddenly when they were expected to live, had facial expressions of surprise and hate.
E. Open Awareness in Dying

I have not included the "open awareness" context as part of the typology of Suspicion in dying. Since 'open awareness' refers to "whenever both staff, (family) and patient know that he is dying, and acknowledge it in their actions (Glaser and Strauss, 1965:80) there is no suspicion. I will touch on this topic since open awareness may be complex and may affect each patient differently. Furthermore, at any time in the suspicion context of dying, "open awareness" may occur. But even in this "open" context there are instances where the dying individual's self in open awareness is subject to "appropriate ways of living".

Norms prescribe appropriate ways of dying. These norms assume importance irregardless of whether the patient wishes to die in certain ways: without pain, for instance, with dignity, or perhaps in private (Glaser and Strauss, 1965:80). In the case of "open awareness", the patient is responsible for his acts in dying. When a patient chooses to act in a certain manner while dying, there usually is the problem of a "disruption of the usual relationship between the individual actor and his acts" (Goffman, 1961:35). This disruption occurs when the dying individual chooses a manner of dying that is appropriate to him and not necessarily appropriate to others. For instance, a dying patient who is angry complains much. If he cries loudly, he is considered a "difficult" patient and may be finally isolated. The patient may react to dying in his own "normal" way. If the patient
can choose to die as he pleases, then his apparent rebellion or difficult behaviour may be a reaction against the medical institution which denies him his right to die as he pleases. Hospitals as

total institutions disrupt or defile precisely those actions that in a civil society have the role of attesting to the actor and those in his presence that he has some command over his world— that he is a person with 'adult' self-determination, autonomy, and freedom of action. (Goffman, 1961:43)

Dr. Elizabeth Kubler-Ross discovered that mostly all patients whom she informed of their impending death reacted through denial: "No, it can't be me. It's not possible." (Kubler-Ross, 1971:56) But eventually the patient learns to accept his true status. What happens then is that it is incumbent upon the hospital staff to make the required effort to change the dying patient from the denial stage to the acceptance stage. One way of minimizing this shock and denial would be to have a different view of dying in society. If the dying process were more acceptable, the hospital staff could become more sympathetic to the ways individuals have chosen to die.¹

A strong reaction against people choosing their own way to die is seen in suicide cases, victims of gang fights and drunkards. Some physicians will express their displeasure with such persons by saying "If he gets well, he'll probably do the same thing next week." Nurses tend to refer to such styles of dying as saying, "Oh well, he was a difficult person anyway." Hospital norms toward dying, better known as
hospital "house rules" (Goffman, 1961:48) are related to strong codes or standards expected of the patient. When the patient is dying, regardless of whether he knows his real status or not, his behaviour is subject to strong standards from hospital personnel. Positively viewed are such criteria as having a "cheerful" behaviour, being "nice", participating in the ward's social life; in other words conforming to "an acceptable style of living, while dying" (Glaser and Strauss, 1965:86). It is unfortunate that the reverse could not hold true. The hospital staff might treat the patient with the dignity and respect when dying as he was entitled to when living. Staff expectations assume that in practice the patient must not remind them that they someday when dying may in turn also be mortified by others.

"giving up"

On dismissal from the hospital, patients have a tendency to "give up". They may feel that there is little hope for the future, or they may know they will in all likelihood die soon. Since they have a limited, or no future, they are not expected to have goals. Goals are closely associated with rewards, so it would follow that if there are no goals in a person's life, there should be little or no rewards for him. The absence of this "privilege system" (Goffman, 1961:51) can result in a "giving up" stage for the patient. J.P. had shown this "giving up" especially when he found all job opportunities blocked for him because of his past medical
history. The high school system would not accept him on the informal grounds that he was a risk because of his illness, and that, besides, he would probably have trouble adjusting to the school system. (It should be mentioned that before J.P.'s admission to the hospital, he had won top honours in the school for his academic year!)

