Exploring Death and Dying through Discourse

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Abstract: While there is continuous research being done on death and dying, often theoretical abstractions are offered which are removed from the realities of lived experiences. This paper seeks to understand contemporary practices of death and dying, in a Canadian context, through an analysis of the larger discourses which structure our conceptions of death. Guided by an interpretation of Foucault's genealogical and archaeological methodologies, current practices of death and dying are explored by tracing the history of the discourses that structure these practices, specifically the institution of medicine. This paper reaffirms the need to further explore the heterogeneity of death and dying as cultural experience and examines the ways in which those experiences are influenced by broader discourses that limit the possibility of creating meaning in death in a positive way.

Key words: biomedicine, death and dying, medicalization, discourse, end of life care

Introduction

Death has always been an integral part of human existence; therefore, death must be given credence as a pivotal component within individual life trajectories as it is, ultimately (regardless of one's beliefs of afterlife), the end of "biological" life. It is also estimated that "each death in Canada affects the immediate well-being of, on average, five other people" (Carstairs, 2010, p. 12). The death of a family member, partner, lover, friend, acquaintance, or even stranger, affects our lives, often in very intense and critical ways. As Canadians, we are living longer lives; the life expectancies for women and men are 83.91 and 78.69 years respectively (Statistics Canada, 2006); however, it is also taking us longer to die, and we are more likely to die alone in institutions and among strangers (Ziegler, 2009, p.318). The death trajectory has increased because of the proliferation and prevalence of chronic illness, specifically cancer and heart disease. In western Canada, within the final year of life, 62% of Canadian decedents were hospitalized at least once (Canadian Institute for Health Information [CIHI], 2007). A previous study in western Canada on death in long-term and acute-care hospitals recorded that "97% of patients died with at least one continuous life-saving technology in use" (Northcott & Wilson, 2008, p. 48). Death has become medicalized, routinized, and normalized in such a way that it is often devoid of meaning. Kaufman (1992) argued that "biomedicine has come to provide the fundamental framework for understanding death" (p. 721).

Despite its heterogeneous essence, death is controlled and regulated through medical and technological interventions that are practiced within the structure of various levels of administration, under bureaucratic rule. As we look cross-culturally and historically, it becomes more apparent that the ways in which death is managed is largely dependent upon the social and cultural context in which it occurs. This context, however, is not merely an evolutionary progression, but, rather, it is a manifestation of various discourses (beyond linguistics) and relations of power. As the process of death and dying becomes increasingly defined as a technical problem, a medical discourse prevails in which

death is disguised, demeaned, and ignored. Why is this? Have we, as individuals, refuted the celebration of life in death and conceded to become just another body to be fixed, another patient to be regulated, and a piece of paper to be filed? Does society fear death itself, or is it the process of dying that we are afraid of? Is it the physical space we are likely to occupy in death that affects our conceptions of death as a society? Do we fear the process of dying in a sterile institutional space? While the existential questions will always be, in some sense, associated with suffering (be that emotional, physical, or spiritual), the way a society thinks about death largely impacts individual conceptions of the way we deal with both dying and living, individually and as a society. This conceptualization is related to the type of discourses and relations of power that operate in a society. One must consider the larger discourses that ultimately work to influence the meaning (for a population) which affects how we think about and live in our bodies, through the practices that structure the process.

