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AN OUTLINE OF THE STUDY OF THE SOCIAL MEANINGS OF DEATH IN MODERN HOSPITAL[1]

1. The research task

The aim of the research is to find out the social meanings of death in hospital, seen from the point of view of the staff. This is to say, an effort is made to describe how the hospital staff sees and experiences death and dying, and to analyze where this specific way of experiencing stems from.

The approach to the social meanings of death in this study is ethnomethodological-phenomenological. The phenomenological tradition leads us to describe the interpretative schemes, through which death and dying get their meaning in hospital. According to the phenomenological analysis, no experiences are meaningful in themselves. Our experiences get their meaning only when we "return" to our experiences and explicate them with the help of our former experiences, stored as interpretative schemes [see Schutz, Luckmann, 1973, p. 16; Luckmann, 1983, pp. 75-76]. The interpretative schemes related to death and used by the hospital staff could be called, following the ideas presented by Schutz and Luckmann [1983], the staff's social

[1] The aim of this paper is to outline the approach applied, and the central results received this far, in a sociological study of social meanings of death in modern hospital. The study is carried out by me at the University of Tampere, and it is tutored by Professor Seppo Randell. The study has been going on since August 1986.

stocks of knowledge related to death. Thus the research task, seen from the point of view of the phenomenological sociology, is to describe them.

The ethnomethodological tradition points to the ever ongoing process of production of meanings. The starting point in ethnomethodological ethnography is, as Robert D i n g w a l l [1981, p. 134] puts it, "the question of how the participants in some event find its character and sustain it, or fail to, as a joint activity". The character of the events is not pre-given to the people participating in them. The character is defined by people themselves, as a joint activity. This activity takes place within the flow of events, or more precisely, it is part of the events themselves. Anthony G i d d e n s [1986, pp. 238-241] has adopted this perspective in his theory about the constitution of meaning: "The sense of words and the sense of actions do not derive solely from the differences created by the sign codes [...]. They derive in a more basic way from the methods which speakers and agents use in the course of practical action to reach "interpretations" of what they and others do" [G i d d e n s, 1986, p. 538]. Following the policies of ethnomethodological ethnography, I will try to describe those activities, through which the members of hospital staff find and sustain the meaning of death.

The research is based on an ethnographic field work. Active field work lasted six months. I spent almost the whole working days and weeks at three wards of a Finnish university hospital. My role as a researcher was evident to everybody at the wards; the staff was informed about my topic being death and dying, but the patients were told only that I was doing research on the interaction between the staff and the patients. I recorded everyday occasions and talks in my field notes. Besides that I also made and tape-recorded 25 unstructured interviews with the staff members.

2. Some preliminary results

2.1. The social stocks of knowledge related to death

During the fieldwork, and while reading through my field notes and the interviews, two different layers of knowledge related to death took shape. The layers are 1) moral and cognitive principles, 2) symbols.

Both layers take part in the constitution of the meanings of death in hospital. They refer to concepts used by the participants, i.e. the hospital staff. In other words, they are not constructions made by the researcher (cf. Hammersley, Atkinson 1983, 178). But their grouping as separate layers and their explicit formulation is naturally done by the researcher.

2.2. The moral and cognitive principles

The fundamental layer of knowledge related to death is composed of a number of moral and cognitive principles. These principles from an underlying pattern, reflected in the everyday talk and other activities at the ward. A novice in hospital - whether a new staff member or an ethnographer - learns this underlying pattern step by step while participating in conversations and action [cf. G a r f i n k e l' s analysis of the documentary method of interpretation, in Garfinkel, 1967, pp. 76-193]. The events related to death are then interpreted in the light of these principles.

My formulation of the principles consists of twenty items. It is evident that if somebody else were doing this research, he would explicate the principles in a slightly different way. This is due to the fact that the explicit formulation is done by the researcher; in themselves the principles are for great deal something tacit and taken for granted [cf. G i d d e n s, 1984, pp. 21-23]. My formulation of the principles is the following.

1. **Postponing death.** This principle is an assumption about the role of the hospital and hospital staff in relation to death

and dying. It is used in making decisions. The core of the principle is that dying is something to be avoided. It is the hospital's task to keep people alive.

2. **Death as a result of underlying, identifiable physical processes.** It is taken for granted that processes taking place in the patient's body before death are continously defined with the help of medical knowledge and facilities. The most important definition, the diagnosis, is followed by a continuum of minor definition and assesments based on daily examinations and tests. The "cause of death" is always identified. The final conclusions are usually drawn after reviewing the results of the autopsy. The physicians have the active role in producing the definitions, but everybody working at the ward uses them in interpretation of the patients' situation.

3. **Time of death as an object of professional knowledge.** Both in discussions related to the decisions about the treatment, and in everyday talk, the staff is supposed to be aware of the coming death of the patient. The patient's and the family's awareness of the death is regularly assessed[2]. There is a vague norm obligating the staff to inform the patient and the family about the coming death.

4. **Dying patient as an object of active intervention.** It is taken for granted that the hospital staff, using various facilities at hand, intervenes the body and also the mind of the patients. Forms of physical intervention aim at postponing death, gaining knowledge about the physical processes in the patient's body, and at the alleviation of pain. The intervention into the mind of the dying patient takes place through the use of consultative techniques, the purpose of which is to help the patient and his family to come to terms with the approaching death. The use of these techniques is quite incidental, in comparision

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[2] G l a s e r and S t r a u s s [1965, pp. 29-106] have used the notion of "awareness contexts" - different combinations of patient's and staff's awareness about the coming death - as a guiding idea of their work. My observations show that the idea of awareness contexts is not primarily a professional sociological construction, but a part of the staff's stock of knowledge.

with the systematic and definite character of the physical intervention.

5. **Minimizing the suffering.** When talking about and giving reasons for what they do, the staff members use as a measure the idea about minimizing the suffering of the dying patients and their families. E.g. when a nurse is reporting me her ways of acting with a dying patient, she is pointing to how her doings alleviate the mental suffering (the negative feelings, see principle 9) of the dying. And when assessing the decisions about witholding active treatment, a relevant argument is whether the treatment cause a lot of suffering.