"negotiations"

A person who has "open awareness" of his true dying status reacts through denial and anger in the first stages. In the last stages, he accommodates with bargaining and acceptance. The stage of bargaining occurs both in the hospital and in civil life. The patient may negotiate with the nurse to delay baths, to have access to previously denied food. He may make such statements as "I'll eat if you promise to stay here awhile." It should be noted that negotiations can occur even in contexts of closed awareness and suspicion awareness. But these are more difficult to detect. It is in the context of open awareness that the patient makes these clear.

Outside the setting of the hospital, the bargaining stage can take place through the form of negotiations through religion. The rationale usually takes some sort of saying that "If God has decided to take us from this earth and he did not respond to my pleas, he may be more favourable if I ask nicely." (Kubler-Ross, 1969:72) Once J.P. had been dismissed from the hospital with little hope of recovering, nego-
tations began with God. At first the parents would mention
that God was punishing them for something they might have
done. When that apparently failed, the father became very
bitter against God and his Catholic religion. Religion seemed
to be the only comfort remaining, but that had failed as well.
Finally, on my own trip to Canada's east coast in August
1971, J.P.'s parents asked if I would bring him to a "faith
healer" in Montreal. But doing this only proved to be another
loss of hope.

At the time of this writing, negotiations have ended and acceptance of the dying situation by the parents seems to be the last turning point.

II. Secrecy and Dying.

The second situational adaptation which is based on norms regulating behaviour and communication with the dying individual is known as secrecy. The secret of one individual is acknowledged by another and it can be intentionally or unintentionally respected. However,

the intention of hiding . . . takes on a much greater intensity when it clashes with the intention of revealing. In this situation emerges that purposive hiding and masking, that aggressive defensive, so to speak, against the third person, which alone is usually designated as secret.
(Wolff, 1950:330)

The secret is therefore a direct intention of hiding realities by negative or positive means. Even if one of the two parties is not aware that a secret exists, the behaviour of the con-
cover is affected by it. The application of secrecy to
dying has the sociological consequence that it may be revealed to the one who is dying. The concealer must modify his behaviour in his interaction with the dying person. This modification occurs primarily because it is considered a fault against the other person holding the secret if it has been revealed to the third person—i.e. to the dying person. As a consequence of this behaviour modification, the persons holding the secret have to conceal their best when in the presence of the one concealed against. As a result, the concealer approaches the dying patient in various ways: the physician does not tell the patient the true nature of his illness thus causing the individual to be "stripped from honesty". The nurses must give the patient a "runaround" treatment when referring to his oblique future, or they must use props to help them conceal the secret of his future. The individual can soon feel that he is "stripped emotionally and physically" from the dignity of being treated as a human being, producing a "loss of identity equipment". The family who conceals this secret from the patient also acts as a team who is preserving its audience (the dying patient) from getting knowledge of his situation.

The next section will deal with some of the rationales that people employ for keeping the secret of dying and the effects this secrecy has.

i) Betrayal:

The secret holds a tension that should someone
reveal it, the other holders of the secret would be betrayed. In dying, the tension remains among the nurses in not telling the patient the reality of his illness for fear of reprimands from the physician, hospital staff, the family and the patient. The physician faces the tension of fearing the patient's shock upon the knowledge of his future. The family is under an obligation to support the patient emotionally. The tension here is not to upset the individual emotionally, but rather to make his last living days as comfortable as possible. Revealing the secret to him could lead to an upset, thus betraying the family members who wanted to preserve this secret and provide emotional comfort instead. However, the patient may find himself abandoned from his family and friends especially when his dying is prolonged. The sociological significance of the secret in these examples is the temptation to reveal the secret, a revelation causing betrayal.

ii) Protection:

As soon as information becomes a secret, the reaction to the secret is to protect it. If the doctor has knowledge that the patient is going to die for sure, he is very careful about the persons to whom he tells the truth. The relatives also are careful about persons being told. For example, J.P.'s parents did not reveal the knowledge of J.P.'s future to their own children at first. They first told other relatives, who then "passed" the word, trusting each other to protect the secret from being made known to J.P. himself.
Protection of the secret that someone is dying requests that all members honour this confidence once they become its recipients.

iii) Sociation:

Not only must a secret be protected from disclosure, but it must be protected from certain contents.