This paper explores these questions by examining the literature surrounding death and dying, enabling a greater understanding of current practices that exist by tracing the history of the medical discourses that structure these practices and the ways in which the historical construction of these discourses affects the management of death (expressly for older adults) in the way that it occurs, specifically within an institutionalized space. This is not to say, however, that institutions should be understood as tangible entities that merely exert power over individuals, but rather they should be conceptualized as a site of power relations and discursive practices. Much of the literature surrounding death and dying in the social sciences, as well as in medical and ethics journals, is now predicated upon opposition to a biomedical model of death to understand (and define) a "good death" in comparison to a "bad death" (both quantitatively and qualitatively). Kauffman (1992) refers to this as a cultural conversation in which a "good death" or "death with dignity" is conceptualized in relation to "personal control in dying on the one hand, and on the other hand, the pain, suffering, loneliness, and lack of autonomy brought about by the use of advanced technology medicine in the hospital setting" (p. 715). While there are varying approaches and means of operationalizing a "good death" within the literature, it is generally understood to include some aspects of palliative (and/or hospice) care philosophies (Gott, Small, Barnes, Payne & Seamark, 2008; CIHI, 2007). Death, however, cannot practically (or even theoretically) be reduced to a binary. These contemplations bring forth my primary research question, which is to examine how death and dying is managed in Canada, in relation to a Foucauldian conception of discourse. The intent is to critically engage not only current conceptions of death and dying, but also to provide a better understanding of the impact of historical processes on the manner in which death and dying is conceptualized in the context of North American health care.

Theoretical Framework

In order to question the management of death and dying, this paper draws largely on Foucault's (1977) methodologies (as well as his work) as a framework for conducting research. Foucault uses the term archaeology to describe the study of statements throughout history: specifically, what is included and excluded, and the ways in which these statements are used to structure and legitimize certain types of knowledge. Foucault uses genealogy to describe the search for connections between ideas (that affect practice) and institutions:

> If we were to characterize it in two terms, then 'archaeology' would be the appropriate methodology of this analysis of local discursivities, and 'genealogy' would be the tactics

whereby, on the basis of the descriptions of these local discursivities, the subjugated knowledges which were thus released would be brought into play. (p. 72)

In an attempt to operationalize discourse, this paper draws on Foucault's (1979) proposition: "a delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts or theories" (p. 199); this elaboration is not restricted to words but also incorporates actions and practices.

Power, Knowledge, Truth

Discourse(s) work to construct regimes of truth, and, as such, it becomes the "medium for struggle" (Purvis & Hunt 1993, p. 489) through various relations of power. Power must be understood beyond repression, as it is both positive and productive, and the relations of power that allow for certain regimes of truth to occur are inextricably linked to the production of certain types of knowledge. Knowledge must be contextualized within the historical and social space in which it is produced as a discourse. The analysis of discourse, then, becomes imperative. This process seeks to understand which statements, in relation to knowledge, are legitimated and which are excluded, and the relations of power which permit this to occur. Power is not reducible to knowledge, nor is knowledge reducible to power. Relations of power occur within and amongst individuals and institutions, and through these processes specific discourses emerge as dominant forms of knowledge. Truth, then, is context-specific. "Truth" does not operate outside of power, and mechanisms of power produce different types of knowledge; and the "effects of truth are produced within discourses which in themselves are neither true nor false" (Foucault, 1977, p. 118).

With the latter conceptions of discourse in mind, then, the biomedical paradigm is not necessarily an external or objective truth. Nor is it, essentially, a form of power that merely represses, "for power inevitably creates and works through resistance" (Lupton, 1997, p. 101). The institution of medicine is a discourse that relies on science and the idea that there is a knowable truth. And truth "is to be understood as a system of ordered procedures for the production, regulation, distribution and circulation and operation of statements" (Foucault, 1977, p. 133). Lupton (1997) summarizes Foucault's argument, stating that "over time, various medical paradigms have provided important systems of knowledge and related practices by which we have not only understood but also experienced our bodies" (p. 99). Through a process of normalization, (through the *production* of texts, disciplines, practices, which have not preceded this *idea* of medicine), this particular conception of medicine and the body is legitimated as a discourse. Medicine has come to be understood as a dominant and progressive institution despite its multiplicity and heterogeneity, resulting in specific discursive practices that draw on a singular conception of the body, and the assumptions from this perspective manifest in the justification for the management of death and dying. As such, its de-legitimization must be acknowledged within the discursive realm. By conceptualizing the institution of medicine as it currently exists as a discourse (including discursive practices), one can problematize the production and maintenance of this discourse through power relations and mechanisms of power. What constitutes truth is entirely dependent upon the mechanisms of power that produce it and the power relations that structure what is counted as true. Because truth is fluid and dependent upon the condition of its production, the potential for alternative truth(s) can be understood within the process of competition between regimes of truth.