6. **Close contact with the dying.** When discussing with me about the dying patients, the staff members regularly made references to the patients' need of close and intimate presence of other people. It is seen as a task of the staff members to be close to the dying. Speaking with the dying patients about their feelings and thoughs is defined as an important aspect of the care.

7. **Distance from the dying.** This principle is in a close contact, and in opposition, to the preceding one. It was often said by the staff that one could not stand this work if one were involved with the feelings of the dying patients and their families. You have to keep distance between yourself and the patients, between your private life and your work. I was told several times how those working in the hospital forget the patients immediately when leaving the ward; only exceptional deaths are remembered at home.

8. **Primarity of the everyday practical affairs.** The everyday practical affairs - nursing care and medical examinations, giving the medicine, washing the patients, helping them to empty their bowels, and so on - are given primarily in the course of the everyday activity at the ward. Accomplishing these tasks composes the rhythm of the working day. The everyday practical affairs determine for a great deal which of the patients get a special attention in the staff's talk; it is those who require most treatment and other measures. When talking with the patients the staff members usually concentrate on current practical issues.

9. **Death as a source of negative feelings.** The staff takes it for granted that the dying patients and their families have strong feelings of grief, anxiety and sorrow. A vague developmental scheme was used very often when talking about patient's or family mambers' feelings: the stages of denial, depression, anger and the like are seen to follow one another[3]. The staff members themselves are also supposed to have feelings about the death of their patients; but on the other hand I was told several times, with regret, that actually one does not feel too much when somebody has died. When patients or their families behave in a strange way, e.g. a patient withdraws from interaction with the staff, or the family members a deceased patient are aggressive towards the staff, this is often interpreted in the discussions among the staff as an indication of hidden feelings about the death. This model of interpretation is sometimes used also about staff members: the reason for their troubles may be the repressed bad feelings caused by the death of the patients.

10. **Avoiding dramatic scenes.** The staff handles the situations of death and dying in a detached manner, avoiding expressions of feeling. The families and the patients are also supposed to control manifestations of affection; scenes like shouting and crying are regarded as exceptional. Tranquil patients and family members are sometimes even admired in the informal talk among the staff members. Administering sedatives, tranquillizers, sleeping medicine, and analgesics is a practical and videly applicated means of keeping the patients calm; tranquillizers and sleeping medicine are often offered to the family members of deceased patients as well.

11. **Adjustment to death.** When telling about the dying of patients, the staff members regularly made references to the patient's adjustment to her/his death. Underlying these references there is an idea that people can and should accept their dying.

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[3] E. K u b l e r-R o s s [1969] presented twenty years ago a theory about five stages of dying. Kubler-Ross's theory has since then received a very wide audience. It is evident that this theory has given rise and legitimation to a "folk model" in the

The stages of various emotions before death can end in acceptance. To die without having accepted it is more tragical than dying when one is well adjusted to death. The staff members are also seen to go through a psychological developmental process, thus learning to accept the fact that some patients die.

12. **Hope and struggle as responses to severe illness.** When talking about the patients, references are often made to whether they are struggling against their illness and death, or have given up. In the leukaemia ward the way of talking of the physicians and nurses is consciously designated to keep up the spirits of the patients. In general, hope and struggle are valued as positive responses to illness. But a patient still struggling and hoping at the immediate face of death behaves in an inappropriate way.

13. **Fear of death.** The idea of fear of death is at the staff's disposal when describing the patient's, family's, other staff member's or even one's own relationship to death. People tend to fear death and the dead; but one can also get rid of that fear.

14. **Importance of pain.** When dealing with and talking about dying patients, pain is a matter of high relevancy. The pains of the patient are monitored through asking questions and making inferences. They are controlled with the help of analgesics. When telling about the dying of a patient to her family, a description is usually given about the pains of the patient.

15. **Dying patient as a member of the family.** When the patient approaches death, the family becomes highly relevant in the discussions and gossip among the staff, and in the staff's actions. The family members' reactions, feelings and awareness are monitored and assessed. The family members are usually informed about the approaching death, and immediately after the death they are contacted. In the case that a patient has suddenly come to the hospital in bad condition, and is likely to

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form of a proposition-schema [Quinn, Holland, 1987, pp. 24-26], or a "lay social theory" [Dingwall et al., 1983, pp. 55-56] of the patients emotions before death, used by the staff.

die soon, every effort is made to find his family. When the patient is in bad condition or unconscious, the family is supposed to represent his will when discussing the line of the treatment. In summary, the issue of dying is bound to the family of the patient in various ways. A dying patient is seen as a member of his family[4]. The connection in this extent does not exist in the case of those patients who are not supposed to die.

16. **Right to a full life-cycle.** The death of an old person is experienced and defined entirely unlike that of a young person. Young persons's death arouses more affection and it is remembered longer. In discussions the staff members told me that it is much easier to accept the death of old people than that of young, because young persons die untimely. Underlying these considerations there is an idea of a full life cycle as a norm, as something belonging to everybody.

17. **Death as a natural fact.** When discussing with me or among themselves, the staff members often described death as a natural part of life. As a natural fact, it has to be accepted when it comes.

18. **Harmony in death.** The view of a preferable death, presented and referred to in various occasions, is characterized by harmony. Death is harmonius when the patient has accepted his death, when he has no pain, and he dies while sleeping, without noticing the final moments. He has no unsolved problems with his family; and those close to him are accompanying him during the last moments. A metaphor used very often as a substitute for dying is "to sleep away" (nukkua pois); an attribute reflecting harmony is often added: "to sleep away in peace" or "to sleep neatly away".

19. **Horror of death.** When describing and discussing the deaths of the patients, a dimension of horror is present. Certain kinds of deaths are defined as horrible: to choke to death, or

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[4] Applying the concepts of H. S a c k s [1974], one could say that the membership categorization "dying patient" implies categorization as a member of ones family, too.

to die because of massive bleeding, and to be aware of what is happening, is horrible. Being left alone when dying is also regarded horrible.

