Death and dying in contemporary society: an evaluation of current attitudes and the rituals associated with death and dying and their relevance to recent understandings of health and healing

Stella Mary O’Gorman BA(Hons) DPSN RGN RMN
46 Poll Hill Road, Heswall, Wirral L60 7XW, England

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INTRODUCTION

This paper will begin by establishing the current attitudes to death and dying. The historical development of these views will be examined from social, professional, and individual and family aspects. A model will be developed based on Illich (1990) Sweeting and Gilhooley (1992) which will set out the sequence of these developments.
Stages in the process of social death in 'primitive' societies

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Stages in the process of social death in modern western societies

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Figure 2 Rituals associated with death and dying. Reproduced with permission from Sweeting and Gilhooly (1992).

Stage 1
15th century 'Dance of the Dead' — death became autonomous

Stage 2
16–17th century 'Dance of Death' — death became independent by paying for health care

Stage 3
17–18th century 'Bourgeois Death' — death avoidance by paying for health care

Stage 4
19th century 'Clinical Death' — the emergence of the scientific doctor

Stage 5
20th century 'Health as a commodity' — health is seen as a civil right

Stage 6
20th century 'Health is a commodity' — health is seen as a civil right

Stage 7
Late 20th century — Changes in attitudes

Stage 8
'Social Death' — Professionalization of death rituals. Sweeting and Gilhooley paradigm (1992) (Figure 2)

Stage 9
'Return to holistic concepts' — contemporary education endorses understanding of death as 'right of passage'

Figure 1 Stages in development of current attitudes to death and dying.

The relevance of recent understandings of health and healing to current attitudes concerning death and dying will be illustrated by the model.

One perspective will be chosen from the developed model for more detailed study. Rituals associated with death and dying will be discussed with reference to Sweeting and Gilhooley's paradigm (1992) (Figure 2). Again the perspective will be evaluated critically from the social, professional, individual and family aspects, and the relevance to recent understandings of health and healing considered. The author will reflect on personal experience of rituals associated with death and dying with comparisons of English and rural Irish encounters.

DEVELOPMENT OF CURRENT ATTITUDES TO DEATH AND DYING

Illich (1990) claims that in every society the dominant image of death determines the prevalent concept of health.
that this represents a readiness by the society of that time for a radical change in attitudes and for death to become a 'natural event'.

Dance of death

Illich's (1990) 'Stage 2' is highlighted by the 'Dance of Death' (The Danse Macabre). Helgeland (1985) finds this image in poetry and sculpture all over Europe and the British isles and refers to Holbein (1971) depicting every person accompanied by the figure of death, represented by a skeleton. Helgeland (1985) maintains that from the 12th century onwards the death of a cultural system with many of its institutions is represented in society's preoccupation with death. He is of the view that 'the dance' depicts the death of the old society, class ridden, with honour as its pivotal criterion, and the birth of dignity for all humanity divested of socially imposed roles or norms. Illich (1990) subscribes to the view that 'the dance' represents a change from death being a transition into the next world to the accent being placed on the end of this life, and that as institutions gave way in the Middle Ages people were thrown back on themselves to provide their own meaning and purpose in life. Death became a 'force of nature' with which to do battle.

In the early Middle Ages the most influential professional group of the time was the church. The Reformation undermined this power and according to Helgeland (1985) the dispossessed mendicant monks left their cloisters for the roads and cities, and were the great disseminators of 'the dance', warning that all society was under attack in an age of transition. Illich (1990) tells us that doctors at this time could assist healing or help the coming of an easy and speedy death. Any attempt to prolong life was regarded as blasphemous (Illich 1990).

