

Thanatological problems in Polish classical medical sociology

Piątkowski W.¹, Majchrowska A.^{2*}

¹Independent Medical Sociology Unit, Medical University of Lublin, Poland
Department of Medical Sociology and Sociology of Family, Institute of Sociology, Maria Curie Skłodowska University in Lublin, Poland

²Independent Medical Sociology Unit, Medical University of Lublin, Poland

ABSTRACT

Introduction: The phenomenon of death has always accompanied the humanity. Formerly, it was familiarised, interspersed in human life, natural and unquestionable. Currently, it is treated as 'taboo', controlled medically and pushed to the limits of capability, though inevitable. From socio-medical point of view death is a multidimensional phenomenon encompassing a range of social situations which accompany the process of dying. However, passing away itself is not the main interest for sociology but the gradual 'process of dying' with timeframe set by the diagnosis and death.

Purpose: To present the range and specificity of thanatological issues which have occurred in classical Polish sociology of medicine.

Material and methods: The study is theoretical and has been compiled on the basis of the selected

literature on the topic from the period between 1960 and 2013.

Results: The issues of death and dying have always been present in Polish sociology of medicine. It first appeared in western and Polish socio-medical literature in the seventies of the twentieth century. The main topics of social analysis refer to communication and interaction between the environment and the moribund as well as institutionalisation of death and dying, social attitudes towards death and all the problems that the close and relatives of a dying person struggle with.

Conclusion: The role of critical sociology is also worth mentioning because it challenges inadequacy of hospitals as bureaucratic institutions to situational requirements of the process of dying.

Key words: Medical sociology; death as social phenomenon; process of dying.

***Corresponding author:**

Independent Medical Sociology Unit
Medical University of Lublin
ul. Staszica 4/6
20-059 Lublin, Poland
Tel.: +48 81448 6963
e-mail: anita.majchrowska@umlub.pl

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INTRODUCTION

It is obvious to say that death is a phenomenon that has accompanied mankind from the beginning. Once a familiar part of the trajectory of human life, natural and indisputable, it is now treated as a “taboo”, controlled by medicine and postponed to the limit, but still inevitable. Analyzed from the sociomedical point of view, death is a multidimensional phenomenon involving a range of social situations that accompany the process of dying. It is not the act of death itself that is the central focus of sociological interest but the complex process of “slowly dying”, whose temporal framework is defined by unfavorable diagnosis and human death. The process of dying observable in the present form in contemporary societies is a consequence of progress in medicine and of the possibility to “postpone” the moment of death through increasingly effective treatments available in terminal diseases. Magdalena Sokołowska calls this time “added time” and says that it is beneficial to the patient because it allows him/her to put his/her affairs in order and participate in family life [1]; however, it produces a number of problems and challenges faced by both the family of the dying person, the personnel of the institution where the process of dying takes place, and finally by the dying person. The awareness of inevitable death changes the specificity of environmental interactions with the dying persons: it has an impact on the forms and ways of communicating, and on the whole social situation involving the participants in this special process.

Our text is mainly concerned with characterizing and interpreting Polish studies in sociothanatology: in order that this perspective could be all-embracing, this kind of reconstruction has, of necessity, to take into account the impact of views and research ideas inspired by Western medical sociology. It should be emphasized that when the Polish sociology of health, illness and medicine was taking shape, it was clearly influenced by research theories and ideas that had been developed as part of the American and West European (chiefly British) version of “medical sociology”. The fundamental role in this transfer of knowledge, views, and patterns was played by the founder of Polish and a founder of European medical sociology, Magdalena Sokołowska (1922-1989): her active involvement in the world’s scientific life, intense contacts with US universities (she graduated from Columbia University) resulted in the “import” to Poland of Western models of practicing science [2]. In sociomedical literature, including that concerned with sociothanatology, two distinct currents of reflection were observable: one inspired by the views of American authors, and the other by the European authors, usually English, French, or Scandinavian [3]. If we adopted the