20. **Religion as a help for the dying.** When talking about death, religion is sometimes referred to. Religious patients and staff members are supposed to come to terms with death more easily than the others. In some actions related to the death - like covering the body with a sheet and deciding about the autopsy - the church affiliation of the patient has to be taken into account. In an atheist's sheet a cross should not be folded, and a Jew would never permit an autopsy. All the ways in which religion is regarded reflect an idea of individual religiosity: religion is a quality of individuals. The hospital as a collective has no religious dimension, in the view of those who work there.

2.3. The symbolic layer

The other layer of knowledge related to death refers to the symbolic level of meaning and signification. In this paper I shall describe it only briefly.

Traditional society's ways of dealing with death have been one of the main areas of interest of social anthropologists. Robert H e r z [1960] adopted a symbolist account on mortuary rituals. He tried to understand the symbolic meanings of the ways of dealing with the corpse. H u n t i n g t o n and M e t c a l f [1979, pp. 184-211] have adopted Herz's perspective in their analysis of American funerals; they state those represent the idea of life as fulfilment, and death as a state of peace.

The meanings and activities related to death in modern hospital can also be analysed from a symbolist perspective. I find here the definition of symbol given by Paul R i c o e u r [1974, p. 12] very applicable: "I define »symbol« as any structure of signification in which a direct, primary, literal meaning designates, in addition, another meaning which is indirect, secondary, and figurative and which can be apprehended only through the first". Alfred S c h u t z' s [1971, p. 337, 343] defini-

tion of symbol follows the same lines. By studying carefully the literal and direct meanings of care of the dying, summarized in the 20 moral and cognitive principles, we can find behind them some indirect, secondary and figurative meanings.

The symbolic meanings found behind the principles are **the notion of control** and **the notion of communion.** Thus, in spite of the fragmentary characther of the principles, a thematic likeness can be found in them. But the two symbolic themes are in conflict with each other.

Several principles imply the idea of control and management (see principles 1, 2, 3, 4, 5, 8, 12, 15). The hospital staff manages and controls dying through knowledge and activities. Death cannot be avoided, but it can be postponed and anticipated. The patient's situation is defined in biological and psychiatric terms. His body and soul are intervened with the help of adequate professional techniques.

The notion of communion is also implied in several principles (see principles 5, 6, 7, 9, 14, 15, 16, 20). Death seems to be in a very close connection to the idea of solidarity and strong ties between people. Communion is supposed to exist between the dying person and her family, and also between her and the hospital staff.

When interpreted from a symbolic perspective, taking care of the dying people is to warrant them control and communion. Sometimes problems and tensions arise because of the incompatibility of these two things. It is felt to be difficult to control and manage the events, and to love the patients at the same time.

2.4. The principles and the social reality

The principles overviewed above are quite dissimilar in many respects. Some of them are primarily normative, and the others interpretative; although in most of them the normative and the interpretative aspects are mingled. Thus the principles, or imply, both normative and interpretative rules. Some principles are tacit, so that they can be "read" only from people's ways

of acting and doing things, and the others discursive, e.e. they have been verbalized by the staff members themselves[5].

It is evident that several principles are in conflict with each other. One principle (6) gives a norm and a description of the staff's closeness to the dying patients, and another (7) of its distance from them. One principle (9) presupposes an affective reaction to death, and another (10) recommends restrained behaviour. Besides the overt conflicts - which might be interpreted as expressions of the opposite poles of the same interpretative dimensions - there are deeply rooted implicit conflicts among the principles. E.g. principle number 3 (Time of death as an object of professional knowledge) implies a norm about the distribution of the knowledge from professionals to the family and the patient; but principle 5 (Minimizing the suffering) may be used as a legitimation for not sharing distressing information with them.

Because there are overt and implicit conflicts between the principles of the care of the dying patients, they can not be regarded as simply determining the meanings of death in hospital. The constitution of the meaning of death in hospital is a much more complicated issue than a derivation from these general features of the stocks of knowledge related to death.

Formulations, which make it possible to understand better the dynamics of the meanings of death in hospital, have been presented in the ethnomethodological tradition, and recently also in the "cultural models" research developed from the cognitive anthropology. The basic idea proposed by these two traditions is the following.

Cultural and social knowledge, like the principles presented

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[5] G i d d e n s [1984, pp. 22-23] has said that social rules can be characterized by the following dimensions: intensive vs. shallow; tacit vs. discursive; informal vs. formal; weakly sanctioned vs. strongly sanctioned. The principles presented above could be formulated as rules, most of the principles containing several rules. Different rules would have different characteristics proposed by Giddens. But this kind of presentation would become very complicated; that's why I'll content myself with principles, having the two characteristics, namely interpretative vs. normative, and tacit vs. discursive.

above, giving rise to the meanings experienced in concrete situations, has an **indefinite and partial** character. Because of the partial character of the cultural knowledge, there is inevitably room for negotiations, alternative constructions and differing views [see K e e s i n g, 1987]. No rules or principles, or sets of them, are complete enough to cover all the contingencies and surrounding facts in their application. They never can determine how people define their situation and act in it [see H e r i t a g e, 1984, pp. 103-134; D i n g w a l l, 1981, p. 126]. This is an appropriate way or seeing also the principles of the care of the dying people. They all have and indefinite and partial character.

Because of the open and fragmentary character of the moral and cognitive principles, a definite formulation of them is impossible. All closed formulations - such as the one done by me - hide something while presenting something else [cf. S h a r r o c k, A n d e r s o n, 1986, p. 52; G i d d e n s, 1984, pp. 21-23].

Q u i n n and H o l l a n d [1987, p. 10] say something about cultural models that could very well be applied also to the principles presented above: They "are better thought of [...] as resources or tools, to be used when suitable and set aside when not" Robert D i n g w a l l [1981] points to the same, when he says that the actors are to be seen as cultural producers rather than cultural products. **The principles are a resource at the staffmembers' disposal, when they produce and organize their everyday life and setting through their action**[6].

