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Social Aspects of the Prolongation of Life

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Foreword

Russell Sage Foundation's interest in the social sciences and human biology has evolved from an earlier concern with the social aspects of health and medical care. One of the links between the social and biomedical sciences lies in the events and decisions that surround the prolongation and termination of life. Currently the Foundation is supporting a number of research studies on and reviews of the social adaptation of man to rapid biomedical advances and innovative medical practices.

As part of the Foundation's work in this area, Diana Crane was commissioned to review past and current research and to determine where more research is needed. Russell Sage Foundation will continue to support work in this area, but the resources of a single foundation cannot cover the broad spectrum of research programs that are required. Dr. Crane's review is published in the hope that it will stimulate scholars, foundations, and government agencies to further study death and dying in American society. The Foundation stands ready to advise and collaborate with other groups sharing this concern.

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The Social Issues

Concern with the ethical, legal, and social problems surrounding recent medical advances continues to mount within the medical profession, among policymakers, and in the community at large. Because of their dramatic character, organ transplants have undoubtedly contributed sharply to the level of interest in the prolongation and termination of life. Nonetheless, radical surgical interventions are only one of a large number of striking medical advances that have extended the physician's control over the timing of death. In turn, greater control over life and death has increased the number of difficult decisions that doctors have had to make regarding the prolongation and termination of life and the allocation of medical resources. Moreover, changes in the leading causes of death from acute diseases to chronic ailments have meant that more individuals are surviving for long periods with terminal illnesses.

A gradual transformation of social values also is related to the attention now paid to the issues that surround the medical care of the very ill. Although there has not yet been any definitive documentation of the view, it seems fairly apparent that Western society has gradually become increasingly humanitarian in its outlook. Suffering is no longer believed to have religious value. A decline in the belief of an afterlife has meant that the importance of *this* life is magnified. These factors have contributed to concern for the quality of both life and "dying."

There has also been a change in social attitudes toward human intervention at both the beginning and the end of life. Birth and death are now viewed as events which need not be blindly accepted by human beings. Contraception and abortion are becoming more acceptable practices, at least among large numbers in the community. Suicide and euthanasia are being tolerated to a greater extent, or at least viewed differently. Consequently, we are in the midst of developing new ethics. How should doctors exercise their control over birth and death and what should be the role of patients in these decisions?

In a number of areas, organized medicine has failed to adapt to the changed demands being made upon it. Reforms in medical practice and in the ways medical organizations work have not been introduced rapidly enough, and many sound policies have been resisted by persons in the health field. These failures aggravate the problems of dying patients. Hospitals continue to be administered inefficiently and without realistic attempts to plan for the future. Problems of staffing, space, and inefficient utilization of facilities contribute to the discomfort of the dying. The medical profession has failed to increase its membership in proportion to the demand for its services and has done virtually nothing to develop paramedical personnel. Shortages of highly trained medical personnel, with consequent overburdening of practitioners, make it difficult for health professionals always to cope adequately with the needs of dying patients. The roles of the nurse and the intern, who often have the most contact with the terminally ill, have increasingly become untenable.

Refusal on the part of the majority of the medical profession to accept the importance of social and psychological aspects of patient behavior, as documented by Duff and Hollingshead (1968), has also had negative consequences: a failure to provide training in the nonmedical aspects of patient care for medical students and nurses, and failure to utilize behavioral science findings to improve medical practice. Both of these deficiencies have contributed to the poor quality and insufficient quantity of treatment often received by the dying.

There is some evidence, however, that the medical establishment is being challenged. Medical leaders' research orientation toward illness is being mediated by a greater concern for the patient's welfare. This reorientation makes the problems of dying patients salient, since the new approach emphasizes the person and not the illness which is producing another death statistic. Society is moving, however, slowly toward more equitable health care for patients of all social classes and economic backgrounds. This course should produce improvements in the allocation of medical resources to dying persons and, in particular, reduce the inequities in present allocations.

In the past, social scientists have undertaken only minimal research on dying and death, regarding the area as less urgent for study than social problems whose solution would benefit particular groups such as juvenile delinquents or the unemployed. Emphasis on such categorical groups is understandable, for knowledge in these fields could increase their effective participation in society for considerable periods of time. From this point of view, improvement in the environment of the dying seems a "luxury item" in social science. It benefits a class of people who do not contribute much to the rest of society.