Here, secrecy is its own sociological purpose: certain insights must not penetrate into the masses; those who know form a community in order to guarantee mutual secrecy to one another. (Wolff, 1950:335)

All those who share the knowledge of the secret are supported psychologically against the temptation of disclosure. Sociation must isolate and individualize acts against the one who is having the secret concealed. The patient can find himself isolated into a room based on the rationale that he can receive better care, but it may as well be an act to prevent the patient from knowing his real situation which is nearness to death. The focal point of sociation is the fear that someone may become "weak" and reveal the secret to the individual about his nearness to death.

iv) Freedom:

In as much as the structure of North American society contains the element of democracy, such a society values a measure of freedom. Unfortunately, the element of freedom in dying prescribes that members involved with the dying person have freedom to set norms for their behaviour toward the dying individual. Yet, the freedom for the in-
individual to choose his dying behaviour is not respected. Dying people are expected to die by the "proper style of dying". Therefore, people concealing the secret of another's dying justify it by their claim to the right of freedom to do so, not respecting the dying person's right to know his real status nor acknowledging his right to die as he pleases.

III Meaninglessness in Dying

1. Meaninglessness to others and the patient:

We live in a society which focuses on youth and health so that a dying person is a reminder that youth and life are not to last forever. As a result, few people who must associate with the dying can "be comfortable in the presence of someone whose dying forecasts their own future." (Mervyn, 1971:1988) Although people find that they cannot be comfortable in the presence of those dying, the reality that death will happen cannot be ignored. Moreover, the reality that the individual must live while dying involves a recognition that dying is not only a biological but a psychological, spiritual and social event as well. Consequently, others prefer to withhold the knowledge of death or even the awareness of it from a dying person. To his dismay, the patient experiences attempts of others to prevent him from discussing his thoughts about death with anybody. It relegates all relationships to the superficial and meaningless. (Kneisl, 1968: 552)

The breakdown of these relationships is referred to as "role
dispossession" (Goffman, 1961:15) since his present role of
dying blocks meaningful interaction. The converse results
in a conspiracy of silence rules, or rather his "deference
obligations" (Goffman, 1961:17) to hold his peace. The
individual is left so to say, "on his own" to make it to the
end of his dying experience.

These negative responses to the social process of
dying have removed all social worth of the individual.
Kalish (1968) has defined

social death as the individual's perception that
he is "as good as dead", that his social role
has ceased. This type of perception appears to
represent a form of anomie, the feeling of isolation
and meaninglessness which the individual tends to
experience when he is not a member of any cohesive
group. (Durkheim, 1951, in Crane, 1970:318)

This "stripping of one's belonging group" is
mortifying to the individual since he has not chosen to be a
member of the dying status, nor does he have many defenses
against this isolation and meaninglessness. What the person
has to do is to choose a behaviour which he believes will be
acceptable to others. Seeman (1958:786) suggests that when
"the individual is unclear as to what he ought to believe... he
cannot predict with confidence the consequences of acting
on a given belief." Consequently, a "situational withdrawal"
(Goffman, 1961:61) may result when the patient balks and holds
his silence, or the converse, he may choose a behaviour whose
norms are not "appropriate to the style of dying" (Glaser
and Strauss, 1965:86). Whatever the individual's choice in
his behaviour toward dying may be, the final outcome results in high alienation.

In the dying context, there may be high meaninglessness when the person has no norms by which he can behave toward his end, especially because he is not expected to have any end other than that of his death. If there are no prescribed ways for his behaviour, almost any type of behaviour will be looked upon as unintelligible. The reactions to the dying person's behaviour which have been discussed as producing a "mortification of the self", actually alienate the individual from all those who must interact with him.