general-view perspective in this part of our discussion and the chronological order at the same time, we will easily notice that the sociothanatological issues are being gradually marginalized and “pushed” out of mainstream sociomedical publications (which started in the 1970s). Instead of classical terms “death”, “dying” or “bereavement”, relevant Subject Indexes more and more often contain notes “see also mortality/morbidity”. In the later period, problems related to death clearly evolve towards deinstitutionalization, descriptions of extra-hospital care and support, while on the other hand these issues focus on analyzing the impact of new medical techniques on “scenarios of dying”, on the need to develop other, socially acceptable death criteria: biomedical, cultural, and religious [4]. It should be observed at this point that the sociomedical handbooks of the time devote comparatively little room to the individual, personal perspective in the reception of occurrences and phenomena associated with “ars morandi”. This may be caused by few qualitative investigations in the classical, academic medical sociology of the time. Studies on social responses to dying are also sparse: the family in the situation of death and a “social phobia” around these phenomena in consumer societies, etc. are also seldom written about. An exception here is a study by American sociologists on the awareness of dying, which is of fundamental importance for understanding the process of dying under hospital conditions [5]. Scholars focus more on the demographic and statistical aspects of the phenomena in question, describing the standardizing of mortality rates, their economic, racial, or ethnic determinants, or the socioetiology of infant mortality [6]. It is only in the 1990s that social researchers begin to notice qualitative changes in the field in question: the increasingly prolonged process of dying, and the new needs and expectations of terminal patients (communication, support techniques, diagnosis of needs). Studies long waited by caregivers and volunteers appear, which define the rules of management of this patient category (rules of home care, foundations of socio- and psychotherapy, instructions on how the families “which accompany dying” should function, etc.). At the same time the “sociology of dying” reflects the wave of criticism concerning “the formatting and technologization of death” in large clinical hospitals (“death in the culture of biomedicine”) [7]. The subject of discussion is, in particular, the fact indicated by patients’ families (sometimes family members are also respondents in qualitative studies) that present-day hospitals and their personnel are ill prepared to communicate with terminal patients and their close relatives. Following the emotional and intense discussions that took place in most Western European countries in the late 1980s and early

1990s, the specific taboo was broken surrounding the process of dying in hospital clinical departments: this led to the common practice of organizing training for medical personnel to improve their knowledge, competence, and sensitivity in contact with the patient whom medicine offers the “care” type of help rather than measures defined as “cure” [8]. A new theme also emerges in the debate on the “scope and manner of free decision-making about one’s own death” prompted by the appearance - in this line of discussion - of the elements “of economic calculation” indicated by managers of geriatric and palliative medicine departments, who emphasize the “dramatically rising costs” of the care of persons with nil chances of recovery. Discussions on these aspects, which form the context of the process of dying, led in turn to disputes over the criteria and standards that should be met by procedures for “persistent life support in the case of a moribund condition”. It was pointed out that most costs of the use of medical procedures were connected with the last weeks of the patient’s life; as a result, controversies arose over the limits of medical interventions and the rights of the patient who consciously demands that life-saving treatments be terminated. Opponents of “liberal” solutions emphasized the real danger of relativization and “subjectification” of procedures and regulations applied in the management of persons in the final stage of life, which may result in the popularization of the phenomenon of “passive euthanasia”. Among those opposing arguments there were again opinions on the necessity of continuing investigations on “the awareness of dying”, stages of dying, limits and rules guaranteeing the patient’s passing away in privacy and in dignity, respect for religious practices in public hospital, etc; research projects were also suggested concerning sociological analyses of rites associated with mourning [9]. A well-known British sociologist Hannah Bradby points out that in the first decade of the twenty-first century, death and dying have become part of public discourse connected with the necessity of redefining the limits of life in the context of revolutionary changes in medical technologies (transplantology, genetics, intensive treatment). At the same time, the progressing secularization of Western societies may advocate under the liberal banners the widening of the possibility of “abortion on demand”, and “the right to die” for the sake of “maintaining the quality of life of the aged”. On the other hand, doctors are aware of the activities of “pro life” groups and of arguments emphasized by anti-abortionists who advance moral, religious and ethical reasons, which poses new requirements on medical personnel who should take conscious, responsible and lawful decisions [10].

Another research perspective developing in the early twenty-first century in the research conducted by behavioral science in the context of thanatology is “sociology of the body”. It is within its framework that the themes of cultural functioning of the human body in the process of dying, the treatment of the human corpse by present-day culture, interpretation of the body in the context of “museum discourse”, today’s funeral customs”, etc. are introduced. For example, S. Nettleton emphasizes that the growing impact of the media, mass culture, fashion and the Internet enable more and more extensive interventions in the human body, manipulations with corporality, as well as designing and transforming the body. Social norms, value patterns, hierarchies guaranteeing respect for and inviolability of the human body in the process of dying and after death are being relativized, reinterpreted, and challenged, which arouses a growing and justified wave of criticism and fears [11].