This rationale for neglecting the dying, however, is incomplete and faulty. Some individuals who are needlessly defined as dying could be restored to useful roles in society. Not only have the numbers of people for whom the process of dying is an extended one increased, but concomitantly the complexity of the issues involved in their care has become more serious. Aside from the altruistic goal of improving the "quality" of dying, relatives and medical personnel alike are in need of the kind of information that social scientists can provide. The problems of life and death also have ramifications extending beyond these groups. As the government becomes increasingly involved in providing medical care, policy-makers can benefit from more information about these problems. The resolution of legal questions concerning the dying could also be improved by studies of the kind being suggested. In short these problems have ceased to be solely the concern of doctors and their clients. Members of other institutions are involved in the decision-making process. Sociological research could help to assure that these decisions are made wisely.

1. *Review of Research on Terminal Care*

The literature on terminal care is varied but not extensive. Four general categories of research can be defined: (1) studies of the relationships between dying patients and both staff and relatives; (2) studies of the allocation of medical resources to terminal patients; (3) studies of ethical aspects of terminal care; (4) studies of health economics and medical planning.

RELATIONSHIPS WITH DYING PATIENTS. Without exception, studies indicate that communication between dying patients and both staff and relatives is poor. There are few normative guidelines for such relationships and a high degree of negative affect on both sides. There is a strong tendency to avoid interaction with dying persons (Kalish, 1966; LeShan in Bowers, 1964). Weisman and Hackett (1961) refer to the "bereavement of dying" and suggest that the dying patient may suffer more from abrupt emotional isolation and deprivation than from his illness. Quint (1964) describes women who had mastectomies and who were unable to discuss their fears about dying with their families. Glaser and Strauss (1965) show that interaction between dying patients and others is affected by whether the patient knows he is dying and whether staff and relatives are willing to admit to him their knowledge of his condition. Withholding information about the outcome of his illness from the dying person is common practice although most studies suggest that few patients die from chronic illness without becoming aware of their prognosis.

Medical personnel prefer to treat dying persons as if they were expected to live (Duff and Hollingshead, 1968). Oken (1961) found that not only did 90 per cent of the 219 physicians he studied prefer not to tell cancer patients their unfavorable prognosis but that their commitment to this policy was based largely on emotional reactions rather than on a rational assessment of the situation. Effective emotional support of dying persons by medical personnel apparently occurs relatively infrequently (Duff and Hollingshead, 1968). Glaser and Strauss (1968) argue that medical personnel need to be systematically educated in the appropriate ways of handling dying patients.

There is only fragmentary information about how dying patients respond to knowledge of their deaths. Glaser and Strauss indicate that among geriatric patients the end is often welcomed. Among younger patients the degree of adjustment varies. Some patients are able to make appropriate arrangements for their deaths both in terms of business matters and in terms of their relationships with relatives. Others lapse into what Kalish defines as "social death," the individual's perception that he is "as good as dead," that his social role has ceased.

Cappon (1962) found that a majority of dying patients favored euthanasia. Nevertheless, the complexity of the problem is indicated by the fact that in the same study dying patients were less likely than healthy patients to want to be told whether they were going to die from their present condition (an illness or injury imagined by those who were well and real for patients).

There is also some evidence which suggests that, if communication with dying patients is to be meaningful, skilled assessment of their psychiatric status may be necessary. Cappon (1959) found a relationship between mental illness and some physical illnesses. Anxiety and depression seem to be connected to heart disease and schizoid and schizophrenic reactions to cancer. Other studies show that, particularly among older patients, mental changes occur prior to death which affect the individual's ability to interact with others (Weisman and Kastenbaum, 1969:28; Lieberman, 1966).