2. The ideology of dying and meaninglessness:

With advances in technology, it has become increasingly difficult for the patient to die with dignity. His life may be prolonged unnecessarily with machines, or he may be subjected to painful tests and treatments for the sake of research purposes. The key factor in the ideology of dying is that the person has no freedom in determining his dying. Marcuse (1959) suggests that

man is free only if he has conquered his death; if he is able to determine his dying as the self-chosen end of his living; if his death is internally and externally linked with his life in the medium of freedom. (1959:66-67)

No matter how free a society may think itself to be, a man within it is never free as long as death has not become really "his own", that is, as long as it has not been under his own autonomy. It is not surprising then to note that patients remove needles and tubes or eventually commit suicide. The
meaninglessness of an individual's freedom to choose the manner of his dying and eventual death will remain as long as the individual feels "powerlessness" (Seeman, 1958:784 and Marcuse, 1959:76) in his final choice in respect to his life.

**Conclusion of Suspicion in Dying**

A person's dying status involves interaction and knowledge of "who knows what", both by the patient and significant others. The combinations of who knows what are known as awareness contexts. As soon as significant others become aware of the patient's dying process, interaction between both parties is increasingly difficult. The difficulty in interaction in the dying process lies primarily on the individual's future. Because he is dying, he is not expected to have goals in life, thus limiting communication oriented toward future goals. Since the process of dying is seldom talked about openly, suspicion becomes the major criterion in observing patterns in dying. Observations of dying patterns in the suspicion context include (1) the suspicion of significant others that the patient may or may not suspect his status; and (2) the suspicion of the dying person that others may or may not suspect that he is dying.

The awareness context used to observe suspicion is grouped under the following heading:

(a) **mutual pretense awareness**: both others and individual pretend that the other party does not suspect.
All parties pretend that the patient is going to live. Interaction with the patient takes the form of a "make-believe" game with the involvement of future-oriented topics. Interaction usually leads to abandoning or ignoring the patient, which in turn leads to withdrawal and loneliness for the patient. Loneliness results in the patient's reaction of keeping silent. This indicates situational withdrawal, which might be seen as a form of situational adaptation.

What interaction there may be simply involves putting the patient into the "part of not-dying patient". Such a form of pretense uses props to avoid patient-oriented interaction. Impersonal treatment creates a "stripping of one's identity kit", with consequent "loss of identity equipment". The patient reacts in terms of unacceptable behaviour, which is seen as a refusal to let the hospital continue its humiliations upon him.

(b) suspected awareness:

(i) others do not suspect that the patient knows; and (ii) the individual suspects that others know.

In suspected awareness, the patient must look for cues and try to interpret them by himself. Cues may be expressed through the use of "runaround" answers to queries from the patient, especially those referring to his dubious future. The truth is withheld from him, thus producing a "civil death" for him. He is stripped of honesty and his "right to live". He rebels. This rebellion can as well be rebellion from the fear of the "loss of self" in dying.
Finally, the nurse is under a strain to avoid the individual's true illness by making reference to a future biography. The family is also under strain to perpetuate a display based on the member's awareness. For the individual concerned, strain causes him to experience "stigmatization", once he realizes that he can no longer conceal his past or his present.

(c) closed awareness:
(i) others suspect his death;
(ii) individual does not suspect his own death.

Closed awareness in dying focuses mainly on others showing that they are preventing the patient from suspecting his true status. Although others can successfully keep the patient in a closed context, this does not disregard the fact that he may be suspecting or may even become openly aware of his status. In order not to tell the individual the truth, he is subjected to anxieties created when he is given vague explanations for extra tests and treatment. This anxiety causes a "fear of physical integrity" since the patient has little say concerning acts done against him in a hospital.

Three types of "contaminative exposure" found in a hospital situation are present in and out of medical institutions:

i) violation of one's informational preserve is present when all but the patient himself can view his status;

ii) physical contamination in interpersonal relationship and exposure to both sexes for medical reasons;
iii) experiential mortification, others seeing a person close to them being subjected to physical "assault" and not being able to do anything about it.

Finally, closed awareness can be a strong moral support for the family and nurse in terms of the patient who may look upon his status more optimistically, since he is not openly aware of it.

(d) no awareness: neither others nor individual suspected sudden death.

(e) open awareness: both staff, family and patient know that he is dying and acknowledge it in their actions.