An attempt to outline the chronology and main problems examined in the sociothanatological trend as part of the Western sociology of health and illness can be the background and special point of reference for presentation of the Polish version of “sociology of death and dying”; in this way it is easier to see the proportions between “the universal” and “the Polish specificity” that have always accompanied theoretical reflection and empirical studies carried out by social researchers.

Thanatological themes in Polish sociomedical literature have been clearly discernible since the 1980s. Earlier studies were mainly publications by doctors who noticed the psychosocial aspects of death and dying [12, 13]. As early as 1973 the translation of the publication by L. Pearson “Dying and Death” appeared in Poland with the preface by T. Kielanowski [14]. The book is a collection of interdisciplinary approaches to the problem of death and dying: one of the first to examine the issues of dying and death from such a broad interdisciplinary perspective. The first Polish sociomedical studies of that time also contained thanatological texts, often reprinted from Western publications [15, 16, 17], showing the psychosocial perspective of the dying process; their common characteristic was that they focused on the dying person, his/her problems and expectations, the special role of the medical personnel, and on ethical and procedural aspects associated with the fact of death.

In sociological analysis, death appears as a social phenomenon, subject to sociocultural determinants, and, although in the biological sense it is an objective and universal phenomenon, it is constructed by society and culture in the sociological approach, while attitudes towards death are historically and geographically varied.

Social attitudes towards death

Problems of social attitudes, including those towards death, seem to be one of the issues that are naturally placed in sociology. In sociomedical literature, M. Sokołowska was the first to study these problems in the classical publication "Socjologia medycyny [Medical Sociology]" (1986), pointing out changes in attitudes towards death in contemporary societies [1]. Death in the old days was as natural as human life was natural. The common fact of death, its proximity and "visibility", caused it to be perceived in a fatalistic way, as the common fate and destiny of mankind [1], an indisputable event that everyone would experience. In contrast, at present – in the words of M. Sokołowska – death is treated in terms of "a technical error", "which is not talked about in the twentieth-century [and twenty-first century; the authors' note] societies" [1].

A significant factor that determined the attitudes towards death and dying was religion, in particular Christianity, which gave a meaning to death by treating it as the moment of transition to the eternal life. According to A. Ostrowska [18] it was secularization processes that exerted the greatest influence on changes in attitudes towards death. The secular conception of death not only deprived it of its symbolic meaning of "transition" to the new life but it also stripped death of religious rituals accompanying the dying process that helped decrease the fear of death [18].

A number of processes and transformations that took place in societies over centuries have determined the contemporary attitudes to death and dying. The most important of them, according to A. Ostrowska [19], are urbanization and the dynamic development and specialization of medicine. Urbanization and the accompanying tendency to create one- or two-generation families caused death "to become distant" from the mainstream of life. In a multi-generation family the children were able to observe and experience the death of the oldest family members. At present, nuclear families live more and more often in places very distant from the family of origin, which prevents full participation in the life and illness and death of the parents/grandparents. Furthermore, changes in the position and prestige in families make seniors no longer as highly respected as they used to be while their illness and death do not make family members so greatly involved.

The dynamic development of medicine, A. Ostrowska believes [19], significantly redefined the understanding of death. This development has abolished the distinct boundary between life and death, offered the possibility of artificial life support, thus giving an illusion that it lasts, and allowing one to "cheat death" in a specific way as well as postpone in time the final moment of its occurrence.

Consequently, death has ceased to be treated as a necessary natural phenomenon. According to P. Ariés [20] the advent of death is now regarded as an accident, a result of helplessness or ineptitude, which has to be forgotten comparatively quickly. Although, as Bauman says, one does not deny the truth that death is eventually inevitable but "it can be removed from the agenda, replaced with another truth that each particular case of death [...] can be stopped, postponed, or jointly passed by" [21]. One could risk an assertion that death has been marginalized, banished into the fringes of social life, and pushed out of its mainstream as improper and embarrassing. In thanatological literature the term "pornography of death" appears which refers to the treatment of death in terms of a social "taboo". J. Kolbuszewski [22] explains citing G. Gorer that the term "pornography of death" is used by analogy to the term "sexual pornography", just as "prudery of death" is used by analogy to "sexual prudery". In practice it comes down to pretending that there is no death, to omitting the question of human mortality in conversations, to the use of euphemisms and replacement of the word "death" with gentle metaphors, e.g. instead of "died" – "passed away, departed", or "went on a long journey" [22-24].