ALLOCATION OF MEDICAL RESOURCES. To date, the allocation of medical resources has been studied mainly in terms of statistical distributions. The utilization of medical services by patients of various social class backgrounds has been the subject of considerable research (Mechanic, 1968: 154–155). As in other areas of sociology, sociologists have tended to concentrate their research efforts upon the lowest-status members of the system. More is known about patients and their attitudes, behavior, and decision-making than about doctors. With the exception of Knutson's study of health professionals (1968), decisions by medical personnel concerning the allocation of medical resources have received little attention. Fox's study (1959) is an example of the kind of research that should be done but it is concerned with medical experimentation and not with clinical practice. Sudnow (1967: Chapter 4) discusses how patients' social characteristics influence doctors' decisions; Glaser and Strauss (1965, 1968) also touch on this subject, but the principal focus of these studies has been elsewhere.

STUDIES OF ETHICAL ASPECTS OF TERMINAL CARE. Few empirical studies have been done in this area. Fox's study (1959) of terminal patients who were the subject of extensive medical research explores some of the issues surrounding the relationships between doctors and terminal patients. Knutson's study of health professionals (1968) provides an indication of the attitudes that members of this group are willing to reveal to a nonmedical audience. Numerous discussions of the ethical aspects of terminal care and of innovative medical technology have been appearing in the medical literature (Hall and Swenson, 1968; Wolstenholme and O'Connor, 1966). These discussions indicate the need for empirical information that would provide the basis for reformulation of medical and public policy in this area.

STUDIES OF HEALTH ECONOMICS AND MEDICAL PLANNING. Valuable background material is provided by another new but growing field, that of health economics (Somers and Somers, 1966). This field concerns itself with how medical resources can be utilized in the most efficient manner from an economic point of view. These studies are relevant since some important problems surrounding terminal care are caused by a shortage of medical resources or an inefficient use of them.

Examination of the literature shows that most studies of terminal care have been concerned with the problems of interacting with terminal patients. Even in this area much remains to be done. The role of the family in particular has received almost no attention. Decisions to allocate medical resources to the critically ill should be thoroughly studied. The economic, legal, and ethical aspects of the allocation of medical resources have yet to be examined by sociologists. Studies of the psychosocial behaviors related to successful avoidance of terminal illness have never been done.

The Range of Needed Research

In the following pages, illustrative research projects are briefly outlined in five areas related to problems of terminal care: (A) decisions concerning the allocation of medical resources; (B) legal and ethical aspects of the allocation of medical resources; (C) economic aspects of the allocation of medical resources; (D) communication with dying persons; (E) the family and the dying person; (F) epidemiology of "staying alive" (psychosocial behaviors related to successful avoidance of terminal illness).

1. *Decisions Concerning the Allocation of Medical Resources*

GATEKEEPERS TO EMERGENCY MEDICAL CARE. Critical illness can strike suddenly. Accidents, heart attacks, and strokes usually occur without warning and require immediate medical attention. There is considerable evidence that emergency medical service in the United States is in urgent need of reform. Emergency medical care is needed in cases of disasters, natural or man-made; public disorders; automobile accidents; sudden onset of critical illness; and accidents that occur at home or at work. The American medical care system does not handle any of these problems satisfactorily. It cannot mobilize medical resources with sufficient rapidity and efficiency to deal adequately with disasters that occur infrequently and in unpredictable locations. It is unwilling to allocate sufficient resources to cope with the recurring problem of automobile accidents. Ambulance services are underequipped and staffed with undertrained, poorly paid personnel who often contribute to the deaths of their clients instead of saving their lives. Finally, the emergency rooms of most inner city hospitals are in a state of crisis. Although they are extremely crowded, a large proportion of their patients do not have emergency problems. These patients, mainly from the lower class, come to the emergency room because they have no other source of medical care.

The National Academy of Sciences (National Research Council, 1966) has developed guidelines and recommendations for the solution of a number of these problems. It is advocating nationwide coordination of resources for providing emergency medical care and the introduction of "emergency medical technicians" in ambulance services and in hospitals. To ease the load on emergency services, hospitals in some large cities are experimenting with the development of small medical care centers to handle routine cases in ghetto areas.

