

Death and the experience of dying in Magdalena Sokolowska's research conceptions

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ABSTRACT

One of the many research passions of Magdalena Sokolowska, regarded as the founder of Polish and co-founder of European medical sociology, was socio-thanatological problems in the broad sense. Magdalena Sokolowska's version of "socio-thanatology" presented at the end of the nineteen-seventies and the early eighties consisted first of all in sociodemographic considerations. The deontological and ethical-moral problems, as well as individual existential experiences associated with the process of dying, being disregarded during the period in question, appeared in M. Sokolowska's research conceptions and papers in the nineteen-eighties. She was particularly concerned with the patterns of dying in medical institutions, conceptions of dying trajectories, processes of "waiting for death", mechanisms of the institutionalization, commercialization and medicalization of dying, differences between the conditions and context of

dying at home and in the hospital, consequences of "slow dying" for the range of social roles performed by the doctor and the nurse, the scope and character of changes in the function and structure of the family in the course of the process of dying and as a result of the death of one of its members, analysis of social behaviors after death in the institutional and non-institutional context (hospital, hospice, home), etc.

The analysis of Magdalena Sokolowska's "socio-thanatological" achievements allows us to notice a clear evolution of her conception: from the "epidemiological-demographic" approach, oriented towards analysis of mortality, to a preference for "qualitative" interpretations based on the investigation of "subjective emotions" that accompany dying persons.

Keywords: Magdalena Sokolowska, death, dying, medical sociology

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INTRODUCTION

One of important research themes and an area of theoretical considerations in Polish and Western medical sociology from the nineteen-fifties was the subject of death and dying. It inspired major trends in the theoretical orientations of sociology, inter alia phenomenology, symbolic interactionism, and ethnomethodology [1]. These issues were of no small importance in the development of views of such phenomenologists and symbolic interactionists as Anselm Strauss, Barney Glaser, and John Hinton [2], and already at that time they became a permanent part of the canons of that sociological subdiscipline, including in Poland [3,4]. Already in the sixties the main research directions became established within the developing socio-thanatology: they included inter alia attitudes towards death and dying, ethical-sociological problems (the social context of euthanasia), behaviors and social rites over the bodies of the deceased, patterns of relationships with terminal persons, the mechanisms of institutionalization and medicalization of dying, the family context of mourning, etc.) [3,5].

In Poland, in the nineteen eighties, under the Central Basic Research Program (CPBP 09.02) "The Condition and Transformation of Contemporary Polish Families" coordinated by Zbigniew Tyszka, a focus group headed by Maria Ziemska, which investigated "the foundation of integration of marriage and family", also conducted a sociomedical analysis of thanatological themes [6]. The researchers sought inter alia to show the influence of the death a family member on the way of the family's functioning, and the characteristics of experiences associated with death and their socio-cultural and demographic determinants. On the basis of the analysis of official documents (pertaining to 4000 inhabitants of a large city) and interviews conducted with 230 respondents, the study investigated in particular the influence of the death of husband/father, wife and child on the life of the family [6].

The adoption of the sociomedical perspective in the foregoing investigations by Antonina Ostrowska and Mirona Ogryzko-Wiewiórska into death and dying was partly inspired by Magdalena Sokolowska's publications on the subject and by their treatment of her socio-thanatological conceptions; the interest of the founder of Polish medical sociology in the outcome of the work of those two scholars should also be emphasized.

Magdalena Sokolowska as the Pioneer of Polish Studies on Death and Dying

The reconstruction of Professor Magdalena Sokolowska (1922-1989)'s research conceptions is a significant trend in the scholarly inquiries by one of the present authors (Piątkowski), who has published since the late nineteen-eighties [7]. The conceptions of the founder of Polish medical sociology have so far been

presented and discussed in a series of lectures published at home and abroad, in a multi-author monograph (under his editorship) and in his monograph [8]. Magdalena Sokolowska's scientific, teaching and organizational achievements are well-known not only in the field of sociology, medical science and health sciences but also in such disciplines as anthropology, psychology of medicine, or health education [9]. Magdalena Sokolowska, recognized as the founder of Polish and co-founder of European medical sociology, initiated the process of institutionalization of the subdiscipline and the development of its scientific foundations (taxonomy, methodological models, and theoretical foundations). She is also attributed with having created "the Polish school of medical sociology" [10,11].