This phenomenon is undoubtedly a consequence of axiological transformations of contemporary society since this is a society of youth and vitality, of earthliness and pleasure. Is there room for death and reflection on it in such a society? According to Z. Bauman [21], both modernity and postmodernity have banished ("evicted") death from their consciousness and the field of vision of mankind [22]. It is a paradoxical fact, however, that, while it is difficult to talk about, look at and be affected by death in the private space, the sight of death in the public and media space does not seem to make a particularly strong impression on the onlooker. Every day, the audience and readers of the media are bombarded with pictures of death, both fictionalized and real, which occupies the central position in daily news and crime columns. Death, marked with sensationalism and drama, which - interestingly enough – does not offend or embarrass, and arouses interest rather than fear. M. Ogryzko-Wiewiórska notes that "mass culture specialists have noticed the mediagenic appeal of the phenomenon of death. Business technopoly commercializes everything that is connected with death: from computer games [...] to film accounts of suicide cases" [25].

This duality of attitudes towards death was pointed out by W. Kuligowski and P. Zwierzchowski, who made a distinction between the normal and the scandalous in the perception of death. In their view, "death is normal when it is

turned into a spectacle [...], when it pretends to be happening in the conventional environment of the television, videos, rings, stadiums, or the Internet web..."[26]. In contrast, a scandal is private real death, evoking sadness and loneliness: "recognized as part of private life it has been thus banished from the theater of public life, it has become a little, embarrassing, and insignificant secret of an individual or of a small family circle" [26].

In science, "the conspiracy of silence" about death was broken long ago, which is evidenced by an abundance of thanatological publications that analyze death from various perspectives, both research and theoretical ones. An example of systematic reflection on this issue is a Wrocław Scientific Society series of publications "Problems of Contemporary Thanatology" analyzing the phenomenon of death and dying in a broad perspective, both medical and anthropological-cultural, or socio-humanistic [27,28].

However, death is still tabooed, "evicted", or covered by the curtain of silence in the collective awareness. If it does appear, then it is mainly in instrumental-medical discourse: death is rationalized and reduced to medical measures taken to stop it, postpone in time or perhaps even to avoid it.

Institutionalization of death and dying

The outlined process of driving death out of the collective social awareness originates *inter alia* from the physical removal of death from the natural family environment to the institution, which is a hospital or hospice. In contemporary societies it is in these areas that the vast majority of deaths occur. Death is usually the final stage of a terminal disease; as Z. Baumann states, nowadays "one does not simply die; one dies of disease or murder" [21]. Because the process of being ill most often takes place in hospital, death has also moved into it. Modernity has "demetaphysicized" mortality, stripped it of the sphere of the sacred, rationalized and technologized it. Death has been given its new, segregated location in social space, put in custody of specialists, and has been linked to a network of techniques and practices of measurable efficiency and effectiveness [21]. Traditional rites and actions performed for the dying person by the family or a priest have been replaced by technologized routine procedures performed by medical personnel in order to postpone death in time. P. Ariés writes that the time of death is prolonged depending on the doctor's will: s/he cannot defeat death but can decide how long the process of dying will last, whether it will be several hours, several days, months, or even years [29]. God and fate no longer decide about life and death, but it is the doctor and medical procedures s/he has prescribed. One cannot but agree with the words of U. Domańska: "never in history has this process been so extended over

time, never has it caused the dying person and his/her family so much suffering arising from the awareness of dying and from invasive and overburdening treatment" [30]. Yet at the same time, never before has it been possible to prolong the dying process so effectively, to "cheat" death, and to offer the patient an "additional" time to live.

