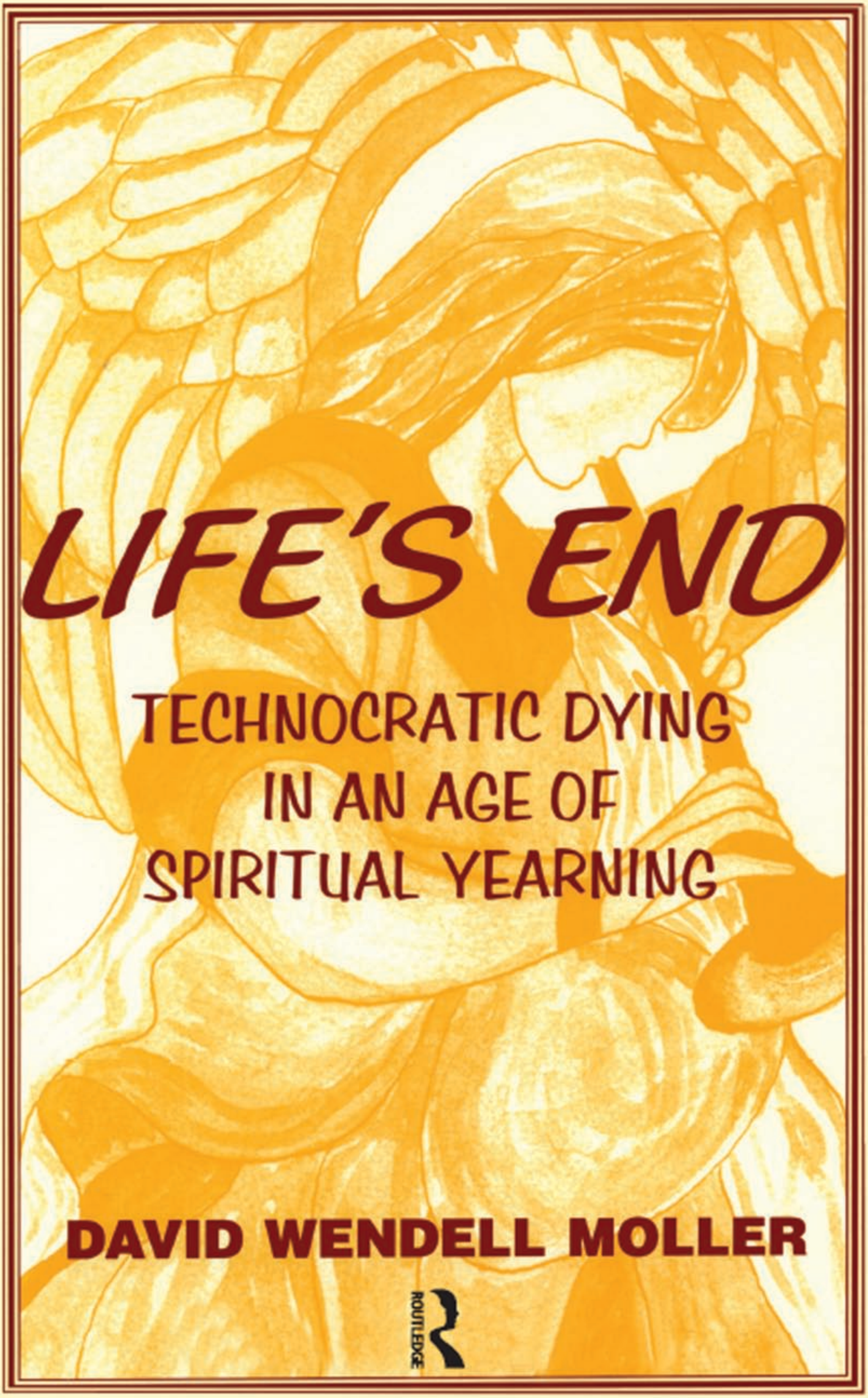

LIFE'S END

TECHNOCRATIC DYING IN AN AGE OF SPIRITUAL YEARNING

DAVID WENDELL MOLLER

ROUTLEDGE

LIFE'S END
Technocratic Dying in an Age of Spiritual Yearning

DAVID WENDELL MOLLER
Indiana University

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in honor of the
beauty that she is
and radiates.
I Love You!

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Preface

One indispensable measure of the human condition is how humanity responds to suffering, tragedy, and death. Dying is not just a personal experience or medical process. It is a part of life that has enormous symbolic and social significance. Patterns by which individuals die are created by and reflective of patterns by which they live. Thus, the ways of dying embody meanings that reveal the place of mortality in cultural life. Moreover, modern patterns of dying symbolize and contain many dreaded conditions of human existence: fear, loneliness, pain, unrelieved suffering, physical deterioration, helplessness, and meaninglessness. In this way, the prevailing icons of modern death are not only permeated with threatening and catastrophic images, they also represent and inform us about both the present state of living and dying in the culture.

Ironically, death teaches much about life. The specific arrangements of personal and social life lay the foundation for certain forms of dying. In this way, my indictment of the suffering-infused pattern of modern death which fills the pages of this book is, at the same time, an indictment of the conditions of modern life. Hence, a critique of the patterns of death is simultaneously a critique of the patterns of life. Death cannot be distinguished from life. Rather, it is a mirror and reflection of life's meanings, values, and folkways. Taking that into consideration, it is essential to explore the experience of dying in explicit connection to the values, institutions, and patterns of behavior which organize modern society.

At its simplest, the quality of dying is indicative of the quality of living; a measure of the condition and worth of the life of dying persons. On a deeper level, the styles of dying are suggestive of perplexing and complex psychosocial issues that characterize the contemporary cultural context. In this regard, the study of death has tremendous existential and social significance. It facilitates insight into the conditions of our lives and establishes a foundation upon which life can be transformed. In this way, despite its seemingly morbid aura, thanatology is potentially emancipating, life affirming, and life empowering.