McNeill (1976) theorized that the Black Death changed the course of history and the individual's view of his own mortality. Helgeland (1985) rejects this idea, arguing that the social turmoil at the time could itself have been the cause of the plague. Certainly people became increasingly dependent upon themselves rather than their shabby institutions and the death of a person became all the more shattering and frightening for the individual (Tuchman 1978). People turned to secular advice such as the Ars Moriendi. O'Connor (1966) discusses the development of the Ars Moriendi as a complete guide to the business of dying well. How a person had lived became secondary to the hope of doctors to control the outcome of specific diseases certified by the doctor. Shryock (1947) describes this new role of playing lackey to the squire, a family friend to other notables, paying occasional visits to the sick and sending complicated cases

Bourgeois death

'Stage 3' in Illich's (1990) theory is called 'Bourgeois Death'. In the 'Dance of Death' the mower was seen using his scythe regardless of the rank of the individual. The Industrial Revolution began to create employment and wealth, an enlarged bourgeoisie and a society which was beginning to want good health into old age (Illich 1990, Foucault 1991). The 17th century onwards shows the rise of the bourgeois family and those who could afford it began to pay to keep death away. To die whilst courting a grand-son's mistress was an enviable goal (Illich 1990). Foucault (1991) dates from this time the current organization of disease as a political and economic problem for social collectivities to resolve as a matter of overall policy. The health of a nation became relevant factors in economic management. An apparatus ensuring the constant increase of a population's usefulness had to be organized. Death was regarded as an 'untimely event' when it came to those who were not both healthy and old.

Foucault (1991) states that the medical market — the extension of a network of personnel offering qualified medical attention— started in the 18th century. Illich (1990) is dubious of the worth of the treatment given at that time, but medical care for protracted illness had become a mark of distinction. The state began to dismantle the old charitable institutions and allowed the doctor to become the social and political reformer of the late 18th century (Foucault 1991).

Foucault (1991) and Illich (1990) note the changes in the status of the family which is now assigned a linking role between general objectives regarding the good health of the social body and the individual's desire or need for care. The ethic of good health becomes the duty of parents and children to uphold. A qualified professional body of doctors recommended by the state supplies the necessary knowledge. The middle classes employ doctors to tell death when to strike.

Clinical death

Illich's (1990) Stage 4, 'Clinical Death', places the doctor centre stage struggling against the roaming phantoms of consumption and pestilence. Books of the late 19th century show the doctor battling with personified diseases at the bedside of his patient. Death had become the outcome of specific diseases certified by the doctor. Shryock (1947) notes that the hope of doctors to control the outcome of diseases gave rise to the myth that they had power over death. The new powers attributed to the profession gave a new status to the clinician. By the mid-19th century he had become a member of the now powerful middle class.

Shryock (1947) describes this new role of playing lackey to the squire, a family friend to other notables, paying occasional visits to the sick and sending complicated cases
to his clinical colleague in town in one of the new special-

tist hospitals. Foucault (1991) cites how the Middlesex

Hospital opened in London, England, in 1745 for the treat-

ment of smallpox and the practice of vaccination, and the

London Fever Hospital opened in 1802. Illich (1990) main-

tains that ‘clinical death’ originated in the emerging pro-

fessional consciousness of the new scientifically trained

doctor.

Health as a commodity

Illich (1990) tells us 19th century art depicts death taking

the initiative in dealing with the doctor or the sick, whereas

that of the 20th century shows the doctor taking the

lead and interposing himself between his patient and

death. Illich (1990) proposes that this represents ‘Stage 5’
in society’s concept of death. Individuals began to see

death whilst undergoing treatment by clinically trained

doctors as a civil right (Illich 1990). By the middle of the


and Dubos (1959) acknowledge the fact that health has

become a commodity undermining the unique spiritual

and intellectual strength of the human race which enables

them to rise to the challenges of dying and death.

Death in intensive care

Illich’s (1990) ‘Stage 6’ is epitomized by the patient in a

critical condition in the intensive care ward of a hospital.

Protected against dying and defeated by the victory of

medicalization over society, the patient is no longer able

to set the scene for his own death; nor can the professionals

who have taken control of life and death agree amongst

themselves what actually constitutes death (Sweeting &

Gilhooley 1992). Moreover, doctors and nurses consider

themselves to have failed if a patient dies (Pietroni 1991).