One of Magdalena Sokolowska's many research fascinations was socio-thanatological problems in the broad sense. It should be added, however, that these problems were not her special research priorities. Her achievements in this field should be nevertheless noticed and recorded because the founder of Polish medical sociology investigated the subject (although with different intensity) from as early as the late nineteen-seventies until the close of the eighties. According to Antonina Ostrowska: "*In Poland in the nineteen-seventies the first to investigate the problems of dying in their studies were Tadeusz Kielanowski, Magdalena Sokolowska and Bogdan Kamiński*" [3,12].

A major background element underlying the interests of "the founding mother of Polish medical sociology", which only her closest associates knew about, was certainly her years-long struggle with an incurable form of cancer. Having a PhD in medicine, Magdalena Sokolowska was well aware that the actual chances of overcoming this incurable disease were slim. In her fight against fate, she appeared, however, to adopt the strategy of "shutting out the awareness" of bad prognoses resulting from subsequent diagnostic tests and the successive necessary surgical interventions which, regrettably, were nothing more than defensive measures.

The analysis of the scholarly legacy left by Professor Magdalena Sokolowska shows that the thanatology-related issues became the subject of her interests already in the mid-sixties. Her unpublished typescripts, personal notes and remarks written on the margins of the book she read allow conclusions that she owned and knew most of the then English-language publications on the subject [e.g. Jeanne C. Quint, *The Nurse and the Dying Patient*, The Macmillan Co., New York, London 1967; Tor-Björn Hägglund, *Dying. A Psychoanalytical Study with Special Reference to Individual Creativity and Defensive Organization*, University Central Hospital, Helsinki 1976].

Under her inspiration, other persons in the PAN (Polish Academy of Science) Institute of Philosophy and Sociology's Division of the Sociology of Health and Medicine also began to be interested in

the problems of death and dying (mainly Antonina Ostrowska, and Barbara Uramowska-Żyto in a different, more theoretical context). In Magdalena Sokolowska's publications of the late seventies three main research trends were clearly seen as oriented towards illness (socioetiology, social consequences of illness, determinants influencing the process of being ill, changes in the picture of contemporary diseases), towards medicine (understood as "knowledge and the system of activities") and towards the problems of "socio-thanatology" in the broad sense [13]. In her approach to these issues she emphasized the demographic and epidemiological aspects, which, it seems, stemmed both from her medical education and from her professional work in the field of social hygiene and occupational medicine [13]. Consequently, Magdalena Sokolowska (which is rare in sociomedical literature) analyzed general mortality rates, specific mortality rates, standardized mortality rates, etc. in the context of the data obtained from National Censuses, as well as their social and demographic determinants (age, gender, marital status, socioeconomic position, etc.). She pointed out that the high position on the "stratification ladder" prognosticates lower morbidity and longer life expectancy while "being poor" increases the risk of frequently falling ill and earlier death. She regarded the infant mortality rate and the direction and dynamics in the changes of this factor as a significant indicator of the condition of the population's health [13].

We can therefore assume that the version of "socio-thanatology" presented by Magdalena Sokolowska in the late seventies and early eighties consisted first of all in sociodemographic discussions; at that time the area of her interest comprised mainly such themes as recording of mortality, dynamic changes of its rates, their socio-economic and stratificational determinants, and forecasting the future directions of transformations in mortality at the end of the twentieth century. The deontological and ethical-moral problems, as well as individual existential experiences associated with the process of dying, being all disregarded at that time, appeared in M. Sokolowska's research conceptions and papers in the nineteen-eighties. A new stage, preferring a more sociological approach to the phenomenon of death and "experience of dying", was connected with the reception of Western views in the field of "sociothanatology" and with reading of the now classic monographs on the subject, inter alia those authored by B. G. Glaser, A. L. Strauss, D. Sudnow, O. G. Brim, H. E. Freeman, S. Levine, or N. A. Scotch [1]. Magdalena Sokolowska's handwritten notes on the margins of this publication show that she was particularly interested in the patterns of dying in medical institutions, conceptions of dying trajectories, processes of "waiting for death", the evolution of the death criteria and limits of the dying process, mechanisms of the institutionalization, commercialization and medicalization of dying, differences between the conditions and context of dying at home and in the

hospital, the consequences of "slow dying" for the range of social roles performed by the doctor and the nurse, the scope and character of changes in the function and structure of the family during the process of dying and as a result of the death of one of its members, death as a result of suicide, analysis of social behaviors after death in the institutional and non-institutional context (hospital, hospice, home), etc.

