Death: a foe to be conquered? Questioning the paradigm

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Abstract

There are few certainties in life—death is one of them. Yet death is often thought of today as the ‘loss of the battle’ against illness, where in traditional societies it was the natural, meaningful, end to life. Medical knowledge and technologies have extended the possibilities of medical care and increased our life span. People living in most developed countries today can expect to survive to an advanced age and die in hospital rather than at home as in the past. Owing to these and other historical, cultural and social factors, our views on death have been skewed. Medical technology provides an arsenal of weapons to launch against death and the ‘war against disease’ has entrenched itself in medical philosophy. We now primarily experience death through the lens of a camera. Representations of ‘death as spectacle’ distort our perceptions and leave us ill-prepared for reality. Additionally, death as a natural consequence of life has become much less visible than it was in the past due to our longer life expectancies and lack of infectious disease. The continued thrust for treatment, wedded with a failure to recognize the dying process, can rob individuals of a peaceful, dignified death. Progress being made in Advance Care Planning and palliative care is limited by the existing paradigm of death as a ‘foe to be conquered’. It is time for a shift in this paradigm.

Keywords: death, terminal care, attitude to death, care goals, ageing, older people, end of life care

The ‘fight’ against disease and common description of death as having ‘lost the battle’ reflect a thoroughly modern notion of death. This approach implies that death is an unexpected, unwarranted outcome to any illness. This is at odds with traditional views of death and can be unhelpful, failing to prepare a dying patient and their family for end-of-life and grief. Here, we explore some of the societal changes that have shaped our attitudes to death.

Advances in modern medicine allow us to live meaningful lives with chronic illness. This has resulted in a blurring of the distinction between living with and dying of chronic illnesses, particularly in older patients [1]. Ageing is associated with both increased frailty and risk of death. The illness trajectory of older people with a large burden of chronic illness is largely characterised by a steady decline, punctuated by episodes of acute illness, any one of which may be terminal [1]. This population may live well with chronic illnesses, or they may succumb to death through cumulative frailty [2]. Given the complicated health status of older and frail patients, more aggressive treatments have an uncertain rate of success and it can be difficult to determine whether treatment should be focused on symptom relief or cure. When curative treatment is attempted, the patient may recover from the acute illness but with a reduced level of function. Cardiopulmonary resuscitation (CPR) represents the extreme of advances in treatment. Initially, it was a procedure to reverse an arrest in previously fit and healthy patients, but it is now standard care for all hospital inpatients, including chronically ill older people, unless instructions to withhold CPR are documented in advance. Some older patients believe that there are fates worse than death, which include loss of independence or cognitive function [3, 4]. Many studies show that dying people themselves fear ‘lingering’ on unnecessarily, and have priorities such as retaining a sense of control and not being a burden on loved ones [5, 6, 7]. These views need to be taken into consideration by clinicians.
This dilemma is illustrated in a recent article written by a general practitioner (GP) for a national newspaper, about a man in his 80s who was not granted his wish to die in peace (see Box 1). The GP questions whether such treatment is a triumph of modern medical care [8]. Many factors conspired to deprive this man of the peaceful death from natural causes he desired. Fragmentation of care with increasing complexity of medical process can result in patients’ wishes being lost or overlooked. The fear of legal consequences may drive the decision to continue to treat. Involvement of the patient in decision-making and documentation (such as Advance Care Plans) prior to end-stage illness will help to support patients’ wishes around end-of-life care. While under-treatment is a potential risk to be considered in discussions of treatment limitation, the prevailing ideology of death as a ‘foe to be conquered’ may stand in the way of acceptance and preparation for death for many doctors and family members, even if the patient accepts the inevitable.

Historically, death was viewed as an opportunity to celebrate notions of individualism and the ideal life, to die at peace with God and one’s neighbour [9], and as a common-place event people faced many times over before drawing near to their own end [10]. Death was a public experience, with loved ones gathering around the deathbed [10, 11, 12]. Nineteenth-century industrialisation and urbanisation, and the impact of decreased religiosity in the Western world, along with a growing understanding of and ability to treat disease, have shifted both the site of death and attitudes towards it [11]. Once a shelter for pilgrims and the poor, hospitals became a place where people were healed, and ‘struggled against death’. Dying patients were cloistered down the end of the hospital corridor [11, 13]. The loss of female family caregivers, through higher participation of women in the workforce and fragmentation of the extended family, have made dying at home more impractical [13, 14], and much less common [15, 16].

Death as the natural end of life has become relatively invisible. In 1870, 32% of all people born in Britain died before they reached their twentieth birthday [10]. Most people living in this period would die before they could reach middle age. Those who reached adulthood in this society would witness death many times, particularly as infant and maternal mortality was very high. Today, average life expectancy in most developed countries is now >80 years, and we can expect to live to old age [17]. Few in our community have intimate experience of death as most deaths now take place in institutions, not homes, and many will not experience the death of someone close to them until reaching middle age [10].