In sociomedical literature, the institutionalization of death, which M. Sokołowska called "hospitalization of death" [1], is a frequently discussed theme. And sociological analyses have agreed on this point for many years: the hospital is not the right place to die. Critical sociology invariably emphasizes the inadequacy of the hospital as a bureaucratic organization not meeting the situational requirements of the dying process. The task of the hospital as a social institution is to implement entirely different objectives than provide care of the dying person. The hospital's technical equipment, the technologies used and applied management procedures as well as the ideology of the hospital in its most general sense are meant to diagnose, treat, save lives, and restore health. Death in hospital is treated as a setback, a result of medical helplessness, a treatment failure, when nothing more can be done. J. Barański observes, "there are no longer fatal diseases, in contrast, there is a lack of the ability to support life" [31].

In sociological analyses the hospital appears to be a highly bureaucratized social institution. Its operation is subordinated to organizational norms that "form a system of intentionally established, impersonal and abstract rules that regulate the behaviors of people in an organization" [32]. Their goal is to achieve the highest possible efficiency and effectiveness of action. The hierarchical structure and the clear system of interrelationships and subordination in hospital, the standardization and formalization of personnel behaviors are conducive to rigidity and schematization of their activities. As A. Ostrowska emphasizes, "untypical problems have to be dealt with in a typical way" [19]. Can the patient's death be treated in a "typical" way, however? Can the behaviors, expectations, and emotions of the dying person and his/her family be translated into hospital procedures?

The development of medicine and its progressing specialization and technologization have contributed to transferring death to the hospital institution, yet without finding the right place for it. An exception are palliative care departments, in which the personnel does not have to pretend anymore that they are saving the patient's health and life, they can devote themselves to everything that will allow him/her to die with dignity. C. Saunders [15], a precursor and founder of the idea of hospice, writes about an extremely important moment in the process of being ill and dying, the identification of which is the duty of the

medical personnel. This is the moment in which treatment turns into the care of the dying person; the persistent use of active and invasive treatment ceases to be justified, while the act of prolonging life turns into the act of prolonging the process of dying.

The idea of the care system that includes symptomatic treatment serving to eliminate and alleviate ailments caused by a progressing disease as opposed to active treatment (the cure system) is implemented in the model of hospice care as a desirable alternative to hospital, in which the patient spends the final time of his /her life.

A hospice is also a form of institutionalization of the dying process, which is pointed out by many authors, but both its structure and modes of operation essentially differ from the institution of hospital. Regardless of the organizational form that a hospice takes, the fundamental principle is always to attend to the dying person and his/her family in the last moments of his/her life. The patient is provided with multi-aspectual care by an interdisciplinary team, in which the participation of doctors is minimal. The personnel are mainly nurses, but there may also be a psychologist, social worker, priest, volunteers, as well as the patient's family members. It is essential that care is also offered to the patient's family, even after his/her death, thereby supporting the next of kin in coping with the loss [23].

The principal difference between a hospital and a hospice seems, however, to be the visibility of death and the awareness of it, which determines the specificity of the patient's interaction with the people around. Patients in hospice are aware of their condition, therefore death is treated here in an open and natural way [23]. They can talk about it openly, and share their fears, sadness, and sorrow. This allows them to genuinely spend the last moments of their lives with their close family and friends. In a hospice, the patient is the center of attention, his/her needs and expectations being the most important, which makes it possible to achieve the principal goal of hospice activity: to ensure that the patient will die in dignity when any treatment is no longer justified. Controlling of the disease symptoms allows the patient to live the last moments of his/her life under optimum conditions, maintaining necessary relationships with his/her family and friends [33]. This is what makes the idea of a hospice a highly regarded model of care of the dying persons, both in thanatological literature and in medical sociology itself [34-39].

Family in the face of death

It is a cliché to say that death affects not only the dying person because the greatest burden of death is borne by the living. Paradoxically, the research theme concerning families coping with the

problem of the death of a family member has been negligibly present in Polish sociological literature. An exception is a sociological study by M. Ogryzko-Wiewiórska [40], which investigates the problem of death from the perspective of family life. The death of a close family member, wife, husband or child, is an immensely stressful occurrence; in the Holmes and Rahe stress scale [41] it is regarded as the most stressful life event exerting a huge impact on the emotional and social functioning of family members.

The situation of the family facing death is determined by many factors related to the process of dying. The death of a child is experienced in a different way than that of an elderly family member, dying at home produces changes in family functioning different from dying in hospital, and the duration of the dying process, its stretching over time, can also be a significant variable determining the strategies for adaptation of the family to this crisis situation. M. Ogryzko-Wiewiórska [40] calls this anticipation of death: the gradual advent of death preceded by long illness makes death easier to accept.