The Institution of Medicine as Discourse

In an attempt to explore the history of Canadian medicine, I draw heavily on Foucault (1973), as his genealogy of medicine in *The Birth of the Clinic* is often cited in sociological literature regarding medicine and health. In order to understand contemporary practices surrounding death and dying, it is imperative to understand how the process of medicalization came into being through the institution of medicine. In *The Birth of the Clinic,* Foucault (1973) seeks to undertake a study that attempts to "disentangle the conditions of its history from the density of discourse" (p. xix). Foucault situates the study of the birth of medicine in relation to the moment in which the treatment of disease became discursive, as a "new alliance was forged between words and things enabling one to see and to say" (p. xii), which Foucault (through English translation) refers to as the "clinical gaze." According to Foucault, the history of medicine has emerged as a specific discourse through the reorganization of the clinic. It was during the 18th century, Foucault (1989) writes, that the conversation between the doctor and the patient shifted from "what is the matter with you?" to "where does it hurt?" (p. xviii). This was the moment in which one can discursively locate the premise of contemporary medicine. Disease came to be understood as situated within the body, rather than of the body. The "clinical gaze" is understood as a mechanism of diagnosis stemming from a conceptualization of the body in terms of volume rather than "the body as process" (Foucault, 1973, p. 136). The observation of patients in their beds became a central component of new medicine and the new clinic: a new way of seeing coupled with a new way of teaching and researching (Foucault, 1973). The clinic became representative of the medical experience (Foucault), resulting in a hegemonic discourse through a reorganization of the hospital and the patient. The institution of medicine, then, can be understood in relation to the ways in which various discourses (medical paradigms) become reference points for practices that become a part of these same discourses. It is important, however, to realize that this is not to say that there is a centralized, singular conception of medicine, but rather it is "a series of loosely linked assemblages each with different rationalities" (Lupton, 1997, p. 100). Drawing on *The Birth of the Clinic*, we can understand how various medical discourses have become reference points that guide contemporary practices surrounding the management of death and dying.

Biomedical Model

Understanding historical conceptualizations of disease and the ensuing practices as discourses is imperative to understanding contemporary conditions of death and dying and the ways in which it is controlled, managed, and regulated within larger bureaucracies (although, this is not necessarily the source of repressive power, but a form of enactment, a mechanism through which the discourse is both maintained and altered simultaneously). Conceptualizing disease and medicine as a discourse allows one to understand contemporary conditions of death and dying in relation to a biomedical paradigm which is rooted in empiricism. According to Nettleton (2006), the biomedical model is based upon five primary assumptions and is generally an accepted means of describing the initial theoretical positioning of western medicine.

The first assumption is that there is a mind-body dualism in which the body is considered separate from the mind; the body is the space in which doctors look to find disease. The second assumption within this model is a conceptualization of the body as a machine that can be repaired by "experts" and is referred to as the mechanical metaphor. The third assumption is that there is a technological imperative inherent in medicine, as technological developments appear to operate parallel

to science and intervention is justified. The fourth assumption is that this model is reductionist, that explanations of diseases focus singularly on the biological without reference to the social and cultural contexts in which they exist. This conception of reductionism is rooted in a doctrine of aetiology which seeks to understand causation from a perspective of pathology or epidemiology; this is the fifth assumption of the biomedical model.

