Introduction

Good and bad death: Introduction

The idea for this collection arose during a workshop chaired by Sjaak van der Geest, for which Clive Seale wrote an initial review paper (Seale 2000), and took place in November 2000 at the 15th Social Science & Medicine conference in Eindhoven, The Netherlands. The workshop provided participants with a fascinating opportunity to explore the considerable cross-cultural variation in patterns of disease, demographic factors and cultural norms that influence the experience of death, dying and grief. Participants included medical and other health sector workers, sociologists, anthropologists, epidemiologists and others, each of them finding something of relevance in a wide ranging discussion. The positive experience of the workshop stimulated our desire for a more formal outline of cross-cultural variability, particularly with regard to the cultural construction of different forms of dying as either 'good' or 'bad'.

In the months that followed we approached a number of authors to contribute to this collection. We made a special effort to also include some historians since variations in cultural perceptions of death seemed particularly prominent and interesting in the comparison of different periods of human history. The collection presented here contains contributions of workshop participants as well as authors approached in the later phase.

Death, at one level, is a problem that all humans must face, yet there is great variety across cultures (and over time) in people's explanations for why death must occur, in perceptions of what it is to die well or badly, and in how bereaved individuals are expected to respond. This variability has a number of implications for those involved in planning and providing health services for people towards the end of life. For example, there is considerable cultural variability in the degree to which an 'aware' death is perceived to be desirable, this having implications for communication of diagnoses and prognoses. There is variation in the ways in which people expect-or hope-to control the manner and timing of their deaths, this having implications for ethical issues involving requests to terminate treatment or end life. There is variation, too, in the degree to which death and grief are regarded as medical events, or matters that require the specialist intervention of professionals.

Additionally, variability in longevity and disease burden means that the actual experience of illness towards the end of life is variable, and the meaning of a death when very old may vary greatly from the deaths of children or middle-aged adults. We may ask, for example, whether it is possible for the deaths of the very young to be 'made good' in places where infant mortality is high, or speculate on the meanings of death in areas of the world where survival to old age is relatively rare. A variety of mourning rituals are employed by peoples around the world in order to 'make' death 'good', and the degree to which religion and afterlife beliefs are widely held will often determine the success of these. The meaning of suffering is very different in an 'anaesthetic' culture where medical remedies are widely resorted to, if compared with a religious society in which human suffering may have positive moral significance (Illich, 1976). Conceptions of what could make a death 'good' is not static: the development of specialist services for terminal care has itself played a part in redefining the meanings of death and grief.

Many of these matters have been explored in the work of anthropologists, historians and sociologists. The papers in this issue represent perspectives from all three of these disciplines, sharing the common goal of revealing variation in human social organisation and cultural norms, even where these refer to apparently incontrovertible biological facts of life, such as the inevitability of death. The papers in this collection describe these activities in a variety of different locations (Japan, North America, Netherlands, Britain, Australia, Papua New Guinea, Ghana) and time periods (modern times, Biblical times, Classical Greece and Rome). Together, these papers reveal that 'making' a death good or bad is an active process in which both dying people and those around them participate, showing some elements that appear to be shared across many cultures, and others that appear less widespread.

The papers by Counts and Counts, and by Van der Geest report anthropological fieldwork from Papua New Guinea and Ghana. These make clear that bad deaths in both locations are regarded as socially disruptive. A violent death, a suicide, an unexpected death in childbirth, a death away from home, or where a

body cannot be returned home for burial, are all like this. On the other hand, good death occurs at the end of a long and fulfilled life, in which wealth has been accrued, children and grandchildren raised and provided for, and dying occurs at home when surrounded by family and community, often followed by elaborate funeral rituals. All of this appears in line with the beliefs extant in the much richer societies on which other papers in the collection focus. Yet these two studies also reveal beliefs that appear to clash with these: stigmatisation of those who die in childbirth (Van der Geest); the view that most deaths are bad and are caused by sorcery (Counts and Counts). Others seem disturbingly close to features that have caused concern in 'Western' societies in recent years. For example the 'social death' of an elder by the carrying out of a funeral ceremony some years before his biological death by children who sought to take on their father's social role (Counts and Counts), the resentment of long-lived elderly people by a younger generation accusing the old of living long at their expense reported by Van der Geest—these things are reminiscent of concerns about the maltreatment of elderly people that surface from time to time in the mass media of 'Western' societies and are reflected, for example, in debates about euthanasia.