In summary, it has been said until now that the social meanings of death in hospital are a result of the staff's selective use of numerous cognitive and moral principles, in their everyday work at the hospital. This conclusion is anything but satisfactory. Can't we find any deeper logic in the use of the moral

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[6] Cf. the maxim presented by G a r f i n k e l [1967, p. 33]: "A policy is recommended that any social setting be viewed as self-organizing with respect to the intelligible character of its own appearances [...]". In the process of organizing their own setting, the members of the ward use the principles.

and cognitive principles? Can't we say something more than that the principles are used "when suitable and put aside when not"? In other words, we must now make an effort towards a more detailed description of the member's **methods in accomplishing social order** in the circumstances that are full of ambiguities and seem to provide no pre-given order [cf. Atkinson, 1978, p. 180].

I think that one step further towards understanding the logic of the use of the moral and cognitive principles can be taken with the help of Goffman's conception of **frame.**

2.5. Four frames

In analyzing the various perspectives on death opened by the twenty moral and cognitive principles, the concept of frame, developed by Erving Goffman, is very useful[7]. Goffmann [1974, p. 10-11] says that the way we have framed a certain situation influences strongly on how we define that situation. Frame refers to principles of organization governing events at hand and our subjective involvement in them. Anthony Giddens [1984, p. 87] follows Goffman and says that "frames are clusters of rules which help to constitute and regulate activities, defining them as activities of certain sort and as a subject to a given range of sanctions".

Taken together, the definitions of frame by Goffman and by Giddens point to three things. First, frames consist of different kinds of explicit and implicit social rules, those of interpretation (consitutive rules) and normative, regulative ones. The staff members' rules related to death and dying are included in 20 principles. Each principle is composed of several indefinite rules. These rules can be grouped as clusters, forming frames. Secondly, frame refers to the principles of organization governing events. As I understand this, it refers to what people are

[7] Goffman's frame analysis has been succesfully applied in the field of medical sociology by P. M. Strong [1979] in his study on the interaction between physicians and parents with sick children. My way of using the concept of frame is slightly different from Strong's.

doing in a given moment, and in which context. This course of activity makes them see events around them from a given perspective. And thirdly, frame refers to the degree and type of involvement in events at hand. People with different kind of involvement see things differently.

What makes some rules belong together, form a cluster? The rules that belong together are the ones applied in occasions where there is similar organization governing events, and people having similar involvement in them. This means that the framing of a situation may be seen as an important factor eludicating the selective use of the principles and rules contained by them. To put it in the simplest possible way: the staff members'choice between the conflicting principles and rules depends on what they are doing.

I think that the reflection of the meanings of death in terms of frame analysis has two advantages. First, it helps to find the connections between the social stock of knowledge related to death and the practical actions of the staff [cf. S i l v e r m a n, 1985, pp. 172-173]. And secondly, it helps to understand the conflicting nature of the meanings of death in hospital. Some of the conflicts between the different principles related to death are due to the existence of the different frames of death.

When the clusters of rules are formed, it turns out that one principle in some cases contains rules belonging to different frames. This makes the overall picture quite complicated. But I will try to explicite it.

Following these lines of thought, four different frames of death, prevailing in a modern hospital, can be identified. The frames are the practical frame, the biomedical frame, the lay frame, and the semi-psychiatric frame[8]. Each frame opens its peculiar perspective to death; the meaning of death is different in each.

[8] As S p y b e y [1984, p. 319] has noticed, any organization is likely to contain several frames. This is the case also in hospital. Here I refer only to those frames that are actualized in the care of the dying patients. Besides these there may be others having no relevance in the issues of death and dying.

The first of these perspectives refers to the **practical frame** of death. Seen from this point of view, death and dying mean the set of practices enforced when somebody is dying at the ward. These practices include items like heavy nursing care, cleaning and dressing the body after the death, announcements to the family of the deceased, writing the death certificate, contacting the pathologist, etc. All difierent professional groups have their own tasks. The principle of organization governing the events in this frame is everydaylike means-end rationality. Everybody does her or his job following the well-learned habits trying to get through the working day with a relatively low strain. The subjective involvement in the tasks is rather low. The central rules in this frame are implied especially by the principles 8 (Primarity of the everyday practical affairs) and 10 (Avoiding dramatic scenes) and 7 (Distance from the dying). Besides these, the practical frame has as its constituents numerous rules defining in detail all the practical tasks that have to be done in the case of death[9].

Another frame is the **biomedical** one. Seen from this perspective, death and dying mean biological processes in the patient's body, which cannot be reversed by the therapeutic action. Within this frame, the central activity is to define the patient's situation in biomedical terms, and to decide on the course of the therapeutic action. Diagnoses made during the life-time of the patient are usually followed by the conclusions made by physicians

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[9] D. S u d n o w [1967] has offered a very detailed analysis of the impact of the practical work considerations of hospital staff to the categories of hospital life, such as illness, dying and death. He summarizes his point as follows: such categories "are to be seen as constituted by the practices of hospital personel as they engage in their daily routinized interactions within an organizational milieu". This perspective has then been applied by M u r c o t t [1981] to the typification of "bad patiens", and by P e t e r s o n [1981] to an analysis of the work of the kitchen maids at hospital. The typification of bad patients, and the categories related to hospital food, are derived from the staff's interest to get through the days work. My idea of the practical frame applies this perspective, too. But from my point of view the whole story can not be restricted to the limits of the practical frame. The sense and meaning of dying and death is derived also from other sources, in the case of the three other frames.

after reviewing the results of the autopsy. Involvement in the events is low, and of neutral scientific nature. Central rules within this frame are contained first of all in the principle 2 (Death as a result of underlying, identifiable physical processes) and also in principles 1(Postponing death), 3(Time of death as an object of professional knowledge), 4(Active intervention) and 17(Death as a natural fact). Besides these, the biomedical frame is constituted by all those interpretative rules, by the help of which physicians and nurses make their infrences about the patients' medical condition[10].