Critiques of the biomedical model have been articulated as critiques of medicalization, in which various events in life become defined and regulated through the discourse of medicine. Death and dying, in this sense, became problematic in society in a certain way. Upon the emergence of the ability to define disease within the body, particular methods for observating and analyzing the body came to be normalized and became a part of dying. According to Lupton (1997), medicalization critiques originate from Marxist theories and liberal humanism, which emphasize "the importance of liberal freedom, human rights and social change" (p. 95). This type of argument is predicated upon a conceptualization of the dominance of the institution of medicine over individual's agency, with power existing in the hands of a particular group of people. For the purpose of this paper, a "Foucauldian" perspective is drawn upon, which argues that "society is medicalized in a profound way, serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity" (Lupton, 1997, p. 100). With this positionality, the authors hope to avoid conceptualizations of the institution of medicine as a centralized, essentialized form of power (power as a possession residing in a social or political group) that exists outside of discourse.

However, as doctors, and the institution of medicine in its entirety, have legitimized status, the way death is managed in Canadian society must be contextualized within this framework. The management of death and dying falls primarily on the institution of medicine. Life prolonging technologies are rampant. Pain management and relief have become directly related to the "healing" function that doctors must fulfill. The dominance of the institution of medicine becomes reified through these processes while it is simultaneously challenged. It is imperative to move beyond a singular conception of doctors as an oppressive force, relegating power to a possession. Considering the positionality of doctors, in an attempt to remove oneself from the sociological urge to distinguish between good and evil, I seek to conceptualize doctors as "links in a set of power relations,...people through whom power passes or who are important in the field of power relations" (Foucault, 1984, p. 99). While doctors often act within the confines of discourse, these discourses are fluid and dependent upon competing regimes of truth. Patients, then, are not merely rendered docile but actively consent and comply with medical and physician dominance. There are continuously relations of power between individuals and doctors and the institution of medicine, and subjectivity is constructed through these discourses on both the part of the "patient" as well as the doctor.

Mastery over Death?

Foucault argues that modern medicine is born as an enterprise of hubris of mastery over death, or "bringing together life and death under the same controlling gaze" (Bleakley & Bligh, 2009, p. 372). This gaze can be abstractly applied to the institution of medicine in its entirety. Because of the prominence of medicine (and the "expertise" of physicians) and its premise on the biomedical model (body as machine, etc.), the process of death has become medicalized; the natural event of death comes to be defined as a condition which must be treated and controlled by medicine, and this generally takes place within an institutional setting. As our faith in medicine and technology increases, we have given

way to the prominence of medicine and in many ways concede to its "curative function and ability to extend the lives of the dying" (Ziegler, 2009, p. 318). Death can be resisted through entirely artificial means, through life support machines and ventilators. The dead body can be brought back to life through cardiopulmonary resuscitation. We are even "able to use organs from brain-dead donors whose heart is still beating to replace malfunctioning organs in others" (Van Biesen, Lameire, Veys & Vanderhaegen, 2004, p. 539). Technological advancements have created the means to intervene in ways that have never before existed. But what has not simultaneously occurred is consensus on the ethical ways in which these mechanisms of control over death should be employed. The individual circumstances surrounding death have become structured in an institutional space whereby morality and ethics are implemented in the form of routinized legal and medical practices.

As death emerges within a biomedical paradigm (as failure) and we concede to hand over our bodies (even in death) to the institution of medicine, we renounce the meaning of our lives through the resistance and ignorance of dying. Death is no longer understood as a natural part of life but becomes something that must be resisted and intervened upon. Even upon acceptance of a lack of cure, it continues to be regulated, controlled, and managed in an impersonal way because of the functions of bureaucracy. Bleakly and Bligh (2009) remark that the medical profession shapes, guides, and controls death across the boundary of the doctor-patient relationship. This boundary is inclusive of institutional spaces in which discourses of medicine permeate in conjunction with specific rules and regulations.