Arcting (1971) found that doctors were more afraid of death

than a control group of patients. Kubler-Ross (1970) disco-

vered that when professionals identified that a patient was

dying, they withdrew from the bedside because they were

unable to cope with the process of death themselves, let

alone support the patient in his final moments.

At the turn of the century in Britain, death was a com-

onplace event. Fewer people reached old age, many died

of incurable diseases, the rate of infant mortality was high

(Ham 1994, Draper 1991). Wahl (1959) believes that

through knowledge of medicine, man has succeeded in

gaining for himself an average 36·7 years of extra life. Ham

(1994) claims that increased life expectancy was brought

about through the developments in the system of public

health. Whatever justification is put forward for our

increased life span, Barley (1995), Illich (1990) and

Helgeland (1985) subscribe to the view that our preoccu-

pation with health and living has repressed any meaning-

ful acceptance of or preparation for death. Wahl (1959)

states that we go to extraordinary lengths not to refer

directly to death. He mentions elaborate euphemisms such

as ‘passed away’ or ‘departed this life’. Barley (1995) finds

society adopts euphemisms so as not to disrupt the flow

of conversation. In the language of the politician or

upwardly mobile manager death is ‘failing to fulfil one’s

wellness potential’ or ‘suffering a terminal inconvenience’.

In Bolivia a dead person will have ‘gone to cultivate

chilli pepper’.

Social death

Sweeting and Gilhooley’s (1992) paradigm investigates the

differences between the rituals seen in so-called ‘primitive’
societies and those of Western cultures. Due to pro-

fessionalization of the rituals of death and dying an indi-

vidual can be socially dead before being biologically dead.

It will be suggested in this paper that social death is Stage 7

in the developed model and is directly due to the grieving

process and its associated rituals no longer being observed.

Return to holistic concepts

Nevertheless, Illich’s (1990) depressing description of the

contemporary view of health and its divorce from and pre-

cedence over death and dying has been challenged by

other authors since its original publication in 1976. Recent

literature supports the theory that attitudes to death and

dying have changed dramatically over the second half of

this century and society is adopting more holistic views

(Wahl 1959, Elias 1985, Bertman 1991, Moller 1993,

Rinpoche 1995).

Ramsey wrote in 1974: ‘There is a growing agreement

amongst moralists that death has again to be accepted and

all that can be done for the dying is to keep them company

in their final moments’. About this time Elizabeth Kubler-

Ross (1970) began her multidisciplinary seminars on the

care of the dying patient. She proved that with uncon-

ditional love and a more enlightened attitude, dying can

be a peaceful even transformative experience. Greyson

(1989), Moody & Perry (1988) and Ring (1985) show that

near death experiences (NDE) have given humanity the

hope that life does not end with death and there is a life

after life which should not be feared. Parkes’ (1986) classic

work amongst widows and widowers acknowledges that

death cannot be ignored because it has a profound effect

on those who are left behind in this world, causing anxiety,

depression and physical illness.

Rinpoche (1992) and Pietroni (1991) agree that the hos-

pice movement pioneered by Dame Cicely Saunders (1979)
at least attempts to address the inadequacies and difficult-

ies encountered by patients, relatives and the staff caring

for the terminally ill. 70% of which Pietroni (1991) tells

us die in institutions. Rinpoche (1992), however, states

that practical and emotional care is not enough. People
need something more profound. They need to embrace the holistic perspective of contemporary health and healing and discover a meaning to death and to life.