Magdalena Sokolowska's Conception of "Added Time"

Trying to compare the "American realities" accompanying death and dying with the situation in Poland, Magdalena Sokolowska pointed out that the outcome of technological progress in medicine is the period of "slow dying", in which one can no longer apply the strategies of restorative medicine to patients but offer only warm-hearted contact, words of comfort, elements of socio- and psychotherapy, understanding, and emotional support. She stressed that Polish doctors were not prepared for such behavior, which caused fears and led to avoiding contact with terminal patients [14]. Magdalena Sokolowska devoted a lengthy text to these problems, published in *Studia Socjologiczne* in 1985. As she herself said, the article is about the sociological and psychosocial aspects connected with the problems of death and dying, but she admits that she focused her attention precisely on the foregoing question of "slow dying" [15].

In sociology, it is not the act of death that is the central focus of interest but the sociological process of "slow dying", whose limits are marked by two moments: making an adverse diagnosis and finally, the death of a person. The achievements of modern medicine have made it possible to considerably prolong this process, and increasingly effective therapies used in terminal diseases provide a chance to delay the moment of death and postpone in time the ultimate event of death. Magdalena Sokolowska calls the time that both the patient and his/her environment gain "*the added time*". The high level of medical technologies, the change in the definition of death, (the cessation of higher brain functions) and first of all the reorientation of treatment in relation to the dying person, with a high value being ascribed to the prolongation of life [15], are the major factors that caused the "added time" to have lengthened considerably. As U. Domańska says: "*never in history has this process been stretched so much in time, never has it brought the dying patient and his/her close family and friends so much suffering stemming from the awareness of dying and of the invasive, highly burdensome therapy*" [16]. At the same time, never before has it been possible to prolong the process of dying so effectively, "to cheat" death, and give the patient the increasingly long, "added" time to live.

According to Sokolowska, it is a benefit to the patients because it allows them to put their matters in order and take part in the family life as long as possible

[15]; however, it produces a number of problems and new challenges to be faced both by the family of the dying patient, by the personnel of the institution in which the process of dying is taking place, and ultimately by the dying patient him/herself.

The awareness of the approaching death releases sadness and sorrow, both in the dying person and in his/her family members, which disturbs the specificity of daily interactions, thus causing emotional instability, growing anxiety, and a series of other mental changes that may cause nervous disorders or, Sokolowska suggests, even depression [15]. Sokolowska also emphasized that death in the biological dimension is usually preceded by the symptom of "social death" consisting in diminished activities, limitation of contacts with other people, loss of independence, progressive isolation, and an increasing withdrawal from community life [15].

The extended period of treatment also means additional expenses by the family and the deterioration of their financial condition, physical overburdening resulting from taking care of the patient, and the necessity of reorganizing the family system. The death of one family member causes deficits in the system of family roles and entails the need to fill them. The family is forced to internally reorganize their social roles and to take over the duties of the person who is no longer there. This may result in the emotional and physical overburdening of the family members, thus becoming the secondary factor producing additional problems of the family. The subject of the problems (signaled by Magdalena Sokolowska) of the family trying to cope with the death of a family member was further studied by the abovementioned Ogryzko-Wiewiórska [6]. Also other authors, including Ostrowska, point to a number of psychosocial changes with which the family are grappling in the crisis situation of a terminal disease ending in death [3,4,17].

The fact of "slow dying", which Sokolowska pointed out, also implies many special behaviors, inadequate to the patient's expectations, on the part of the personnel of the institution in which the process of dying is taking place. The questions of the dying patient about the condition of his/her health, prognosis, or about the possibility of additional treatment, are a special challenge to the medical personnel and place both doctors and nurses in an uncomfortable situation. Furthermore, *"to a doctor, the continuing period of dying is something of a failure, the awareness of which stays with him/her for a long time. The medical personnel not only experience frustration because they were unable to save life but they also feel it for a long time, face to face with the dying person"* [15].