When one dies within an institutional setting, the feature of bureaucracy is a dominant force. Efficiency is a key component to a successful bureaucracy, and the efficacy of death management relies on mechanization and routinization. This space is theoretically incongruent, or rather, it severely limits or restrains the acknowledgement of existential issues relating to death, thus limiting a conceptualization of death as a positive experience or as a natural life event that could be celebrated. The institution of medicine, which includes the biomedical model, expertise, and bureaucracy, can be used to explore the space of long-term care facilities, which also operate as totalizing institutions and bureaucracies that function under administrative rule.

Total Care, Total Institution?

Drawing on Goffman's (1957) essay *Characteristics of Total Institutions*, one can understand a total institution as a space which encompasses the whole of one's being. Through a regimented pattern of life, which takes place in one setting, the subject becomes relegated to a collective and therefore loses individuality. Long-term care homes can be understood as totalizing institutions as they too operate as regimented structures, spaces in which "human needs are handled in a bureaucratic and impersonal way" (Weinstein, 1982, p. 268). This process may also be understood in relation to Goffman's references to custodial care which includes "routinization, surveillance, and mortification of the self" (Askham et al., 2007, p. 20). Paraphrasing Goffman, Askham (2007) describes how attempts are made to "mortify and alter the inmates' sense of self: their sense of self-determination is curtailed; and previous or preferred identities are disallowed" (p. 3), in order to carry out caring tasks in the most efficient way. (p. 9). These functions of a total institution can be applied within the context of the dehumanization and depersonalization within long-term care homes.

The depersonalization of death can be understood within the context of the de-personalization of life upon entry into long-term care homes (McMurray, 2004). This process of de-personalization

begins through an administrative process whereby existence becomes encapsulated within a file containing various medical and legal documents. The positionality as resident (and as such, technically client or employer) becomes subsumed by the bureaucracy that manages the efficacy of care. As it is easy to theorize about these issues, it is important to also note that the relationships and interactions between staff and residents are complex and diverse, as are all interactions. Discursive practices largely shape these relationships in many instances, and often the role of "patient requiring care" takes precedence. However, it is also imperative to note that it is inaccurate to generalize all interactions that occur within this framework; there is always some element of social interaction that cannot be reduced to the theoretical realm. Pollak (1981) describes this as a form of anticipatory dying, while Neimeyer (1995) describes it as prolonged dying, whereby the individual is conceptualized as dying because of the space in which he or she physically and socially resides. This can be framed within the context of the institution, in that those who live within this space are devalued or feared, because of their close association with death and dying; loss of independence is associated with this process which is intensified within a collective space - the totalizing institution.

Beyond the Body: Holistic Philosophies

Death has shifted from the private sphere to that of the public, as it has become increasingly medicalized. At the same time, it is argued that death and dying has been removed from "public scrutiny and consciousness to the hospital" (Northcott & Wilson, 2008 p. 14). Dying in hospital (as well as within long term care homes) has been the topic of much research across academic disciplines (Wass & Neimeyer, 1995). It has been described as a dehumanizing experience in which advancements in medicine and technology intervene on the body in such a way that the existential issues surrounding death and dying have been ignored. However, alternative conceptualizations of death and dying and the care associated with this process have emerged over time; they are not just specific to the present. The proliferation of holistic philosophies of care can be understood as forms of knowledge which have specific discursive practices. The roots of contemporary forms of resistance against the medicalization of death can be understood in relation to subjugated knowledge and the emergence of alternative discourses surrounding death and dying.