Ikeda (1988) tells us that the long-cherished Christian ethic has effectively vanished leaving society distinctly a-religious and even amoral and with confused ideas regarding health and death. Ikeda (1988) states that we need to make choices — either to revise the old Christian values or adopt new sets of values better suited to our times. The interest in complementary therapies during the last 30 years or so, demonstrates that people are increasingly challenging the monopoly of power of the medical profession over health issues (Piettoni 1991). Humanistic psychology emphasizes human choice, creativity and self-actualization (Maddi & Costa 1972). The resurgence of the primordial healer or shaman and the renewed interest in Buddhism in the western world indicates a search for a sense of meaning and purpose in the universe (Ikeda 1988, Money 1994). Christians themselves are adapting to the changes and embracing the holistic approach of eastern philosophies in which peace and compassion and meditation are valued (Mello 1983).

For the moment we all remain in a state of transition, moving from a pre-occupation with health which left us unprepared for death, to realization that death is inevitable for all of us and that in coming to terms with this fact we can enhance our lives. The author puts this forward as ‘Stage 8’ (Figure 1) in the development of contemporary attitudes.

**RITUALS ASSOCIATED WITH DEATH AND DYING**

This section of the paper examines the use of rituals in association with death and dying and how changes in practices have affected contemporary society. Stage 7 in the model (Figure 1) will be developed using Sweeting and Gilhooley’s (1992) paradigm (Figure 2).

Rituals in ‘primitive’ societies

In most non-western societies death is not seen as a single event, but as a process, the deceased slowly being transferred from the land of the living to that of the dead (Helman 1985, Sweeting & Gilhooley 1992, Barley 1995). This process is illustrated by rituals marking biological death, followed by rituals of mourning and then rituals of social death (Figure 2). These practices can still be seen in western society within strict religious groups such as the Orthodox Jews, who are used to illustrate Sweeting and Gilhooley’s (1992) findings.

Cytron (1993) and Helman (1985) describe the process of dying adhered to by Orthodox Jews as having a precise structure accompanied by certain rituals. Cytron (1993) states that there are two over-riding values at the heart of its orientation to death and mourning — ‘kavod hamet’ the requirement to honour the dead and ‘nichum aveilim’ the obligation to comfort the mourners. Both of these are to be found in each of the specific rites of mourning.

Cytron’s (1993) description of the Orthodox Jewish ritual begins as death draws near and the dying person and family take part in farewell rites. The dying ask forgiveness for their errors and express hope for the welfare of the survivors. The family say final goodbyes and recite together prayers of affirmation and hope. As soon as death has occurred the body is prepared for burial by ‘chevra kadisha’, a holy society made up of specially trained lay volunteers. ‘Tahara’ or preparation of the body entails washing of the body and draping it in a simple linen garment. The body is then placed in a plain coffin so as not to impede the natural decomposition — cremation is still frowned upon by the Jews. Sweeting and Gilhooley (1992) would consider these rites marking the biological death of a person.

The rituals of mourning begin during this period of transition from biological to social death. Because the body is now thought to be vulnerable and the soul in limbo, it is watched over until the ‘homecoming’ or final resting place in the earth from where it is perceived to have originated.

The Jewish funeral service begins with the cutting of garments to symbolize the individual being cut away from loved ones (Cytron 1993, Barley 1995). In the synagogue ‘Stage 8’ (Figure 1) in the development of contemporary attitudes begins as death draws near and the dying person and family take part in farewell rites. The dying ask forgiveness for their errors and express hope for the welfare of the survivors. The family say final goodbyes and recite together prayers of affirmation and hope. As soon as death has occurred the body is prepared for burial by ‘chevra kadisha’, a holy society made up of specially trained lay volunteers. ‘Tahara’ or preparation of the body entails washing of the body and draping it in a simple linen garment. The body is then placed in a plain coffin so as not to impede the natural decomposition — cremation is still frowned upon by the Jews. Sweeting and Gilhooley (1992) would consider these rites marking the biological death of a person.

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The first anniversary ‘yahrzeit’ is marked by the family gathering at the cemetery to reflect on the life of the deceased. It is usual at this time to dedicate the tombstone and Sweeting and Gilhooley (1992) describe this as the third phase in the death ritual, signifying that the deceased is now regarded as a dead ancestor. Helman (1985) sees this as the last of a series of funerals during which the deceased gradually leaves the land of the living.