Open awareness can occur at any time in "suspicion in dying". Both the patient and significant others know that he is dying. Hence there is no suspicion once "open awareness" occurs. Open awareness can also produce mortification of the self for the patient, if he does not conform to staff expectations about "appropriate ways of dying". There are strong norms prescribing "an acceptable style of living while dying".

Open awareness can cause seven stages in dying: shock, denial, anger, bargaining, depression, acceptance and detachment. Each stage can occur in different orders, can overlap each other, or may last longer depending on the person dying. The usual sequence of these seven stages is that order in which the well-defined stages are set down above.

A suggestion would be to give patients a chance
to talk more openly about their dying. On the subject of telling patients the truth, Dr. Kubler-Ross states that she does not think any patient should be told that he is dying. He will tell you that when you dare to listen, when you are able to hear it. (1971:56)

The whole context of suspicion in dying requires situational adaptations or adjustments both by the patient and significant others. People react in different ways to the dying individual's status. These reactions can produce processes that mortify the self of the dying patient. There are also advantages and disadvantages in keeping the patient in closed awareness, as it follows that the same effects can result from an open awareness. Suspicion in dying can be minimized, including the mortifying processes of the self, mainly when significant others can treat the dying person with dignity and accept his right to choose his own appropriateness of dying while he is living.

**Summary of Secrecy in Dying**

Secrecy is the intention of hiding realities by negative or positive means. In the social process of dying, the hiding of realities usually takes the form of negative means exemplified in the behaviour and interaction of significant others with the dying individual. These negative means are seen as isolation, abandonment and loneliness for the patient. Rationales for keeping the patient in secrecy are based on:
1) betrayal: that all those holding the secret do not reveal it for fear of consequences to the individual;

2) protection: secrecy involves confidence, forcing people to protect the secret because of the element of trust;

3) sociation: the psychological support to all those holding the secret against the temptation of disclosure. As a result, the patient may be isolated, not so much for better care, but rather to reinforce the preservation of the secret;

4) freedom: those holding the secret hold the right to follow norms prescribing their behavior toward the dying person. This freedom does not recognize the person's right to know the nature of his illness.

In conclusion, secrecy is an important sociological factor in society. There are prescribed norms regarding secrets and their preservation. Unfortunately, in dying, the effects of secrecy unintentionally mortify the dying person's self because of the behaviour from significant others toward the latter in trying to conceal the secret. Some instances of mortification of the self caused from secrecy in dying are "stripping from honesty" and "loss of identity equipment" and "stripping from the right to live".

Finally, in relation to suspicion in dying, "groups which make it their principle to conceal themselves the suspicion that their secrecy hides dangers is all the more readily suggested." (Wolff, 1950:376) Therefore, in four awareness contexts in suspicion in dying, (exception: open awareness) secrets are actually used by groups to hide the
potential danger or adverse reactions which could result from revealing the secret of dying.

Summary of Meaninglessness in Dying

Meaninglessness in dying is closely associated to the supposedly meaningless goals which a dying individual is considered to have. As a result, the concept of "social death" perceives the person as not belonging to any cohesive group but rather he is subjected to isolation and meaninglessness. This subjection exemplifies itself through lack of interaction and abandonment with the patient, usually resulting in negative effects which mortify the individual's self. As a result, the patient is alienated from significant others since he has no prescribed norms to determine the appropriateness of his dying behaviour.

Finally, the only way to lessen meaninglessness and powerlessness in dying is to allow a person to have the freedom to choose the manner of his dying and eventual death.
1 Hospital staffs, doctors and nurses are now being urged not to cut the dying patient adrift. Concentration is focusing not only on the care of the physical aspect of dying in hospitals, but as well with continued social contact. (Katz, 1972)
CHAPTER IV

CONCLUSION OF THEORETICAL PERSPECTIVES IN
THE SOCIAL PROCESS OF DYING WITH
IMPLICATIONS FOR FURTHER STUDY

Conclusion of Theoretical Perspectives in Dying

The dying patient has no goals in life because his life has no future. Because of the meaninglessness in his anticipated future, the patient has no social value. The combination of his social characteristics determines the social loss of the individual only from the point of view of the anticipated future. Attitudes toward people who have no future-oriented goals are exemplified by behaviour which mortifies the dying person's self.

