

# Book Reviews/Comptes rendus

Alex Broom. *Dying: A Social Perspective on the End of Life*. Farnham, UK: Ashgate, 2015

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Developed countries around the world will be facing an aging population within a few decades. One of the issues that this raises is end-of-life care. At present, there is a tremendous amount of discussion on end-of-life care in the medical realm, but there are also many influential social studies concerning end-of-life issues. The author of this book, sociology professor Alex Broom, has done an excellent job in this respect; with plenty of qualitative data, he has successfully mapped out how important social factors shape patients' selves during the dying experience in a hospice setting.

This book is based on data from two sites of fieldwork over the past decade – Australia and the United Kingdom. Author Broom started his fieldwork in the late 2000s in Australia. He collected qualitative data about the experience of advanced-cancer patients in the community as well as of patients with different illnesses in the last four weeks of life and receiving in-patient hospice services in New South Wales (presented in chapters 3, 4, 8, and 9). Then, having been inspired by the research in New South Wales, Broom explored clinicians' perspectives and feelings about patients' end-of-life experiences. After collecting those data between 2012 and 2014, he wrote the material comprising chapters 2 and 6. In addition, Broom conducted research in the U.K. in the mid-2000s, drawing on qualitative data from National Health Services (NHS) cancer patients (discussed in chapter 7).

Throughout this book, the author manages to shed light on the tension between constraints and agency in the construction of dying experiences in hospice settings. To understand the book better, we could perhaps view the content within a framework addressing four aspects of the author's inquiry: *clinical*, *cultural*, *relational*, and *personal*. First, the author discusses the clinical aspect of the end-of-life experience. In chapter 2, he argues that the social construction of the dying experience depends highly on biomedical expert knowledge. Lacking appropriate rhetoric, doctors felt it was very difficult to talk to dying patients and their family members about the futility of further treatment, Broom found. In chapter 3, he notes that although hospice is a place in which doctors can effectively manage patients' pain and symptoms when dying, it is also the place that contributes to a sequestered dying experience for

the patients. For example, spatial isolation in hospice may disrupt physical, social, and spiritual dimensions of patients' selves. Chapter 6 discusses the important role that nurses play in the construction of patients' dying experiences. Nurses are potentially important mediators with professional knowledge in the doctor-patient relationship; they could enhance communication between doctor and patient and maintain patients' and their family members' emotional order in hospice.

The second lens through which readers might regard *Dying: A Social Perspective* is dying's cultural aspect. In chapter 4, Broom describes the interplay between spiritual and religious beliefs as well as medical techniques constructs the normative expectation of both a "good death" and a "timely death" in hospice settings. For example, biomedical and religious knowledge are associated with particular moral codes – for example, encouraging patients to fight on until a natural death – in hospice settings. These moral codes prescribe when a person should die, and represent the meaning of death and dying. Euthanasia, or "accelerated death", is rejected by the hospice institutional culture, with its roots in Christianity.

A third approach to understanding this book's social perspective on the end-of-life is the discussion on relational aspects of dying. In chapter 5, the author argues that dying experiences are shaped by the dynamics of informal care and the tensions between individual desires and family values and needs. For example, the competence of family care for the dying patient influences whether the family sends the patient to the hospital before the advanced stage. Further, the family members' expectation of a "good death" sometimes undermines the patient's personal choice of dying trajectory. Chapter 8 pinpoints the relationship between gender identity and the dying experience through illuminating how the gendered cultural scripts about death and dying play out. This chapter presents a wide array of gendered scripts about death and dying experiences, such as men's more stoical form versus women's more verbal form, with women more often preferring to die in peace versus men more often aiming to die with dignity, decorum, and comfort.

Finally, we can gain an understanding of this book through the personal – individual, psychological, or

identity-related – aspect of end-of-life. Specifically, chapter 7 discusses how complementary and alternative medicine (CAM) helps dying patients reconstruct their selves in the dying experience. The use of CAM helps patients regain and maintain self-control of body, self-responsibility, enthusiasm about life, and self-actualization, and to demonstrate authenticity and individual agency. For example, by doing meditation, controlling diet, and using different therapies, dying patients can actively engage in what they believe is good for their lives every day instead of passively waiting to die. Moreover, chapter 9 discusses embodiment at the end-of-life. The author points out the implication of a disordered body on self-identity and personhood in hospice. For example, the construction of good, bad, and credible images of hospice patients is closely associated with patients' bodily performance.

Considering the limited space of this book (196 pages), the author did a remarkable job of effectively shedding light on the end-of-life experience in hospice. This book successfully updates the development of social studies of death and dying. Broom also provides plenty of evidence to argue that the biomedical ethos is still dominant in hospice; hospice is not, therefore, an ideal place in which to achieve a "good death". Better still, he successfully unpacks the construction of patients' self-identities from a social perspective, through a variety of institutional, relational, and personal factors. This undoubtedly expands the conventional hospice model's understanding of the end-of-life. Not only is it concerned with pain and symptom control, but also with the social factors contributing to change in patients' self-identities at the end-of-life. To preserve patients' identities and dignity, the author suggests that hospices should allow patients to act on their wishes continuously

and autonomously. Readers may gain more insights into how to do this in chapter 7, which discusses how patients regain their self-integrity through using CAM, and in chapter 9, which explains how patients' bodily performances can shape the dying trajectory.

The only weakness I found in *Dying: A Social Perspective* was that although Broom has expanded the conventional end-of-life care model, he has not delved very deeply into the theoretical construction of end-of-life. After all, with plenty of qualitative data, he could easily further develop existing sociological theories on death and dying in the future.

Overall, this book disseminates an important message; namely, that the current hospice institutional culture should be changed in favour of letting patients determine and direct their own dying experience. Broom argues that the medical ethos tends to reduce dying patients to a set of bodily attributes and to constrain the understanding of the dying experience to physical suffering. To regain a more humanized dying experience, an end-of-life care model should address emotion, self, and embodiment issues. Perfectly, to facilitate the exploration of those issues, in the conclusion of this book Broom proposes many potential future research directions in the social study of end-of-life, including class, ethnicity, and geography; the status of dying within the context of a shrinking welfare state; decreasing accessibility of informal care; and the changing social environment of death and dying.

I highly recommend this book to researchers dedicated to social issues of the end-of-life, as well as to social workers and medical practitioners in end-of-life care. Although this is a short book, it has deep meaning and importance.

Achenbaum, W. Andrew. *Robert N. Butler, MD – Visionary of Healthy Aging*. New York, NY: Columbia University Press, 2013

Reviewed by David B. Hogan, University of Calgary

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For nearly fifty years, the psychiatrist Robert Neil Butler was an eloquent advocate for older Americans. An ideas broker, he could flip out proposals as quickly as a "Las Vegas blackjack dealer" according to a *Washington Post* reporter (Kernan, 1976). This was coupled with uncommon political instincts and leadership abilities that he used to good effect in guiding the National Institute on Aging (NIA), the Gerald and May Ellen Ritter Department of Geriatrics and Adult Development (as it was then called) at the Mount Sinai

Medical Center in New York, and the International Longevity Center during their early years. Butler was a charismatic communicator with a fact-filled, "stream-of-statistics" (from a *New York Times* reporter; Henig, 1975) style who is credited with coining short and memorable terms for key concepts in gerontology such as *life review*, *ageism* (in a *Washington Post* interview with Carl Bernstein; Bernstein, 1969), and *productive aging*. In addition to being blessed with manifold talents, Butler seemed to have lived a charmed life.