Despite the lapse of time – thirty years have passed since the publication in which Sokolowska presented her observations – the situation has not fundamentally changed. As the results of surveys on the attitude towards dying and deaths of patients among the nursing personnel show, as many as 35.8% of the surveyed nurses feel awkward and helpless in contact with a dying person, and one in ten is afraid of

possible questions, requests, or even glances from the patient [18]. It is therefore possible to risk a statement that the interactions between the hospital personnel and the dying person are superficial and come down only to performing technical activities for the patient.

The "added time" is now a fact and no one intends to give it up: neither the dying person, nor his/her family and friends, nor all the more the doctors, who try to "cheat" death, and find it a success to prolong the dying patient's life. This is an irreversible phenomenon in the contemporary, highly developed societies; nevertheless, we need to be aware that the "added time" is not merely a benefit, the psychosocial costs of the phenomenon being borne by all the participants in the dying process.

Hospitalization of Death as Presented by Magdalena Sokolowska

The dynamic development of medicine and its progressive specialization and technicality have contributed to transferring death to the hospital institution [19]. The medicalization of social life has not omitted death – it is subordinated to the supremacy of medicine, structured by medical procedures and placed in the institutional framework. Magdalena Sokolowska called this phenomenon "hospitalization of death" [14]. Death has moved from home to the hospital, it has been subordinated to medical rigors and procedures, with the dying person being in the center of medical impingements. The sociological analyses of the institutionalization of death severely criticize this process [4,6,14,15,20-22]. The hospital, although it is the place where people die most often at present, has neither the conditions nor procedures that would guarantee the "departure with dignity".

Already several decades ago, in her article "Patterns of Dying in the Hospital (*Wzory umierania w szpitalu*)" [23], Sokolowska cited the results of the experiment carried out in Canada in the nineteen-seventies, which pointed out to a different course of the process of dying, depending on the specificity of the department in which the patient was staying. Two departments in the same hospital were taken into account: surgery and palliative care. The department of surgery had the features typical of the "acute care" hospital geared towards the examination, diagnosis, treatment and prolongation of life, with the assumption that the patient would return home. In contrast, the palliative care department focused on providing terminally ill patients with the highest possible life quality. As the results of participant observation showed, the two departments differed from each other by the attitude towards the patients, specificity of interaction as well as the forms and ways of communication with them. At the surgery department, the contact of the personnel with the patient was limited, short and sporadic, rather technical, and history taking was hasty. The patients felt loneliness and isolation, and the lack of interest in their condition

on part of the medical personnel, the doctors being not easily available both to the patients and their families. An important feature of the surgery department was the fact of "the invisibility of death", unlike the palliative care department, where death was the pivot around which the behaviors of both the medical personnel and the patient's family revolved. Death was openly talked about, the contacts of the personnel with the patient and his/her family were closer and more intimate, the freedom of behavior of all the participants in this situation being far greater [23]. The survey explicitly showed that the medical personnel of the surgery department were not prepared and the department's procedures were not adapted to the situation of dying.

In the context of the "hospitalization of death" a significant theme of the discussions both in Western and Polish medical sociology was the question of the awareness of dying and the communication of the personnel with the dying patient. Depending on the patient's knowledge of his/her health condition and prognosis, his/her interactions with his environment, and the ways of communication with the family and medical personnel develop in a different way. The classic study by Glaser and Strauss [24], cited by Magdalena Sokolowska [15], resulted in the distinction of four types of the awareness of dying as the framework for specific forms of behavior and ways of communication of all the actors participating in this situation. According to Magdalena Sokolowska, one of the most difficult problems in the "communication with the dying patient" was the form and way of telling the truth about unfavorable prognosis and about no chance of recovery. She emphasized that in the prolonged process of dying a barrier emerges resulting from the predominantly "biological and physicochemical" education of doctors and nurses whereas it is "behavioral competencies" that are particularly needed, e.g. sociological and psychological knowledge on communication with the dying patient and his/her family [14].

The range of Magdalena Sokolowska's interests also included the problems of "social death" (a slow withdrawal of the terminal person from his/her activities, contacts with others, retreating into him/herself, self-isolation), "biological death", as well as the stages of dying, which is evidenced by her comments on E. Kübler-Ross's classic conception of the stages of dying, consisting of: denial and isolation, anger, bargaining, depression, and acceptance [14].