There are many similarities between Jewish rituals and those of other communities such as rural Ireland (Keane 1985, Taylor 1988, Lillis 1991, Toolis 1995). The desire of Irish people to die in their homeland is expressed in current literature (Lillis 1991, Toolis 1995) and facilitated by the services of Funeral Directors advertising in Catholic newspapers (The Universe 1995). Toolis (1995) describes in detail the stages of dying and the rituals associated with the death of his father on Achill Island off the west coast of Ireland. Again death is accepted as a process by the dying man and his family and friends, all of which are given support by the community. The Irish wake ensures that the soul of the dead is protected and the relatives are comforted (Toolis 1993). As in the Jewish tradition there is common remembrance of dead relatives throughout the year on certain holy days when grief is shared and support given (Harty 1975, Cytron 1993).

It is perhaps not unexpected that these similarities are present between Jews and Catholics because their beliefs stem from the same roots (Cytron 1993). Barley (1995) and Irish et al. (1993), however, find similarities in rituals throughout the world. The Torajans of Indonesia travel all over Asia to bring the bones of their dead to be buried in the rock caves hundreds of feet above the ground in Sulawessa (Barley 1995). Buddhists and Muslims, the Mexican Indians and others keep vigil with the dying before and after death (Irish et al. 1993, Rinpoche 1995). Funerals may vary from the simple affairs of the Quakers to very elaborate ceremonies of the Hmong, but exist in some form universally (Irish et al. 1993). Buddhists, Muslims and the Lakota among others recognize anniver-
saries with ceremonies a year after the loved one’s death (Irish et al. 1993). The belief that death is a rite of passage from this world to the next is common in all of these beliefs and affirms the power of human society to transcend the death of an individual and conquer death itself (Toolis 1995). They are beliefs that have survived the passage of time and the changes described by Elicl (1992) (Figure 1).

**Lack of rituals in modern western society**

Many contemporary authors agree that western affluent societies are unable to look upon death and its rituals as a right of passage to be compared with birth, coming of age, marriage and retirement. Barley (1995) argues that we have turned our mortality over to the social workers and with it many of the rituals which gave it meaning. Rinpoche (1995) was shocked by the contrast of lack of positive rituals in the West to those which attest to the majestic vision of life and death underlying Tibetan tra-
dition. Toolis (1995) acknowledges the negative effects of the hushed reverence and deep embarrassment normally associated with the Anglo-Saxon rituals surrounding death. Cytron (1993) condemns the ‘fast grief’ of modern American Jews and speculates that this is due to seculariz-
ation and medicalization of terminal care.

Illich (1990) demonstrated the medicalization of death and dying (Figure 1). Sweeting and Gilhooley (1992) expand on this and argue that in contemporary society social death can precede biological death, and therefore the stages of dying and associated rituals can no longer be applied (Figure 2). The process starts when the patient is admitted with a terminal illness to hospital or institution (Sweeting & Gilhooley 1992). According to Goffman (1963) people entering hospitals undergo the process of ‘mortifi-
cation’ and become dispossessed of roles they held in the outside world. Their relatives often feel unwelcome and uncomfortable especially in intensive care units (Rinpoche 1995).

There is a takeover of the body by the professionals who have developed their own rituals (Illich 1990, Sweeting & Gilhooley 1992). Being scientists in the positivistic mould, doctors have a predilection for slotting the individual into a hierarchy of terms for death and dying. Sudnow (1967) and Kalish (1968) discuss ‘biological’, ‘clinical’, ‘psycho-
logical’ and ‘social’ death. Each definition is affiliated to a set of rituals prescribed by the professionals, none of which satisfy the spiritual needs of the individual and the family involved (May 1973, Illich 1990).