A series of sociological analyses of the emergency care delivery system would be useful. Such studies would examine the ways in which individuals, police, firemen, ambulance drivers, and emergency room personnel respond to medical emergencies. How do individuals with different social class backgrounds react to such emergencies, their own or those of relatives? What roles do the police and firemen play in the delivery of emergency medical care? Does their behavior vary according to the social characteristics of the neighborhoods in which they serve? Sudnow (1967) indicates that ambulance drivers respond differentially to their patients and that this influences the type and speed of treatment the patients receive when they arrive at emergency services of hospitals. Is this behavior learned on the job or do ambulance drivers behave this way as a result of their internalization of cultural norms and values prior to their employment? Studies are also needed of decisions by emergency room personnel to accept or reject patients in need of care.

ACCURACY OF PROGNOSIS. The allocation of medical treatment is affected by the accuracy of the doctor's prognosis. The following questions need to be examined: How frequently do doctors fail to assess accurately the likelihood of death? How often is there disagreement among doctors regarding prognosis and appropriate treatment? How do the following factors contribute to both failures and disagreements: (a) characteristics of different types of illnesses, (b) organizational environment of the hospital, (c) social background of the patient? This topic could be approached by asking doctors in different hospital settings to rate patients under their care with respect to their chances of dying during their current hospital admission. Such ratings could be compared with survival outcomes and interviews could be conducted with doctors concerning outcomes that were consistent and inconsistent with their predictions.

CASE STUDIES OF POLICIES TOWARD THE CRITICALLY ILL IN HOSPITAL SERVICES. Is there an informal culture among medical colleagues in hospital services that influences attitudes and behavior in critical areas of medical practice? Intensive studies of hospital departments handling large numbers of critically ill patients are needed to determine the factors affecting the formation and perpetuation of departmental policy regarding these patients. The following questions need to be explored: How much influence do directors of medical services have upon doctors' decisions? Is there a tendency on the part of directors to recruit doctors who share similar values? Does this produce considerable consistency in the behavior of a hospital unit in these areas? To what extent do doctors influence each other's decisions by their comments and implied criticism? How much controversy occurs surrounding critical decisions in medical practice? Under what conditions do changes take place in department policy? Sociometric data that would reveal who communicates with whom in making different types of decisions would also be useful.

SURVEY OF MEDICAL ATTITUDES TOWARD CONTROVERSIAL MEDICAL DECISIONS. Carlin's study of legal ethics (1966) indicates that critical decisions in professional practice can be studied using survey research techniques. A study of doctors' attitudes toward controversial issues in medical practice would reveal the relationship between behavior observed in the hospital setting and what doctors say they do in these situations. The following issues should be treated in the questionnaire: decisions to utilize treatments that involve risk to a patient's life; decisions to perform surgery on terminal patients; decisions to remove organs when the extent of disease is uncertain; decisions to provide treatment to persons who, if they recover, will be impaired in various ways; decisions to withdraw treatment from dying patients; decisions to perform "invisible acts" in which the drug dosage of dying persons is manipulated in order to hasten death. Other questions should explore attitudes toward suicide by terminal patients, and attitudes toward treating the self-inflicted wounds of attempted suicides; the use of terminal patients in medical experiments, and the problem of keeping such patients alive until experiments are finished; controversies surrounding definitions of death; and selection of patients for the allocation of scarce medical resources.

These issues should be presented to respondents in the form of brief resumes of sample cases. The doctors should be asked to indicate whether they would behave in the manner described and to predict the behavior of persons in the following categories: the director of their hospital service, an intern of their hospital service, most doctors in their service, most doctors in other hospitals in their city, most doctors in other hospitals throughout the country. Comparing the responses ascribed to others with those given for themselves should reveal the locations where they perceive deviance from medical norms.

It would also be of interest to compare their responses to a questionnaire with data obtained by means of participant observation and interviews. Lack of congruence between the data would suggest strong pressures to deviate from formal norms, failure of social control mechanisms, and the need to reformulate policy so that ideal and actual behavior achieve a greater degree of isomorphism. A high degree of congruence would suggest that the system is functioning adequately at present.

Background data on respondents—medical training and experience, religious affiliation, social class of origin, political views, and nationality—should also be collected. Careful pretesting would be necessary in order to develop a comprehensive instrument that would elicit accurate responses.