When analyzing the patterns of dying in the hospital, Sokolowska pointed out, after Glaser and Strauss, to the so-called "critical moments" in the process of dying, which determine the specificity of relationships between the personnel, family and the dying patient him/herself. The fact of defining the patient as "dying" influences the next stages: preparing the family and the personnel for the death of the patient (which s/he would do if s/he knew s/he was dying), then the situation when "there is nothing more to be done", and after that, the final stages that cannot be defined in terms of a specified timeframe and may last

months, weeks, or days. "The last hours" of the patient's life, waiting for his/her death and ultimately death itself, "close up" this process [23]. Sokolowska observed that "when these critical moments come as expected, according to plan, as it were, then everyone, including the patient, is prepared for them. If, however, they happen unexpectedly, they create an even more dramatic situation, both for the family and the personnel, when, for example, the patient is expected to die soon but she/he will not, or when s/he dies, although no one expected that" [23].

Continuing Magdalena Sokolowska's considerations, the contemporary critical sociology emphasizes the inadequacy of the hospital as a bureaucratic institution for the situational requirements of the process of dying [25,26].

The purpose of the hospital as a public institution is to implement entirely different goals than the provision of care to the dying patient. The technical equipment of the hospital, the technologies and procedures applied in it, but also the hospital's ideology in its most general sense, are oriented towards diagnosis, treatment, saving life and restoring health. Death in the hospital is treated as a defeat, the result of the helplessness of medicine, and a treatment failure.

The hospital is still a public institution with a high degree of bureaucratization. Its operation is subordinated to organizational norms, which "create a system of deliberately established, impersonal and abstract rules regulating the behaviors of people in the organization" [27]. Their aim is to achieve the highest possible efficiency and efficacy of operation. The hierarchical structure and distinct system of dependence and subordination in the hospital, the standardization and formalization of the behavior of employees are conducive to the stiffening and schematism of their activities. And when life-saving procedures fail and the process of dying cannot be stopped, then, Sokolowska observes, the institution's personnel "withdraw from the scene" because they do not have the standards of behavior in this situation. This confirms Magdalena Sokolowska's words that "the hospital is not the right place to die" [15].

CONCLUSIONS

To sum up Magdalena Sokolowska's "sociothanatological" achievements, we can observe that her views distinctly changed, evolving from a "quantitative approach" geared towards sociodemographic and statistical analyses of mortality to a "qualitative" approach consisting in the exploration of the existential aspects and "human matters" associated with the final stage of human life. A significant role in the analysis was played by reference to "subjective emotions" that accompanied the dying persons (the taking into account of qualitative sociological analyses and the effects of anthropological studies on the subject). In Sokolowska's later considerations there are themes

concerning "the anthropology, psychology, and philosophy of dying" [11].

The gradual evolution of views, which made Magdalena Sokolowska shift emphasis from "statistical" onto "behavioral" aspects in her studies on death and dying, resulted – apart from the already mentioned personal factors – from the knowledge of the contemporary Western trends which appeared in mainstream medical sociology, for example in discussions on the conceptions of B. G. Glaser and A. L. Strauss, D. Sudnow, O. G. Brim, H. E. Freeman, S. Levin, N. A. Scotch, and others. The handwritten notes found on the margin of books owned by Sokolowska show that she was particularly interested in comparing the conditions of dying in the realities of medical institutions, hospices, and patients' homes. She regarded the context of the place of dying as vital, especially in the situations of increasingly frequent cases of "slow dying", which requires longer contact with a person in a terminal condition as well as competencies in offering support and socio- and psychotherapy.

We can venture a statement that the observations of Magdalena Sokolowska and other medical sociologists of that time who investigated the problems of death and dying caused more attention to be directed to the sociopsychological patterns developed in the hospice wards. The satisfaction of the patient's expressive needs, individual approach to each one, the ability to listen and express sympathy as well as facilitating his/her contacts with family and friends, which is a standard in hospice care, make patients "subjectively" better prepared for death despite their awareness of its inevitability and irrevocability [14,28, 29,30].

Conflicts of interest

The authors declare no conflicts of interest.

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