Responses to modern conceptualizations and practices of death and dying are most explicitly found in hospice and palliative care philosophies. Fox (1981) attributes the emergence of these responses to two "social movement-like phenomena." In 1969, psychologist Kubler-Ross wrote *On Death and Dying,* which contained research on her experience of dying patients. Fox (1981) refers to Kubler-Ross as a "pioneering catalyst, increasing public awareness of death" and credits her "pointing up inadequacies in the established institutional care of the dying" (p. 51). Kubler-Ross has contended that the experience of death and dying can be a meaningful and "life-enhancing," and the "acceptance of mortality [is] not morbid" (Fox, 1981, p. 50). The new hospice is the second social movement-like phenomena to which Fox refers. In 1967, Cicely Saunders opened the first free standing hospice in the United Kingdom designated for the treatment of those with terminal cancer (Semour, Clark, & Winslow, 2005). It is said that as a medical social worker, Saunders had an experience with a dying man in which she realized that care encompassed a variety of treatments beyond the body itself. Saunders is associated with the term "total pain," beginning a movement that focused on dealing with what may be referred to as the existential issues surrounding death, incorporating the social, psychological, and spiritual aspects of dying (Albinsson, & Strang, 2002; Semour et al., 2005). This movement can also be understood as a counter-movement against dominant discourses of biomedicine, and resistance against

a singular conceptualization of the care of the dying. However, the power relations that structure the emergence of these discourses must be understood as the context of religious belief must also be considered, although the complexities of this variable are too large in scope to address in this paper.

In both the past and present, caring for the dying, beyond the physical aspects, is often taken on by family, volunteers, and nursing staff. As can be seen by the changing mentalities (eg. "evolution") of caring for the dying, most notably beginning with the work of Kubler-Ross and Saunders, this type of caring can be framed as forms of subjugated knowledge: "a whole series of knowledges that have been disqualified as…insufficiently elaborated knowledges: naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity" (Foucault, 2003, p. 7). Although there has been a proliferation of these philosophies and this resistance, one must question to what extent these philosophies are subsumed within the biomedical paradigm.

The Palliative Care Foundation of Canada was formed in the early 1980's and was later replaced by the Canadian hospice Palliative Care Association (CHPCA). Although initially introduced in response to the need to treat cancer patients, hospice and palliative care movements are now "appropriate for any patient and/or family living with, or at risk of developing, a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care" (CHPCA, 2009, para. 3). Ferrell (2010) operationalizes palliative care as "both a philosophy of care and an organized, highly structured system for delivering care" that "expands traditional disease-model medical treatments" (p. 221). Hospice and palliative care organizations throughout Canada have some funding from government, but fundraising is also a key component as they operate as not-for-profit. While provincial organizations vary in terms of funding and practice, all include some aspect of in-hospital care as well as home care services. In Victoria, British Columbia, Victoria Hospice has 17 in-patient beds within the Royal Jubilee hospital, some of which are used for respite care while others are designated for long term care. There is a fee for this service that is determined by a case manager. The 2000 Senate report "Quality of End of Life Care: the Right of Every Canadian" and the follow-up report "Still not there" indicate that there is limited and unequal access to palliative hospice services in Canada, although much improvement has been made. The CHPCA and specifically Senator Sharon Carstairs focus on interacting with the federal government and lobbies and advocate for improved access and implementation of hospice palliative programs.

There are varying definitions of palliative and hospice care, and the two terms are often used interchangeably. The CHPCA (2007) uses "hospice palliative care" to describe "whole-person health care that aims to relieve suffering and improve quality of living and dying" (para. 1). While the underlying philosophies of palliative and hospice care are interpreted in different ways, the foci are on end of life care. Because of the ways in which medicine and science operate as dominant discourses and regimes of truth, inherent within the re-conceptualization of end-of-life care movements is the issue of individual control, and it is often framed as the autonomy of the patient in opposition to institutions of medicine (hospital bureaucracy, physicians, etc.). This can be conceptualized within the context of critiques of medicalization from liberal, humanist perspectives.

While the CHPCA does not advocate for right-to-die movements (this can be understood within the politics and power relations of the organization itself and in relation to broader governmental structures as well as society on a whole), the philosophy on which they rely is predicated upon the idea that when people have more control over the experience of dying, they experience a greater sense of

meaning. The key foci include the right to make choices and plan for end-of-life care, specifically in relation to treatment and medication options (CHPCA, 2007). Senator Carstairs (2010) negotiates the issue well by stating that "before we [can] have a debate about euthanasia and assisted suicide in Canada we should be providing equitable access to quality, integrated palliative care" (p. 6). The philosophy of palliative care, then, can be understood as a discursive space which affects the formation of policy and legislation as well as being a discourse that informs end-of-life care and practices.