ALLOCATION OF INNOVATIONAL MEDICAL RESOURCES. Innovational treatments can be examined from two points of view: (a) as examples of the diffusion of medical resources and (b) as case studies in the allocation of medical resources. This study should begin with an attempt to develop a reasonably complete list of major innovational treatments currently being tested. These treatments could be classified as those involving the use of drugs and those involving surgical procedures, either organ transplants or other types of surgery. A complete list of organ transplants and a discussion of their various degrees of feasibility already exists (American College of Cardiology, 1968). With this material, it would be possible to trace the spread of innovational techniques from one hospital to another in the United States. Information about the social backgrounds of recipients would reveal what type of person tends to be selected for high-risk, high-cost innovational treatments. Comparisons of the social backgrounds of recipients and donors and selection of patients for allocation of scarce medical resources. Information regarding the public's attitudes toward critical areas of medical practice might help to liberalize medical opinion in this area.

3. *Economic Aspects of the Allocation of Medical Resources*

Health economics is a field in itself (Somers and Somers, 1966) but certain aspects of terminal care involve economic factors that can be dealt with advantageously by sociological methods.

FINANCIAL IMPACT OF TERMINAL ILLNESS. Glaser and Strauss indicate that there are cases where expensive treatment for a terminal patient is continued until the patient's or his family's resources are exhausted. At that point, the family is forced to accept the inevitability of his death. This raises the question of the economic costs to relatives of terminal care. How frequently does a family incur sizable debts as a result of terminal illness? What are the factors associated with carrying sufficient medical insurance to cover medical care for critical illness? Is there a relationship between absence of financial worries and rate of recovery? Interviews with families of terminal patients after death and of critically ill patients after release from the hospital could be used to obtain information about the financial aspects of major illness.

ECONOMIC APPROACHES TO THE ALLOCATION OF MEDICAL RESOURCES. Key elements of economic analysis are the concepts of "cost-benefit" and "opportunity cost." It seems likely that, implicitly or explicitly, these ideas are utilized by doctors in making decisions regarding the allocation of medical resources. For example, in discussions of birth control pills, it is sometimes argued that the risks to women from the use of this form of contraception are less than the risks that might be incurred as a result of pregnancy. Similarly, one could ask whether the expenditure of $25,000 to save the life of one patient—by means of a heart transplant operation, for example—is justified if the same amount of money used in a different way could save several lives. The difficulty with applying this type of analysis to medical problems lies in the fact that the "costs" and "benefits" can rarely be determined as precisely and as objectively in medical situations as they can in economic analyses. It would be of interest to explore: (a) whether this type of approach to medical decision-making is being used by physicians; and (b) what are the advantages and disadvantages of this approach to medical decision-making?

would be of interest. Information should also be obtained about the procedures for selecting recipients and donors, such as the use of special committees, and the definition of death that was applied in the cases of the donors. Some hospitals have developed very explicit procedures for handling these problems, including controls on the ethical behavior of the surgical staff, while others have nothing of this kind. It would also be useful to compare the procedures used for selecting donors when donors must be dead in order to contribute organs with procedures for selecting living donors.

2. *Legal and Ethical Aspects of the Allocation of Medical Resources*

LEGAL ASPECTS OF TERMINAL CARE. How often do legal cases concerning deceased persons occur? What legal issues are involved? An exploratory study of the legal literature on this problem would be useful. Is new medical technology changing the legal profession's attitudes toward these issues? Fletcher (1968) recently commented: "Doctors are in a position to fashion their own law to deal with cases of prolongation of life, [because] a legal standard of death, which would define the limits of the doctor's duty to his patient, would be an overly rigid solution to a problem that changes dimensions with each medical innovation."

MEDICAL SANCTIONS AND TERMINAL PATIENTS. What types of ethical questions relating to terminal patients are raised in tissue committee minutes and medical society meetings? How are these issues resolved? Has there been an increase in such cases over the past few years in response to the development of new medical technology?