The third frame to be considered here is the **lay frame**. It is a layman's affective perspective to the affairs of death and dying. In other words, within this frame death means to the hospital staff the same as it means to people not working in hospital: an upseting and existential crisis, and a call to human communion. Involvement in the dying person's situation is high, and of an affective nature. Death is accompanied by feelings of shock, anxiety, grief, fear, and perhaps relief. The rules constituting this frame stem from several principles, namely 1(Postponing death), 5(Minimizing the suffering), 6(Close contact with the dying), 9(Death as a source of negative feelings), 12(Hope and struggle), 13(Fear of death), 14(Importance of pain), 15(Dying patient as a member of his family), 16(Right to a full life cycle), 18(Harmony in death), and 19 (Horror of death).

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[10] D. A r m s t r o n g [1987] has in a recent article given a historical account about the formation of the biomedical frame of death. "In the mid 19th century the analytic space on which discourse focussed was established as the biological realm of the human body. It was the body which had to be scrutinized for the secrets of death [...]" (p. 655). But Armstrong continues by saying that after the middle of this century this discourse was caught by a crisis: the ideas of definit biological cause and mechanism of death had to be abandoned. "Death certificates and mortality records moved from being the hard bed-rock of medicin to being a combination of subjective impression, arbitrary rule and professional consensus". According to Armstrong, the crisis led to the development of a new discourse on death, one which pointed to the interaction between the dying man and his entourage, to the anticipatory grief of the dying and to the psychological support to be offered to him. This new discourse refers to what I have called the semi-psychiatric frame of death. Armstrong sees these two ciscourses as following each other historically. One rises when the other declines. On the contrary,

In the fourth perspective, within the **semi-psychiatric frame**, the issue is the experience of the patient, the family and the staff itself, constituted within the lay frame. But the involvement is dramatically different. The definitions and feelings shaped in the lay frame are now treated in a detached manner. They are interpreted and managed in terms of semi-psychiatric concepts, like repression of feelings, denial of death, acting out one's anger, and the like. The central activity within this frame is defining and controlling the tensions created within the lay frame. In this case, death means emotional processes which can be identified, controlled and managed. The rules of this frame come generally from the same principles as the rules of the lay frame, because the semi-psychiatric frame is nested in the lay frame. In addition to them the semi-psychiatric frame gets its rules from the principle 4 (Active intervention), 10 (Avoiding dramatic scenes) and 11 (Adjustment to death), and 20 (Religion as a help for the dying).

Everybody participating in the situation where a patient is dying - physicians, nurses, patients and their families - is acquinted with all of the above mentioned frames. The semi-psychiatric frame however, may be rather strange for a part of the patients and family members. Different groups of people have different statuses in different frames. Physicians dominate in the biomedical frame, nurses in the practical frame, and patients with their families in the lay frame. But still all understand the action within each frame, and can participate in it. For example, patients at the leukaemia ward adopt quite soon the biomedical perspective when staying in hospital. They learn to talk about the last results of different tests made of them - also with other patients and even with their families[11].

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my observations show that they both exist side by side in the everyday life at hospital. The biological discourse may be abandoned in the scientific discussions dealing with death - but in the everyday talk among the hospital staff it still is very powerful.

[11] E. M i s h l e r [1984] has recently presented a sensitive analysis about the problematic relation between the biomedical and lay frames, which he calls the voice of medicine and the voice of the lifeworld. In his study on medical interviews Mishler identifies the voice of the lifeworld mostly in patient's

The dynamics of interaction at hospital is characterized by constant shifting from one frame to another, and also by mixing the frames. Not even a short period of activity usually does take place within one frame only [cf. G o f f m a n, 1974, p. 561]. Let us consider for a while the next, very usual occurrence at the leukaemia ward.

The room of an unconscious patient approaching death, attended by her husband and mother. I have joined them. Two nurses come to the room, and they make a blood test to the patient. They co-ordinate their working by saying brief practical comments to each other. When doing something to the patient, e.g. cleaning her skin or pressing the needle into her arm, one of the nurses tells, regardless of her condition, the patient what she is doing. She also tells the family members what the blood is needed for: it is analyzed in order to find the bacteria in it. After finishing their job one of the nurses says to the family-members that if they want to drink a cup of coffee of tea, she could bring it for them.	*Presence of the family: **Lay frame.** *Taking the blood test and talking about it: **Practical frame.** *Talking to the unconscious patient: **semi-psychiatric frame.** *Giving reasons for the blood test: **Biomedical frame.** *Offering coffee as a sign of approval and encouragement for the attending family: **Lay frame.**

talk, and the voice of the medicine in physicians' way of talking. The structure of medical interviews seems to be quite simple in comparison with the interaction at a hospital ward. In the everyday life at a ward each participant uses each voice available for his own purposes.

In the course of everyday activity, the different frames are laminated on each other [cf. G o f f m a n, 1974, pp. 156-165]. At each moment one of them is on the foreground, and the others are on the background.

Thus there are four different realities of death in hospital, side by side, constituted by different frames. Death means very different things in each frame. A question worth discussing is whether this is due to some specific features of modern hospital or modern society in general, or is it just reflecting formal, invariant properties of the constitution of meaning and interaction.

An absolutely coherent and holistic meaning of death is hardly possible in any circumstances. Even in the most primitive societies there has always been two different orientations to dying, profane and practical on one hand, and sacred on the other, says M a l i n o w s k i [1954, p. 31]. But the sharp differentiation between the four frames may still be something characteristic of our society.

Thomas L u c k m a n n [1983, pp. 181-182] has written about the segmentation of the social order in a modern society. The functionally rational norms of the specialized institutional domains have became relatively independent of the overarching symbolic legitimations of society, and of the biographical context of meaning. The person and the biographical context of meaning have become disengaged from the individual performances within the different segments of the institutional order. The separation between the lay frame on one hand, and the medical and practical frames on the other could be seen as a manifestation of the tendency pointed to by Luckmann. They lay frame refers to the biographical context of meaning, and the others to the institutions of medicine and hospital. If this is the case, the semi-psychiatric frame could be seen as an attempt to bridge these two spheres, the biographical and the institutional. But this is not to say that lay frame would not have its institutional references as well.