Despite our limited personal experiences, postmodern life is saturated with dramatised death in the media, television and film, thus becoming a common spectacle [18, 19]. Rather than helping us reflect on mortality, presenting death in unrealistic ways divorces us from engagement with its inevitability, distanced from the reality of chronic illnesses and dependence in old age that is likely for most [18, 20]. Contemplation on the transitory nature of life has little appeal in entertainment [21]. Publicly sanctioned distortions of death and superficial reactions contribute to repression of emotion and avoidance of authentic death concerns [21].

Death in popular films is usually premature and often violent, accompanied by unrealistic and limited portrayals of grief [21]. ‘Six Feet Under’, the first show to break many death taboos in television, depicts mainly deaths outside hospitals, particularly dramatic accidental deaths [19, 22]. Given the penetration of media into modern life, the ‘death as spectacle’ representation distorts community perceptions of death and likely leaves us ill-prepared for the realities of death [21].

Different social values to death are ascribed at different life stages. The media is pre-occupied with the death occurring prematurely, usually in famous and attractive people. This is presented as the loss of the battle, increases anxiety about mortality and often results in solicitations of money to
fight the cause of stamping out whatever the perceived cause
of death, usually cancer [23]. This feeds the technological
and research imperatives in medicine today, which imply we
can eventually beat death, as we vow to cure cancer or defeat
heart disease [24]. This notion of technology as an arsenal of
weapons to launch against death—an enemy to be conquered
or out-maneuvred—is familiar from the 1960s. President
Nixon’s ‘War on Cancer’ was launched initially as an election
campaign strategy, increasing health spending to eradicate the
’scourge of cancer’, the end result of successful lobbying.
The ‘war against disease’ analogy has now entrenched itself
in medical philosophy and the language of popular culture.
These factors all contribute to barriers to the discussion and
acceptance of death, and boost positive opinions and feelings
about the efficacy of treatment. Advances in medical science
and technology can be lauded even before there is evidence
of widespread applicability or mortality benefit [25]. The
expectation that something more can always be done contrib-
utes to community taboos around emotionally charged
discussions of death. In addition, an emphasis on death
robbing us of life is incompatible with valuing and finding
meaning in death.

Largely invisible in the public sphere, the ‘common’ death
of our society is that of the older person with a large burden
of chronic illness for whom further therapeutic intervention
is futile or burdensome. Good palliative care can provide
comfort and dignity for this population in the final days.
These circumstances underpin a broader set of publicly con-
tested debates such as the right to choose death [26, 27], the
role of patients and family in end-of-life care discussions,
over-treatment, under-treatment and controversies around
DNR orders [28, 29]. Over-treatment is just one aspect of the
failure to recognise the dying process. A ‘lack of recognition
that someone is dying has been described as disenfran-
chised dying and is . . . a consequence of withholding information
about prognosis’ [30]. Disenfranchised dying, especially
when it occurs in institutionalised settings, leads to lesser
awareness of dying; erosion of support; and stigmatisation,
and has been described as ‘shameful death’ [30].

Public discussions about the realities of the ‘common’
death and improved knowledge about end-of-life care will
assist patients and families to participate in discussions about
treatment goals. Progress is continuing to be made in
Advance Care Planning and palliative care, but without tack-
ling changes in perception to the existing paradigm—as
death as a ‘foe to be conquered’—that progress will be
limited. As our population ages, it is imperative that we
address an individual’s right to a full and frank discussion
about the likely outcomes of treatment on quality of life, and
involve them in the decision-making process. The medical
community must ensure that the fragmentation of care
between the various health providers is addressed; older
people who choose a palliative approach to end-of-life care
understand that they will not be abandoned and that
symptom relief and family support will be provided during
the dying process. Railing against the inevitability of death
will not slow its onset, but working towards greater accept-
ance may better enable us to complete our lives meaningfully.

Key points

• Many influences contribute to a perception that death is a
‘foe to be conquered’ even in the face of terminal or
chronic illness.

• Low visibility of death, advances in medical interventions
and the research imperative have reduced our ability to
accept death.

• Presenting death in unrealistic ways as spectacle trivialises it
with resultant negative outcomes.

• All these factors impede discussions and decisions about
medical care, adding to the distress experienced at the end
of life.

Supplementary data

Supplementary data mentioned in the text are available to
subscribers in Age and Ageing online.

References

Only the most important references are listed here and are
represented by bold type throughout the text. The full list of
references is available on Supplementary data in Age and
Ageing online, Appendix 1.

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