NATIONAL SURVEY OF POPULAR ATTITUDES TOWARD DYING AND DEATH. Any attempt to formulate policy in this area needs information about how the public views these issues. For example, how concerned is the public about the way death is defined by doctors? Arnold *et al.* (1968) indicate that the public was greatly concerned about these issues in the 18th and 19th centuries. They predict that, as organ transplants increase, the public will become concerned again and will demand consensus among medical professionals regarding the diagnosis of death. A few small studies of popular attitudes toward euthanasia exist but a large sample of the population has never been polled on a wide range of issues relating to terminal care, such as the use of terminal patients in medical experiments, attempted suicides among terminal patients,

4. *Communication with Dying Persons*

EVALUATION OF THE USE OF CLERGY AND PSYCHIATRISTS TO FACILITATE THE ADJUSTMENT OF DYING PERSONS. Effective emotional support of dying persons by medical and nursing personnel apparently occurs relatively infrequently (Duff and Hollingshead, 1968). Glaser and Strauss (1965, 1968) argue that such personnel need to be systematically educated in the appropriate ways of handling dying patients. Although such training would undoubtedly be useful, it seems unlikely that this would provide a complete solution to the problem. As Glaser and Strauss point out, the hospital does not reward the quality of a staff member's interaction with a dying individual. Effective interaction with dying patients is an exacting and delicate task; such effort is unlikely to be forthcoming unless there is a major change in the allocation of rewards by hospitals. The latter, in turn, would be difficult to bring about.

In the meantime, it would be useful to evaluate the effectiveness of professionals such as clergy and psychiatrists who do perceive this task as within their domain. It is possible that clerical and psychiatric personnel could be utilized more effectively in this area than they have been in the past. Some hospitals do have clergy on their staffs who are called to the rooms of dying patients and who also talk to dying patients' relatives. Little is known about the responses of dying patients to this type of counseling. Would it be worthwhile to have them brought into contact with dying persons at an earlier stage so that they could perform more of a role in easing the adjustment of the dying patient while he still has weeks or months of remaining life?

Psychiatric personnel are also called upon at times to ease the adjustment of especially difficult dying patients. They generally dislike working with the dying patients, however; in addition, their services are so costly that it would probably not be practical to attempt to increase their participation in this area. Instead, it might be a field in which to utilize psychiatric social workers. Experimentation with the creation of a special role for the psychiatric social worker in aiding the adjustment of the dying patient would be useful. To maximize the usefulness of such personnel, the category of dying patient should be defined broadly enough to include all patients whose lives are threatened, even when the chances of saving their lives are considered good. Two studies have found substantial proportions of psychiatric illness among hospital patients (Duff and Hollingshead, 1968) and among dying patients specifically (Cappon, 1959). These findings indicate that special personnel with psychiatric training could assist the adjustment of dying persons. Medical and nursing personnel do not have such expertise and even the addition of certain courses to their training would be insufficient to provide them with the skill and motivation required to perform this difficult role. It seems likely that interaction with dying patients is resisted to such an extent that only as a separate specialty is it likely to be handled satisfactorily and dependably.

SOCIAL-PSYCHOLOGICAL CHARACTERISTICS OF DYING PATIENTS. As indicated above, two recent studies (Duff and Hollingshead, 1968; Cappon, 1959) have revealed a surprising amount of mental illness among hospital patients. These findings suggest several questions for research among nongeriatric patients, patients among whom fatal illness would not be anticipated upon the basis of age alone: (1) Are those who are hospitalized for a serious and possibly fatal illness in youth and middle age an unrepresentative sample of the population? Specifically, are they more disturbed emotionally than a matched sample of healthy persons? Are the dying more emotionally disturbed than those who are seriously ill but expected to recover? (2) Assuming that it is possible to isolate three types of dying patients, a mentally healthy group, a group whose symptoms of emotional illness appeared subsequent to hospitalization for a physical illness, and a group whose symptoms of emotional illness were present prior to hospitalization, the following studies would be useful: (a) Can poor communication between dying patients and both staff and relatives be attributed to emotional disturbance or is it characteristic of the emotionally healthy as well? (b) Among those whose symptoms appeared subsequent to hospitalization, what factors in the hospital setting might have been related to the emergence of such symptoms? Can such symptoms be the result of poor communication with hospital personnel and the subsequent feelings of isolation rather than the cause?