2.6. Frames and institutions

In this theory of structuration. Anthony Giddens points to the interrelationship between social action on one hand, and structural and institutional properties of society on the other. Structures - or structural properties - are realized in institutions. Institutions are defined by Giddens as those social practices that recur systematically in time and space [Giddens, 1984, p. 17]. The main point presented by Giddens here is that the social structure is an essential resource for and product of situated social action [see for example Giddens, 1984, p. 323].

Giddens' theory bears a strong resemblance to the ideas presented by Roy Bhaskar. David Silverman [1985, pp. 77-78] summarizes Bhaskar's point in three propositions: 1)Interpretative procedures are central to the reproduction of social structure, 2)Social structures are real, constraining and enabling forces. 3)Social structures are the condition of social action and are reproduced and changed by it.

These views give a challenge to examine the connections of the four frames of death to different social structures and institutions. Which institutions with their structural properties are implicated as resource for and product of the social action taking place within the four frames of death? Which institutions are implicated in taking care of the dying patients?

First answer to the question posed above is that the twenty principles form themselves a structure of signification. In the first place it is this structure that is implicated in the action taking place within the four frames of death. But we can go still further. The structures of signification must be seen in connection with other types of structures, namely the structures of domination and legitimation. And all these structures are in connection to different kinds of institutional orders [Giddens, 1984, pp. 29-31].

2.7. Tentatively I will propose the following connections

Action taking place within the **practical frame of death** implicates the **formal and informal organizational structure of the hospital.** The division of labour and working times, each groups's and individual's obligations and tasks are the resource and outcome of this activity.

Action taking place within the **biomedical frame of death** implicates the mode of discourse called the **biomedical model** [cf. V u o r i, 1979, pp. 213-216; H e l m a n, 1984, pp. 65-68]. This mode of discourse has its own history (the beginning of which is described by Foucault 1973) and it is nowadays supported by strong institutions of medical education and clinical practice.

The structures and institutions implied by action taking place within the **lay frame of death** are not as easy to recognize as the above mentioned. The institutional foundations of this frame are quite vague. One institutional order is evidently there: **family.** Both the relevance of the family as a category closely bound to the category of the dying patient, and the idea of a family - like close contact between the staff and the patient point to this direction [cf. J a m e s, 1987][12]. The other institutional order, which is much more difficult to recognize and to analyze, could be called the **discourses of feelings.** Feelings and the ways of conceiving them have their own social history [cf. H e l l e r, 1979]; the feelings and talking about them at hospital reflect a modern discourse of feelings.

The semi-psychiatric frame shares the institutional foundation of the lay frame and the practical frame. Because the characteristic activity within this frame is to manage and define the feelings constituted within the lay frame, it also draws upon and reproduces **family** and **discourses of feelings** as institutions. The use of the semi-psychiatric interpretations of death in managing the feelings and tensions at the ward has a

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12 The strong connection between the family and the death has its own social history, originating from the Romantic Era [see A r i é s, 1982, pp. 409-558].

functional connection to the **formal and informal organizational structure** of the hospital. The semi-psychiatric frame namely assures the routine functioning of the hospital. But in addition to these, the semi-psychiatric frame has its own institutional connections. One is the institutions of **medical and nursing education.** These institutions, especially the nursing ones, disseminate the semi-psychiatric interpretation of death among the young staff members and those participating in further education or consultation. The nurses also use the semi-psychiatric frame as a means to legitimate their **professionalism.** The interpretation itself relies on **social scientific discourses** of human reactions, especially those derived from a popularized version of psychoanalysis [cf. B e r g e r, 1979, pp. 48-50, 59][13].

Thus we have identified several institutions that are implicated in the care of the dying people in hospital. The institutions mentioned are those drawn upon, when people face death professionally in our society today. Besides the hospital organization and the biomedical discourse, several other institutional orders are represented here. There seems to be a **carry over of institutionalized meanings** from the sphere of family, discourses of feelings, and even from the social scientific discourses, to the taking care of the dying people.

3. The use of the social stocks of knowledge in practice

The ethnomethodologist ethnographers, like Lawrence W i e d e r [1974], insist that a sociologist should not be content with just describing the conceptual models in the collectives

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[13] A r m s t r o n g [1987, p. 656] says that the new discourse on death, which pointed to the open interaction between the dying and his entourage, and to the psychological support offered to him, also brought with it a more penetrating power of medical interrogation. This is a very important point of view. From a Foucaultian perspective [cf. F o u c a u l t, 1977, esp. p. 224; L e m e r t, G i l l a n, 1982, pp. 57-92] the semi-psychiatric frame of death can be seen as a recent example of the fusement of power and knowledge in institutionalized practices. The semi-psychiatric frame of death has its own - until now rather simple but developing - body of knowledge or discipline, which is used in the control and management of the dying.

studied. The models in themselves do not "cause" behaviour. As S i l v e r m a n [1985, pp. 45-46] has pointed out, with reference to Moerman, the aim of social scientific studies should be to show, how people in their natural settings use the categories and explanatory models that they have.

Depicting the frames of death does not fulfill the requirements set by ethnomethodologists. The frames are still too abstract constructions.

Showing how the members use the frames and principles in finding and sustaining the character of the events they participate in can take place only through a detailed analysis of the concrete everyday activity. That kind of analysis of my data I have not yet systematically made. Thus I can offer only a couple of examples which may give an idea what it could be.