This ritualistic labelling of the dying process of patients by doctors and nurses is thought to be due to contemporary life becoming so secularized, that the sacral dimensions of death are too awesome to admit as a solution (May 1973). Once a death label has been attached, the individual is perceived as an illness rather than a human being, and social death, when a person is treated essentially as a...
seems for many nowadays to be a clean and accelerated way of avoiding the horrors of physical decay and the cost of an expensive gravestone (Barley 1995). Grief is seen as a disease and in a culture rooted in Puritanism needs to be ‘worked out’ and ‘got over’ (Becker 1969).

Sweeting and Gilhooley (1992) question whether the changes depicted in Figure 2 are desirable. According to May (1973) and Illich (1990) nothing has affected quality of life in the last 200 years and our objective capacity to cope with the powers that beset us is the application of technology to disease and death. The individual dies alone in an institution without family support and ostracized by doctors and nurses (Kubler-Ross 1970, Travellbee 1971). According to Fulton and Fulton (1971) when a label of social death has been applied relatives experience anticipatory grief and will have already worked it through to resolution by the time biological death occurs. Parkes (1986), however, disputes this and claims that grief can be intensified due to the way it is socially defined and structured in society. Charmaz (1980) suggests that the contemporary rituals which force individuals to handle grief independently give rise to high disease and death rates among them.

CONCLUSION

The model (Figure 1) presented in this paper gives an overview of the development of contemporary attitudes to death and dying and their relevance to recent understandings of health and healing. The ultimate professionalization of death which removed western society away from the process of death is demonstrated. Figure 2 compares the rituals associated with ‘primitive’ and modern western societies and establishes that in the latter, traditional rituals have been truncated and therefore the expression of grief denied.

In contrast the author’s first experiences of death and dying in rural Ireland were totally disparate and came as an unpleasant shock. There were elements of shamanic practices in the emphasis on the significance of tribe and community, use of herbs in healing, their positive perspective on death and dying (Birmingham 1911, Taylor 1988, Money 1994). The proliferation of thanatology research and literature proves this misgiving amongst professionals responsible for death education. There is recognition of the value of primordial teachings and other religions and beliefs, in the treatment of physical and mental illness and the promotion of good health. Individuals have woken up to the author’s own experiences. It was a communal affair. The individual and the relatives were never alone. Death and dying were a part of everyday life and grief expressed during the ordinary daily routines of life.

The Irish wake seemed incomprehensible to one who was versed in the Anglo-Saxon ways. The body, laid out by a member of the family, in order to receive ‘a special blessing’, would be in the parlour of a country house surrounded by flowers from the garden and lighted candles. Toolis (1995) and Taylor (1988) relate how children are encouraged to visit the dying and to view the corpse. When visitors had paid their last respects they would join the crowd in the kitchen who would then spend all night recounting stories associated with the dead person. Alcohol would be supplied liberally and by the end of the night to the uninitiated the event would appear to be more like a party than a melancholy event. Initially the whole process appeared to the author to be in ‘the worst possible taste’.

Enlightenment comes with age and experience, and with it the realization that in shunning death we are futilely denying our human nature. Like Toolis (1995) the author now believes that rituals like the Irish wake celebrate death as a happy occasion and bestow grace upon those leaving life and upon a community of those who mourn them.
the fact that there is no cure for mortality, that there are limits to life and that it is essential to recognize this so that they can learn to live positively and without the fear of death.

The personal reflections discussed in the essay have done much to clarify the author’s own beliefs and values regarding death. The rituals observed and the death education received in childhood were destructive and undermined the development of a healthy philosophy for life. Experience of attitudes to life and death in rural Ireland introduced a new perspective, which although at first rejected, eventually became the essence of an adult philosophy. It is a philosophy which encompasses ideas from Shamanism, Buddhism, Christianity and the holistic perspectives of contemporary health issues. It has served ‘primitive’ communities well in sickness and in health and at the hour of their death.

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References


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