BORDER CROSSING Tessa Richards

A better way to die

Why dying and death need to be “rehabilitated” back to a more central position in society

Birth and death are rites of passage for which preparation is important. In rich countries, information and support during pregnancy and childbirth are available in spades from a vast range of professional and lay sources. Choice of venue for the birth is often on offer too. The risk is not so much of entering uncharted territory unprepared as entering it overwhelmed by a deluge of advice.

Are we equally well prepared for dying and death? Speaking for myself, the answer is no. I dodged the issue before my own life threatening surgery and floundered as I witnessed my father's slow decline from dementia. Practising medicine conferred familiarity but not understanding, competence, or even compassion. I learnt a lot through following his journey. Not from the half dozen doctors he was nominally under, but from his nursing auxiliaries, who without exception came from poor countries. They tried, as we did, to bring meaning into a life that had been truncated by unexpected loss as well as disease.

During one midnight vigil two days before he died, one of the Filipino nurses gave my sister and me a big hug and said how pleased she was that we were there. “Most of the people in this home die alone,” she said. “It's not like that where I come from. For us death is as important as birth. We take it in turns to sit with the dying and do what we can to ease their passing.”

In *A Social History of Dying*, published last month by Cambridge University Press, the Australian sociologist Allan Kellehear takes readers back to the stone age to make the point that how a society responds to the dying and respects the dead is a measure of its strength and cohesion. Life may have been nasty, brutish, and short for hunter gatherers but their elaborate rituals for the dead, designed to help them journey to the

next world, were seen as vital to the wellbeing of the group as whole.

In the pastoral societies that followed, famine and infectious diseases rather than violence became the common causes of death. There was often time for the living to help the dying plan for succession and carry out their final wishes. Providing support was seen as a moral obligation.

Dying and death, marriage and birth, sowing and harvesting, were familiar components of a predictable cycle.

One of the downsides Kellehear and other social scientists observe in current Western societies, where most people live in cities, is the move away from “social connection.” Life has become focused on individuals. Their needs often take precedence over those of the community. Dying is orchestrated by health professionals and largely takes place behind the “closed doors” of institutions. The ability to acknowledge and accept its onset, and share fully in its management, is limited.

Kellehear argues that dying and death needs to be “rehabilitated” back to a more central position in society. It's a formidable challenge. The sick and elderly have become sidelined in a world that has become more hedonistic and youth oriented. Increased longevity coupled with increasing medical interventions has resulted in a combination of sudden deaths and slow distressing ones. If *A Social History of Dying* has a single take home message for Western societies it is that they must confront the fact that so many of their people eke out their final months in social isolation or penned up and infantilised in care homes and hospitals before dying “shameful” deaths.

When I talked to him last week, Kellehear emphasised that innovative thinking is needed to tackle the problem. He does not believe that even rich societies can afford to roll

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out and sustain professional palliative care services for all that need them. And it is clearly beyond the realms of possibility for poor countries, where even obtaining a phial of morphine is frequently impossible.

His mission is to persuade others of the value of the approach spearheaded by the public health palliative care unit at La Trobe University in Melbourne. In the 10 years since it was set up, community based “health promoting” end of life care has developed to become an integral part of state policy in Victoria. No service for the sick and elderly can be established without credentials to show that it's geared to enhancing the remaining life of its clients, not merely managing it for profit.

Experts in this new branch of public health train cadres of volunteers to go out to schools, clubs, churches, art galleries, and local media and organise “coffee table” meetings aimed at stimulating people to speak openly about their views on death and dying. The aim is to break down societal taboos about discussing death and increasing people's awareness of the physical, social, psychological, and spiritual needs of the dying and bereaved.

Evaluation of this approach has not gone much beyond showing that it increases knowledge but these are early days. Kellehear's next port of call is Copenhagen, where he seeks to convince the head of the World Health Organization's Healthy Cities programme to follow Australia's lead and incorporate health promoting palliative care into its public health programmes.

In 1624, John Donne wrote, “Any man's death diminishes me, because I am involved in Mankind.” Getting involved cannot guarantee our neighbour a good death, but it is a good place to start.

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