3.1. The problem of "too intensive" treatment

I have been astonished by the amount of criticism that the staff itself directs to the active therapeutic line in the cases of mortally ill patients. It was almost commonplace among the nurses to say that if I had cancer, I would never let myself be treated with chemotherapy and radiotherapy as heavily as the patients here are treated. Also the physicians often showed critical attitude towards too intensive treatment - although it is they themselves who make the decisions about the care. How is it possible that the active line of treatment still goes on, when almost everybody seems to be somehow against it?[14]

There must be many reasons for that, and I will point to one. Some light to this puzzle can be attained from the conception of different frames related to death. The policy of active treatment is quite reasonable when evaluated within the biomedical frame. Within it the medical intervention into the patient's body is something taken for granted. It is within this frame that the discussion leading to the decisions on treatment usually

[14] Actually there has been some change. The general policies of treatment of patients with no hope are no more as aggressive as 10-15 years ago. But still there is a great gap between what is said and done.

takes place. But when nurses and physicians criticize active policies, e.g. informally talking to one another or to the ethnographer, they act within another frame, namely the lay frame. According to the rules of this frame, death and dying are to be evaluated in terms of being horrible or peaceful. Intensive treatment obviously tends to make dying horrible[15].

The example considered makes evident that different actors at hospital do not give their support to certain, coherent policies of treatment of terminally ill people. We cannot say that this doctor or nurse is for "cure" orientation and that doctor or nurse is for "care" orientation. In differently framed situations they all can follow and support very different policies. That's because they use different principles and rules in differently framed situations. - Naturally this does not mean that there wouldn't be also individual differences. The individuals do differ in their way of using the various principles and frames.

The fact that different frames of death are so separated from each other seems to perpetuate active policies of treatment in spite of all criticism. A hypothesis can be generalized from this: separatedness of different frames makes power immune to many potential attacs. When the attacs and their target belong to different frames, then the power attacced will not be attained by its critics.

3.2. Involvement in the feelings of the dying

Another problem that the staff, especially the nurses, very often faces is the emotional involvement in the situation of the dying and their families. The staff's response seemed to be very ambivalent. On one hand they showed and told about strong geelings and difficulties to cope with them. On the other hand there

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[15] This is not to say that the intensive treatment could not in many cases be preferred when evaluated within the lay frame as well. Prolongation of life is a central value also in that perspective. But it is accompanied by the rules referred to above, and in several cases the latter weight more.

was an evident feeling of guilt for not having enough affection. On one hand there was a strong motivation to come near to the dying patient and to win her or his confidence, but then again there was a tendency to keep distance between oneself and the patient.

This ambivalence can be made understandable in the light of the conception of different frames of dying. The strong feelings experienced, the affirmed obligation to have affection, and the will to be near the patients are responses constituted within the lay frame. The tendency towards a routinized, non emotional and distant response is constituted within the practical frame. These two responses, in spite of their logical conflict, live side by side in the world of the hospital staff. And nowadays even a third one has grown there. It is constituted within the semi-psychiatric frame, and its core is conscious management of feelings. It is needed because the feelings constituted within the lay frame are so massive that without special management they make working very hard and tend to disturb the activities taking place in other frames.

3.3. Maintaining the tremendous character of death

Most of the writings about dying at the hospital deal with the detached attitude of the hospital staff to the events surrounding death. Within the practical frame - which in some wards and hospitals evidently strongly dominates - the dying actually is a routine event among other routine events. But another facet of death is its tremendousness. The tremendous character of death is usually seen as something repressed in hospital: the standard idea is that the detached attitude is in fact an escape from the tremendousnes that cannot be borne. In the previous ethnographies of dying at hospital, the tremendous character of death has been taken as something that is marginal in the reality of the hospital. G l a s e r and S t r a u s s [1965] - without explicating their implicit position - consider the tremendous character of death as a natural psychological fact. David S u d n o w [1967, pp. 170-173] writes that the shocking character of death is something belonging to the social meaning-textures

prevailing outside the hospital, from where there is occasionally a carry-over inside the hospital.

If we follow carefully G a r f i n k e l' s [1967, p. 33] recommendation, and try to view the social setting "as self--organizing with respect to the intelligible character of its own appearances", we should not be satisfied with these positions. If the tremendous character of death is in one way or another a part of the social reality of the hospital, we should be able to identify some joint activities of the participants of the hospital life, through which this character of death is sustained. And these kinds of activities can be identified.

We will present one instance of the production of the tremendous character of death in the leukaemia ward. It is the institution of viewing the dead body. Many of the nurses go to see the body of a patient who has died. This viewing takes place silently. Something may be said in the room, if there is somebody else too, but voices are low. The corpse itself is neatly covered with a sheet; usually there is also a flower on the breast of the body. The following quotation is from my field notes.

An auxiliary nurse, Liisa, comes with me to the room of a female patient who has died some hours ago. When we enter the room, Liisa says to me that there are really a lot of things here. (In the room there is a radio, other things and some plastic bags belonging to the deceased). Liisa goes to the body, and uncovers her face. First I speak in my normal voice, saying that the dead look peaceful. Liisa whispers; she comments on the blue colour of the deceased. She touches the cheek and hair of the deceased; after touching the cheek she says that the body is cold. She says that it is strange that Anna-Maija is still blue. We stay silently for some time, watching the body, on one side of the bed. Elisa, a nurse, enters the room without uttering a word. She goes to the other side of the body. She watches silently the face of the deceased. Liisa says to Elisa, that it is not so nice that the flower is an artificial one. (Because of the isolation rules, it is forbidden to bring natural flowers to the ward. AP) Elisa says that it still looks nice. She doesn't say anything else. After a while we all three leave the room. Liisa covers the face with the sheet. When leaving Liisa takes my hand and presses it gently. We wash our hands in the vestibule. When we are in the coridor, Liisa says to me that the body of Anna-Maija should be taken out of the ward very soon. The problem is that her husband has not yet come to the hospital, and he might be willing to see his wifes body. After a while she says that if he wants to, the husband can see her wife at the chapel of the hospital; the body shall thus be soon taken away.

This episode begins within the practical frame: Liisa notices the things in the room. From it we move into the lay frame, the tremendous character of death is constructed through our demeanour and way of talking. The dead body is made a very special object. - It is evident that Liisa'a demeanour is partly due to the fact the she sees me as an outsider, a novice and a layman in these matters. But anyway she acts **as a member of staff**, in one of the frames of death that the staff uses. Then we come back to everydayness. The body is not any more defined as sacred, but as an mundane object which must be taken out of the ward within the time-limits set by the rules of the hospital.