The three papers by Long, McNamara and Good et al. describe matters in the 'high-income' societies of Japan, the USA and Australia. Control over the timing and manner of death is an increasingly important concern in wealthy societies' conceptions of what it is to die well, and Long's paper is an eloquent illustration of the fact that such an individualistic philosophy (of life as well as death) may not easily 'carry over' from an American to a Japanese context, where individualism in general may be less valued. Yet Long makes clear that grand ideologies such as individualism are, in the context of everyday life, no more than resources or 'scripts' on which people draw to construct temporarily relevant explanations for events. McNamara and Good et al. focus on the conceptions of professional care givers in their respective societies. Good et al. show that physicians in American hospitals are similar to their patients in striving for 'smooth' deaths that occur in relative comfort and without family conflict; they are similar to their patients, too, in their concern about unnecessary prolongation of life with medical technology, though they do not always share family members' views about when this point has been reached. In hospice and palliative care, an alternative to over-medicalised dying has been developed. Yet McNamara shows that in an Australian setting the original conceptions of dying well held by early hospice practitioners may have been compromised with a more realistic recognition of a 'good enough' death by palliative care practitioners.

Pool and Seale share an interest in the role of the mass media in the cultural construction of death as good or bad. In Pool's paper, the media treatment of 'versterven', death by ceasing to eat and drink, is described. It is clear that the categorisation of this method of death as 'good' or 'bad' is partially dependent on the degree to which this is seen as a voluntary or non-voluntary matter. Seale's paper reminds us of some of the commonalities between Anglophone mass media depictions of bad death, particularly deaths alone or far from home, and those revealed by the anthropologists of less developed societies in the first three papers, where a lonely death far from home is also regarded as unacceptably bad. Media depictions of death are likely to play an important part in the promulgation of the 'cultural scripts' for dying to which Long refers.

The papers by the historians Van Hooff and Spronk are important in demonstrating both continuities and differences with contemporary ways of death. Van Hooff's account of death in Classical Greece and Rome is revealing in pointing out the important heroic ideal of an individualistic, self-controlled death. Additionally, Van Hooff makes it clear that the modern use of the term 'euthanasia' is different from its meaning in ancient times, particularly in relation to medical involvement, which is now assumed always to be present, but which in Classical times was rare or limited to assistance with suicide rather than participating in judgements about whether or not life is worth living. Spronk's account of death amongst ancient Israelites, revealed through an exercise in Biblical scholarship, demonstrates by contrast an almost complete absence of heroic ideals, showing instead a conception of death that is remarkably close to modern ideals—that death at the end of a fulfilled life is good for example, or that deaths away from home, or before children have been raised are bad.

These historical accounts show, additionally, a relative lack of medical involvement in death, a feature shared in large part in the 'less developed' societies. Where health care systems do become involved in death—and their involvement is seen most prominently in the papers of McNamara, Good et al. and Long—it is clear that this is an equivocal affair. Van der Geest, in his contribution to this issue, quotes Rubinstein who speaks of a medicalisation of death. In an article on narratives of American women about their parents' death she writes that the most remarkable about these narratives is '… the extent to which they implicate medical practice as part of the story, indeed as *the* story of the death' (Rubinstein, 1995, p. 260). Concerns about the excessive prolongation of life by medical efforts counter hopes for a medical defence against death, and the role of medical professionals in announcing the presence of life threatening disease, or indeed actively assisting in bringing about death, loom large.

The objective of this collection of papers is to demonstrate, compare and discuss cultural variations in the conceptualisation of 'good' and 'bad death'.

Reviewing the contributions—and some papers and articles not included in this selection—we must however conclude that the most striking and intriguing 'discovery' is the *similarity* of some death perceptions across cultures and times. Some ideals about dying well seem nearly universal: a death occurring after a long and successful life, at home, without violence or pain, with the dying person being at peace with his environment and having at least some control over events. Conversely, ideas of bad death also have a remarkable overlap in very divergent cultures and societies.

Additionally, it may be that some of the most telling differences in the views about dying well occur not between cultures or historical periods, but between groups of people *within* cultures. For example, people with different religious convictions within the same society may strongly disagree about the acceptability of euthanasia, as is shown in Pool's paper. Usually such religious differences also have political implications. Opposing political interests may lead to radically different interpretations of the quality of certain types of death. Violent death in war situations is a prominent example. What is heroic death and martyrdom in the eyes of one party is cowardice and murder, or just suicide, in the eyes of the other (Sande, 1992; da Silva, 2000; Grassiani, 2001). Age differences that may be related to intergenerational disparities can also influence perceptions of death, as Van der Geest shows in his contribution; young people accuse the old of witchcraft, thus turning good death after a long and successful life into an evil thing. Economic variations also influence the extent to which medical care can be accessed, both within and between countries. Finally, there can be disagreements between professionals and lay people about how to achieve a good death, even where they may share the same ideals, as the paper by Good et al. shows. Thus this collection of essays strongly suggest that variations in the perception of good and bad death are not just freely chosen cultural differences but should be understood also in their structural, political and economic context.

References

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