“SOCIAL DEATH” AMONG CHRONICALLY ILL TERMINAL PATIENTS. The patient who must live with his terminal illness for many years presents special problems in this area. Kalish (1968) presents the concept of “social death,” the individual’s perception that he is “as good as dead,” that his social role has ceased. Such perception appears to represent an acute form of anomie, the feeling of isolation and meaninglessness that the individual tends to experience when he is not a member of any cohesive group

(Durkheim, 1951). Do chronically ill terminal patients tend to define themselves as "socially dead?" If so, at what point in their illness do they begin to define themselves in this way? Does the organizational environment of the chronic disease hospital encourage the development of a "socially dead" attitude on the part of the patient? Often, the surroundings in a chronic disease hospital are so lacking in stimulation that the difference between life and death is minimized for its clients. Although patients frequently spend long periods of time in these hospitals and are often well enough to be ambulatory, it is possible that social groups, which could provide meaning to patients' lives and thus counteract the pressures to define themselves as "socially dead," fail to form because of the lack of activities on the wards.

ATTITUDES AND ADJUSTMENTS BY STAFF TOWARD INTERACTION WITH TERMINAL PATIENTS. It seems plausible to argue that the attitudes of medical personnel toward dying and death affect their interaction with terminal patients. An exploratory study is needed to examine the following questions: (1) Do the attitudes of medical personnel toward the occurrence of death in youth or middle age influence their attitudes toward dying persons? The tendency to avoid dying patients (LeShan in Bowers, 1964) can perhaps be attributed to such fears. Are these fears universal or are they concentrated among members of some religious or ethnic groups? How do these attitudes affect the communication between staff and patients in terms of the amount of information transmitted and the amount of emotional support provided? (2) Since interaction with dying patients is stressful, one defense which may be utilized by medical personnel is that of treating the patient as if he were an object, a case in a scientific study. This defense may be useful in minimizing reactions to medical failures. Doctors who utilize the opposite type of orientation, a humanitarian approach in which the individual is treated as an individual, would presumably have more difficulty in adjusting to interaction with terminal patients. (3) What other modes of adjustment are used by staff to cope with the stress of interacting with dying patients? Are high turnover rates of staff on wards with many terminal patients the result of failures to adjust to this stress?

5. *The Family and the Dying Person*

FAMILY STRUCTURE AND BEHAVIOR TOWARD DYING PATIENTS. Exploratory studies by Quint (1964) indicate that families find it difficult to discuss death with dying relatives and provide relatively little emotional support to them. As a result, dying family members often face death alone and their attempts to obtain consolation from their families are rejected. These findings suggest that there may be a relationship between the type of interaction between spouses and the amount of support which one spouse gives another. It is known that marital relationships vary considerably in the amount and characteristics of communication which occurs between spouses. Middle-class spouses have more communication with each other about a wider range of topics and share more interests with one another than lower-class spouses (Blood and Wolfe, 1960). With increasing age, however, the amount and range of communication between spouses declines in both social groups. This suggests that middle-class spouses would be better able to support dying patients than lower-class spouses and that younger spouses would perform this role more effectively than older spouses.

In addition, since women in American society specialize in expressive behavior in the family (according to Parsons and Bales, 1955), it seems likely that they would be better able than men to discuss death with and provide emotional support for dying relatives. This may mean that women are more likely than men to have to face death without emotional support from their families. Since the American family tends to be geographically separated from extended family members, mothers and sisters are often not available to provide support to dying female relatives. When extended family members are available, their involvement in their own nuclear families may preclude such an investment of time and energy upon extended family members.

A study of this kind would require the selection of terminal patients who spend time in their homes during the final stages of their illnesses. Interviews with patients and spouses from different social class backgrounds would provide data for examining the relevant problems.

DYING AND ADJUSTMENT TO BEREAVEMENT. After death occurs, one would expect that the bereavement period will be affected by the normative conflicts that preceded it. Adjustment to the death of a family member may be more difficult if relatives are uncertain that their decisions regarding that person while he was dying were appropriate.