Behaviour towards the dying person is based on the sociological perspective that dying is a secret shared by people who know the real nature of the patient's status. Secrecy holds the values of confidence and betrayal, to the extent that the secret will or will not be disclosed. Dying, then, as a secret, is perceived through an "awareness context" of who knows what. Since the secret is usually not disclosed by those who conceal it, these latter can only suspect whether the patient knows the actual reality of his anticipated future. Suspicion in dying involves five awareness contexts, those of (1) mutual pretense awareness; (2) suspected awareness; (3) closed awareness; (4) no awareness, and (5) open awareness. Each awareness context in suspicion can cause mortification
of the self in dying, although it was observed that it is not always feasible to put the patient in an open awareness context.

The sociological perspective pursued here is to generate substantive theory about the social process involved in awareness of dying. In the analysis of social activity in the process of dying, the researcher is challenged by internal complexities in the phenomenon itself. Dying as a process not only involves a sequence of steps over time. It is furthermore considerably hindered by the lack of "knowledge for sure" of who knows what in dying. The sequence of steps over time suggests that the phenomenon of dying involves role change of the person who is dying and in those persons who have close contact with him. Therefore, the methodology chosen as the research method must involve a theoretical perspective that allows the researcher to actually carry out an activity in everyday life.

Ethnomethodology suggests the possibility of researching a "methodical social activity" (Churchill, 1971: 183) as actually carried out by persons. Since ethnomethodology relies on the knowledge that the methodologist has learned about his own culture, then such a methodology would be quite appropriate to study a social activity in a familiar social setting. Ethnomethodology focuses not only on the phenomenon under study but rather on the effects of social activities on the phenomenon.
In order to generate substantive theory in research, I have introduced the notion that dying as a role involves changes in a person's status. This concept refers to Glaser and Strauss' theory of "status passage" (1971). The ethno-methodological process has included the criteria that:

a) dying is active and subject to change;

b) there are norms-in-use (Churchill, 1971:184) which refer in this study to the norms which people must adapt to for their conduct toward the activity of dying; and

c) the reactions of others to a dying person's status involve their cooperation with each other to maintain those norms to which they have adapted.

The model suggested in this research involves analyzing the status of the patient during the process of dying, in terms of a status passage from a given prior status to a status of no social value. Measurement is viewed as a representation of the products or effects of social activities as represented in the model. These quantitative measures include the processes that could be observed in terms of what produces abasements, degradations, and humiliations of the self in the process of dying. The indicator variables are based on the theory of "mortification of the self" as analyzed in social situations such as hospitals, public places, educational institutions, religion and kinship. A comparative analysis has been made of the changes in status of the dying person in each social situation.
Dying in Terms of a Status Passage

Dying, as conceptualized in terms of status passage includes such properties as:

(i) being an undesirable and involuntary status, i.e. an individual usually does not choose the dying status and for the greater part of persons, it is a status that is desired by few.

(ii) its actual time of occurrence is unscheduled, i.e. the dying status usually is not planned and occurs to any individual, regardless of age, sex, social class, place and time.

(iii) the sequence of steps occur over time, i.e. temporality in dying has to do with matters such as speed, the pace of the process, the steps of adjustment both by the patient and significant others.

(iv) the reactions of all those involved in terms of the important elements of suspicion, secrecy, and meaninglessness, i.e. the circumstances in dying which imply all the social effects caused from the phenomenon of dying.

Status passage includes such notions as dying "takes time", and "evasion of the truth". As a result, the variable properties have included such aspects as mentioned by Glaser and Strauss (1971:9ff).

(a) "the degree to which the signs are disguised":
(in the 'awareness context', the patient's impending dying status is usually not revealed to him, leaving him to suspect his real status on his own.) Processes that produce mortification of the self are known as "civil death", an unfavourable "proactive status" causing "stigmatization". "fear of physical integrity", and the loss of a "privilege system".