BIBLIOGRAPHY

Ariés P., 1982, The Hour of Our Death, New York.

Armstrong D., [1987], Silence and Truth in Death and Dying, Soc. Sci. Med., vol. XXIV, No 8, pp. 651-657.

Atkinson J. M., 1978, Discovering Suicide. Studies in the Social Organization of Sudden Death, London.

Berger P., 1979, Facing Up to Modernity, Penguin, Harmondsworth.

Dingwall R., 1981, The Ethnomethodological Movement, [in:] G. Payne, R. Dingwall, J. Payne, M. Carter, Sociology and Social Research, London.

Dingwall R., Eekelaar John and Murray, 1983, Topsy: The Protection of Children. State Intervention and Family Life, London.

Foucault M., 1973, Birth of the Clinic. An Archeology of Medical Perception, London.

Foucault M., 1977, Discipline and Punish. The Birth of the Prison, New York.

Garfinkel H., 1967, Studies in Ethnomethodology, New Jersey.

Giddens A., 1984, The Constitution of Society. Outline of the Theory of Structuration, Cambridge.

Giddens A., 1986, Action, Subjectivity, and the Constitution of Meaning, "Social Research", vol. LIII, No 3, pp. 529-545.

Glaser Barney G., Strauss A. L., 1965, Awareness of Dying, Chicago.

Goffman E., 1974, Frame Analysis. An Essay on the Organization of Experience, Cambridge Mass.

Hammersley M., Atkinson P., 1983, Ethnography. Principles and Practices, London.

Heller A., 1979, A Theory of Feelings, Assen.

Helman C., 1984, Culture, Health and Illness. An Introduction for Health Professionals, Bristol.

Heritage J., 1984, Garfinkel and Ethnomethodology, Oxford.

Herz R., 1960, Death and the Right Hand, Cohen and West, London.

Huntington R., Metcalf P., 1979, The Celebrations of Death. The Anthropology of Mortuary Ritual, Cambridge.

James N., 1987, A Family and a Team - Nurses' Roles in In--Patient Terminal Care; paper for presentation at Terminal Care Conference, September, Glasgow.

Kubler-Ross E., 1969, On Death and Dying, New York.

Lemert Ch. C., Gillan G., 1982, Michel Foucault. Social Theory as Transgression, Columbia University Press, New York.

Luckmann T., 1983, Life-World and Social Realities, London.

Mishler E., 1984, The Discourse of Medicine, New Jersey.

Murcott A., 1981, On the Typification of "Bad Patients" [in:] Medical Work. Realities and Routines, eds. P. Atkinson, Ch. Heath, Farnborough, Westmead, pp. 128-140.

Quinn N., Holland D., 1987, Culture and Cognition [in:] Cultural Models in Language and Thought, eds. D. Holland, N. Quinn, Cambridge

Peterson E., 1981, Food-Work: Maids in a Hospital

Kitchen, [in:] Medical Work. Realities and Routines, eds. P. Atkinson, Ch. Heath, Farnborough, Westmead, pp. 152-170.

Ricoeur P., 1974, The Conflict of Interpretations, Evanston.

Sacks H., 1974, On the Analyzability of Stories and Children, [in:] Ethnomethodology. Selected Readings, ed. R. Turner, Penguin, Harmondsworth.

Sharrock W., Anderson B., 1983, The Ethnomethodologists, London.

Schutz A., 1971, Symbol. Reality and Society, [in:] A. Schutz, Collected Papers, vol. 1, The Hague.

Schutz A., Luckmann T., 1974, The Structures of the Life-World, London.

Silverman D., 1985, Qualitative Methodology and Sociology. Describing the Social World, Aldershot.

Spybey T., 1984, Frames of Meaning: the Rationality in Organizational Cultures, "Acta Sociologica", vol. XXVII, No 4, pp. 311-322.

Strong P. M., 1979, The Ceremonial Order of the Clinic. Parents, Doctors and Medical Bureaucrasies, London.

Sudnow D., 1967, Passing On. The Social Organization of Dying, New Jersey.

Vuori H., 1979, Lääketieteen historia - sosiaalihistoriallinen näkökulma. (History of Medicine - Social Historical Perspective), Jyväskylä.

Wieder D. L., 1974, Language and Social Reality. The Case of Telling the Code, The Hague.

Anssi Peräkylä

SZKIC O SPOŁECZNYM ZNACZENIU ŚMIERCI W NOWOCZESNYM SZPITALU

Celem badań, przedstawionych w artykule jest opis społecznego znaczenia śmierci w szpitalu z punktu widzenia personelu. Podejście teoretyczne - etnometodologiczno-fenomenologiczne. Tak więc próbuje się odtworzyć proces produkowania znaczeń przez personel szpitala w toku obserwacji uczestniczącej i wielu rozmów z per-

sonelem i pacjentami. W artykule przedstawiono niektóre wyniki badań. Społeczne zasoby wiedzy o śmierci można uporządkować w dwu grupach: zasady moralne i poznawcze (m. in. "śmierci nie da się uniknąć, można ją opóźnić", lub "umierający jest członkiem rodziny") - omawia się 20 takich zasad. Drugą grupą wiedzy o śmierci są symbole związane z kontrolą i wspólnotą.

Omawiane zasoby wiedzy o śmierci są obecne w codziennym doświadczeniu personelu. Aby wyjaśnić logikę ich używania autor odwołuje się do koncepcji ramowej E. Goffmana. Wyróżnia cztery ramy śmierci: praktyczną, biomedyczną, laicką (tzn. nieprofesionalną) i semipsychiatryczną. Owe ramy są związane ze społecznymi strukturami i instytucjami (formalną i nieformalną strukturą szpitala, instytucją rodziny, sposobem kształcenia personelu, jego profesionalizmem).

Artykuł zawiera przykład analizy użycia społecznych zasobów wiedzy w praktyce szpitalnej.