Among the chief problems experienced by the family confronting the death of its member, Ostrowska [23] lists psychological experiences: sadness, grief, and despair. They accompany the family from the moment the diagnosis was made and do not end with the act of death. They continue long afterwards and turn into the state of mourning. They are not always only a reaction to the loss of a beloved person. Very often they are caused by the objective difficulties that the family of the dying or dead person has to cope with. Financial difficulties, insufficient caring capacity, or social isolation are only some of the situations that the family has to cope with, and which can be the cause of additional negative experiences and emotions.

The family has to contend with many social problems. These include inter alia the worsening of the family's financial situation caused both by the loss of income of the dying person (particularly, if his or her income was a significant part of the family earnings) and by the fact of increased expenditure on the care in the last months or weeks of his or her life) [40, 42]. The family's time budget also changes. As the disease progresses there is a growing demand for the care and nursing of the dying person, while the family try to spend all free time with him/her, which leads to the family's time deficits. The realization of the recreational and social-life function of the family is considerably restricted: depressed by the situation and burdened with duties, they neither have time nor are willing to satisfy this kind of needs.

Furthermore, as Ostrowska observes [23], social norms that define behaviors in situations associated with death and dying do not assume

active participation of families affected by the death of a family member in various forms of social life.

The death of a family member causes deficiencies in the system of family roles and makes it necessary to fill them. The family is compelled to internally reorganize social roles and take over the duties of the deceased person. This may lead to emotional overburdening and physical overloading of family members, thus being a secondary factor of the occurrence of additional problems in the family.

The serious difficulties outlined above, experienced by families confronting the problem of death, convincingly show that they should not be left alone to cope with the situation by themselves. Death can threaten the family's stability and functioning when they cannot engage in constructive adjustment processes. Hence such a serious crisis as the death of a family member should activate different forms of social support provision derived both from primary systems (distant relatives, friends, and neighbors) and secondary systems (support groups, social care, or hospices).

CONCLUSIONS

Death as a social phenomenon, this being the context in which it is analyzed in sociology, including the sociology of health and illness, is determined by multiple sociocultural factors. Attitudes towards death and contemporary death practices are shaped by range of sociological factors – the division of labour, migration, rationality, secularization, institutions etc. [43]. Processes and transformations occurring in society shape social attitudes towards death, and these in turn determine individual ways of thinking about death and the reactions to its presence. In postmodern societies, in which vitality values prevail, death is marginalized in social life, being treated as a “modern variety of pornography”. This situation does not make it possible to “tame” death, which, for the contemporary human, is some kind of “scandal” in the hedonistic civilization.

Both Polish and Western authors unanimously agree that death is treated in a natural way in public and media space [44] whereas appropriate attitudes towards death are hardly present in an individual dimension [25,26,45].

The only now admissible discourse on death is medical discourse because it is in medical institutions that death has found its place in contemporary society. The progressing process of medicalization of social life has not left death aside – it has been put in custody and under control of medicine, subjected to medical procedures and placed within the institutional framework. The hospital, despite being the place where people die most often, has neither conditions nor procedures

that make it possible to “pass away with dignity” [46].

Although there is no doubt that the terminal patient would like to die at home, surrounded by the family, it should be borne in mind that it is not always possible, and the great number of tasks connected with the technical side of care of the dying person may exceed the family's resources and threaten its functioning. Sometimes outside pressures (i.e. work, geographical distance and so on) limited the capacity of families “be there” during the last few weeks of life [47]. It is also not always that the dying person has a family or friends who could accompany him/her in his/her last moments; hence death at home is often death in loneliness [48]. The optimum form of solving this dilemma is the offer of hospices, which provide integrated sociopsychological care both to the dying patient and his or her family.

Contemporary societies try to expel death from social consciousness or construct its new cultural meanings that could make it understandable and acceptable to contemporary man [49]; nevertheless, death cannot be avoided because it is part of the essence of life. It is not easy to accept its presence and treat the process of dying in a natural way because it is always accompanied by grief, emotions [50] and a sense of loss. And yet this is possible, which was evidenced by the magnificent “spectacle of death” associated with Saint John Paul II: a social event which, it seems, gave the tragedy of death an optimistic and hopeful note.

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