The literature on responses to death by relatives suggests that pathological reactions to bereavement occur fairly frequently. Gorer (1965), in his study of bereavement in England, characterized the grieving of over one-third of his sample as "unlimited." Many of these people were unable to adjust to their loss. Lindemann's study of bereavement (1944) also revealed intense reactions to death on the part of relatives. A number of studies have shown that the incidence of death among the recently widowed is higher than among married persons of similar age (Hinton, 1967: 174; Rees and Lutkins, 1967). Another study has also shown an increase in physical ailments and psychiatric symptoms among the recently widowed (Parks, 1964).

On the other hand, accounts of the interaction between dying persons and family members tend to emphasize the inability of relatives to respond meaningfully to the fact of death before it occurs. A systematic examination of the relationship between events that took place while a relative was dying and the nature of the subsequent grief reaction has not been made. Gorer alludes to the fact that "the whole relationship between the dying and their partners or close relatives is falsified and distorted in a particularly degrading and painful fashion" (p. 17). He does not, however, attempt to relate the mourners' doubts about their own behavior while their relatives were dying to the characteristics of their grief reactions.

If the relative has perceived normative conflicts concerning the treatment of the dying person, he may find it difficult to adjust to bereavement. For example, adjustment to bereavement may be more difficult if the relative feels that decisions regarding the prolongation or termination of life were made upon an instrumental basis rather than upon an altruistic one. Decisions are probably more likely to be made upon an instrumental basis in hospitals than in patients' homes. Rees and Lutkins (1967) found that the risk of close relatives dying during the first year of bereavement was doubled when the primary death causing the bereavement occurred in a hospital compared with at home. The former is apparently more stressful for relatives than the latter. Another study reported hostility by relatives toward doctors after death had occurred (Hinton, 1967: 169). It is possible that some of this hostility was due to resentment over the ways in which the normative conflicts surrounding the dying process were resolved.

6. *Epidemiology of "Staying Alive"*

SUSCEPTIBILITY TO DEATH: SOCIAL AND PSYCHOLOGICAL CHARACTERISTICS. A recent study of accident proneness (Mellinger and Manheimer, 1967) hypothesized that the psychologically maladjusted have a poor capacity for coping with hazards in the environment. Susceptibility to serious illness may result from a tendency on the part of psychologically maladjusted persons to select behaviors that reduce their physiological immunity to illness, such as refusal to take medication, persistent use of inappropriate medications, alcoholism, failure to seek medical advice for obvious symptoms of cancer, heart disease, and so on.

The opposite concept, "life proneness," could also be postulated. Certain individuals diet when they gain a few pounds and drink moderately if at all. They have responded to recent medical discoveries concerning the causes of heart disease and lung cancer by decreasing their consumption of animal fats and giving up smoking.

Samples of terminal patients and of individuals who have been relatively free of major illness could be compared in order to determine whether there are psychological and sociological differences between such groups. The following hypotheses could be used to explain these differences: (1) A social Darwinist approach would suggest that the "fittest" would be most likely to avoid major illness. One would expect that the "death-prone" in comparison with the "life-prone" would be less intelligent and less adjusted psychologically; (2) Another hypothesis would rely on social-psychological variables and argue that the "death-prone" are less integrated in social groups and therefore less motivated to survive. Some indicators of this type of integration would be the presence or absence of parental family ties, being married as compared to being unmarried or divorced, having children as compared to being childless; (3) Alternatively, the differences in health may be explained largely in terms of class-based social advantages.

SUSCEPTIBILITY TO DEATH: THE SOCIAL CHARACTERISTICS OF VIETNAM WAR DEAD. Among soldiers serving in the same units in Vietnam, similar hypotheses could be used to compare those who lose their lives with those who survive. Here additional hypotheses are relevant. The individual's status in his unit might explain his survival; for example, individuals in leadership positions would be more willing to take risks for the unit. Noncommissioned officers and lieutenants might be more likely to take risks for their units and therefore be more likely to be killed. Similarly, individuals who are popular and admired by the unit might also be more likely to take risks for it. Speed of promotion from the status of private to noncommissioned officer might be one way of identifying such individuals.

Another factor in survival is involvement in the communication network of the unit. As a result, a newcomer to a unit might be in greater danger during the period in which he is becoming acquainted with members of his unit. Data of this sort might be useful to the Army in reducing casualties.

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