(b) "the clarity of signs which are available to the various participants": (what may appear to be causing mortification of the self such as 'situational withdrawal' may well be situational adaptation to the dying status). Here there is the problem of a "disruption of the usual relationship between the individual actor and his acts" especially when the dying person cannot have control over his "style of living while dying".

(c)"the amount of control which the participants, including the patients, have over aspects of his passage": (the patient is found to have little or no control over his dying status. Rather it is the hospital personnel and often the family, who determine control over the manner of his dying, as viewed from the doctors' and nurses' reactions to the patient; the length of visits and interactions; isolation and abandonment from others). Mortification of the self is produced through "stripping
of one's identity kit","loss of identity kit","stripped of the right to live", and "contaminative exposure through violation of one's informational preserve regarding the self."
(d) "whether the passage is traversed simultaneously by multiple patients or he alone is dying"; (it was observed how dying occurs as a solo passage, i.e. the individual seems to be the only one who shares the eventual loss of his self. This is found to be partly due to the suspicion context that the patient is usually kept in.) Supporting literature states that dying patients share the same experiences in dying but are not prone to discuss them. (Quint)
(e)"the potential undesirability, reversibility, or arrestability of his passage":
(i) **undesirability**: an inevitable passage such as dying, is intensely undesirable for everyone, resulting in a need for those people close to the passage to feel the need to be released from involvement, (such as was found in nurses avoiding conversations with the individual; friends and relatives disappearing, fading away or simply becoming inattentive). An exception to undesirability other than suicide is usually found in the situation where a patient is suffering for a long time. In
this case, those involved such as the family and physician, may desire the dying to be speeded up.  
(ii) reversibility: it was mentioned that the dying status is for most patients inevitable and undesirable. When a patient's illness is prevented or reversed such as when he regains his health, his status passage is reversible. However a terminally ill patient does not have a reversible passage.  
(iii) arrestability: linked to reversibility is the status passage that can be arrested or blocked. Some statuses can be stopped, such as leaving work to go back to school. But in dying, this status passage can be arrested periodically, but it is a status that continues in the man's life until of course, the individual passes to his next status, i.e. his death.  

The status passage in dying also includes relevant passages such as:  

(a) Stages in dying: the series of well-defined stages in dying are: shock, denial, anger, bargaining, depression, acceptance, and finally, detachment.  

(b) Appropriateness in dying: the norms that prescribe appropriateness in dying favour the significant others rather than appropriate behaviour for the dying individual.  

(c) Suspicion in dying: this involves five awareness contexts which shift the individual who is dying from various passages in his dying trajectory. These passages are
those of mutual pretense awareness, suspected awareness, closed awareness, no awareness, or open awareness. Although an individual usually does not pass through all five contexts, he usually experiences several such passages. It was found to be that the social effects of the awareness contexts were those of mortification of the dying individual's self.

(d) Secrecy in dying: closely related to suspicion in dying is secrecy; i.e. hiding realities from the individual. The person finds himself in a state of anxiety, never knowing who is telling him the truth. Other sociological perspectives in secrecy include: betrayal, protection, sociation, and freedom.

(e) Meaninglessness in dying: meaninglessness in dying is closely associated with the meaninglessness in goals which a dying individual is considered to have. The result is the passing from social worth to "social death" of the person, i.e. perceiving the person as not belonging to any cohesive group.
Implications Based on the Research

Social and medical scientists alike have no scientifically agreed on definitions of death and dying. Dying and death must be seen in the context of a continuum, i.e. the organism as a whole dies progressively and continuously. Although the physical organs of an organism may be dying, it does not follow that the social aspect of the individual need do so. Both the physical and social aspects of dying need individualized "treatment".

There need be a learning for all those involved with the dying, that we must desist from many useless technological interventions and institutional practices that deny to the dying what is most owed them-- keeping company with the dying and helping them to cope with terminal illness.

The ethic of allowing a person to die includes such interests as protecting his dignity and right to a good death against the onslaught of machinery and institutionalized loneliness. However, the ethic of allowing a person to die based solely on the consideration of the welfare of the dying patient himself, must bear as well the costs and benefits to relatives or society. Society has to agree on whether "life is incommensurable with the cost of maintaining it".
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