Concluding Thoughts

This research paper acknowledges the multiplicity of discourses in relation to death and dying and the inability to ever fully disentangle these discourses. Although palliative and hospice care philosophies operate as alternative discourses challenging alternative health care and conceptualizations of death, they are ultimately subsumed within the master discourses influencing medical practices surrounding end-of-life care. This paper has discussed how several aspects of palliative hospice care philosophies tend to be congruent with the biomedical paradigm and, as a result, pain management has become the central focus in this space and is synonymous with palliative care. This raises a question about what happens to other knowledges and philosophies and why they are excluded and delegitimized in this space. The answer might be that it is a function of bureaucracy but also a manifestation of medical discursive dominance.

Because the institutional space of the long term care home requires a routinization and mechanization of care, this process routinizes and depersonalizes death to the extent that it becomes invisible and unacknowledged. This may be understood as a form of death denial, as an inherent part of the institutionalized space, but it also must be understood within broader discourses of medicine which inform our conceptualizations of death. By not celebrating the lives of individuals, we relegate the meaning of death to the bureaucratic hand that controls, manages, regulates, administers, and then removes the life lived.

While the specific institutional circumstances of death and dying in Canada are diverse, they are, ultimately, regulated by discourses that affect the people who are dying. This paper has attempted to disentangle some of the dominant discourses surrounding death and dying and their intersectionalities, examining how death and dying is managed by the discourses of medicine and how this management is enacted as discursive practices. By understanding medicine as discourse, we see how death and dying is controlled through the practices and ideologies of specific institutions or organizations. Inherent within this conceptualization of discourse is that individuals are actively engaged in this process while simultaneously being confined by discourse and power relations (for example, the doctor-patient relationship, nurse-doctor relationship, etc.).

Although death and dying is a personal and private experience, it is also regulated by law, medicine, and discursive practices that structure institutional space through power relations. As science has come to be understood as an objective truth, medicine legitimizes its practices by drawing on empirical rationality, objectifying and defining how we should conceptualize both living and dying.

One cannot expect that by offering palliative hospice care that the management of death will be "rectified," this type of care can be critiqued as being subsumed to a "moral tale or cultural script" (Seale, 2009, p. 1114). Humanistic alternatives will not necessarily solve society's fear of death and dying. Ultimately, all forms of resistance and challenges to dominant discourse become part of the

discourse; we are always operating within the discursive realm. Again, this is not to suggest that power is only repressive, but that power relations are dynamic and discourse is fluid yet potentially inescapable (although this does not equate to an inability to change).

   In order to alter end-of-life care and practices we need to reconsider the practices and institutional arrangements of not only the way we live but the way we die as well. It is imperative to continuously search for alternatives, but to do so through a process of reflexivity and constant evaluation of our ontological and epistemological approaches. Reforming the way individuals conceive of society is directly related to the ways in which we obtain or maintain our subjectivities and can be cyclical. Therefore, even if we believe that we cannot move beyond discourse, or be outside of power relations, this does not mean that we should not continuously try. How we conceptualize or define death does not really matter in the theoretical sense; what matters is the meaning that is created through these processes. How can we achieve or resolve our existential issues surrounding death and dying? Is meaning and meaning making the solution to our problems? If we attribute value to death, will that reflect the way that we live? What is death? Is death a "temporary, mutable condition that we will someday understand control and overcome" (Fox, 1981, p. 46)? These are the types of questions that we must unpack within the context of discourse and power relations. This must be a continual process: not that we are seeking an underlying truth, but as we continue to learn and experience, perhaps we can reach a consensus based on multiple truths and therefore be given the space to create meaning in death, in a positive way.

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