On a personal note, the individuals whose voices so ennoble this book have been my greatest teachers about life. In their confrontation with mortality, I have seen them at their most vulnerable and perhaps most unflattering moments. I have been impressed with the courage it took for them to face bodily deterioration and death steadily. The real strength of this book lies not in my analysis and interpretation. Instead, it resonates from the words, expressions, suffering, and lives of the seriously sick persons whose stories are profound but mostly ignored. As one patient told me just yesterday: *We have been cast aside, disregarded, and forgotten about!* The needs and concerns of the patients in this study, like most dying people, are largely unrecognized and neglected. Their experience is virtually invisible and concealed by a society that has enormous difficulty in openly confronting mortality. All too often, consistent with values and patterns of modern life, they lived and suffered in isolation.

This book is an attempt to tell part of their story. By doing so, I hope to bring their suffering and tribulations out of the deep freeze of silence and avoidance. Their story, all the more crucial for not typically being told, is an important one. My work in this book is commensurately important because these sick and dying persons have allowed me to speak for them. They honor me with their trust, and I am privileged to try to serve as their voice. If I am able to portray the urgency and extremity of their sufferings with candor, sensitivity, and advocacy I will have served as their representative successfully. And if I succeed, perhaps some value will be derived from their sufferings, dying, and deaths. As one patient emphatically let it be known:

> Maybe some good can come of this effort for others. You know, not for me, but for those who come after me. That's why I'm participating in this study with you . . .

My deepest gratitude is extended to these patients. They have made this book possible. More importantly, they have touched me deeply as a person and as a professional. They will never be forgotten!

Acknowledgments

I am grateful to the many colleagues who have recognized and supported my passion for teaching about life through death. I would especially like to thank Robert White, Linda Haas, Bill Gronfein, Eric Wright, Carol Gardner, David Ford, and Ain Haas. I am grateful to Herman Saatkamp, Jr., for his support. I am honored to have him as an advocate and colleague. My colleagues in the School of Medicine and Program in Medical Ethics serve as exemplary role models for me, for their students, and for other colleagues. My belief in the value of ethics and humanities in the healthcare professions is continually reinforced by the everyday role they play as the ethical soul and conscience of the Indiana University School of Medicine. They are: Greg Gramelspacher, Meg Gaffney, Richard Gunderman, Gary Mitchell, and David Orentlicher. I would like to thank Bill Schneider of the Program in Medical Humanities for his support of this project and other related efforts in the area of thanatology. A special debt of gratitude is owed to Doris Merritt for her belief in the value of my work, and for her faith in me. I thank the Indiana Health Ethics Network for their interest in and support of my efforts to understand and improve the care of the dying. My colleagues in the Living with Dying project are vital sources of support and collegiality. In addition to those already mentioned in other capacities, I want to thank David Smith, Jenny Girod, Betsy Fife, and Dan Pesut for their support of me, and of our continuing effort to improve the care of dying persons. Jerry K. Shepherd, Tina Wiesert, Alice Wong, and Jaime Van Zant have worked hard and provided invaluable assistance in the preparation of this manuscript.

Writing is a solitary endeavor. I am indebted to Linguine, Sambuca, Tubettini, Minestrone, and Spumone for their constant companionship, on my desk, throughout the writing of this book. They are virtually co-authors. Certainly, it is their feline humility and utter absence of need for fame or recognition that prevents their names from appearing on the title page of this manuscript.

I am grateful to my students at Indiana University. They are very special, make my job of teaching enormously rewarding, and have taught me much in return. I am very appreciative of their support and recognition of my efforts on their behalf.

It was Camus and Dostoyevsky who advanced the theme that the path to joy leads through suffering. While this book is clearly about human suffering, I hasten to emphasize that my intellectual and professional passions are driven by a love of and respect for life. It may very well be that, on a personal and societal level, the folkways of dying are the richest representation of human self-expression. It may also very well be that the ways in which human beings face up to the mystery that is the end of life is the final and greatest statement about the value and meaning of life itself. In this way, candid awareness and understandings of mortality and of the life experience of dying persons are essential to understanding the pathways to joy and the means of achieving authenticity in living. Listen carefully to the words of the sick and dying persons throughout the pages of this book. They express two very important messages. One indicts the horribleness of the modern experience of dying; the other loudly affirms the sweetness and essential goodness of living. Thus, this study of death is a study of life. It is motivated by a personal and professional belief in the value and intrinsic beauty of life. It is also driven by my conviction that in facing mortality and committing ourselves to the relief of suffering, the splendor and meaning of life is deepened and enriched.

David Wendell Moller, Ph.D.

Précis

> "Are you dying?" . . . "Why? Can't you see I am?" . . . "Well, get on with your dying; don't raise a blamed fuss over that job. We can't help you" [1, p. 331].
>
> *Joseph Conrad*

In the twentieth-century rush to technologize medicine, the hospital has become an inappropriate place to die. The earlier fear of hospitals as the place where poor people went to die has been overcome. Most people admitted to hospitals are now discharged alive. Thanks to biomedical inventiveness a few remain dying for a long time. When the brain ceases to function, the heart muscle can be kept beating. Quaternary care has become awesome.

Caught up with new medical knowledge—mostly, with halfway technologies—physicians, always uncomfortable with failure, are more reluctant than ever to give up. Technologies are applied beyond reasonable expectations that patients can be restored to functioning human beings. So long as the heart muscle can be kept beating, there is a wish, almost unconscious, that the body ensemble will achieve a recognizably living condition. Who knows? Tomorrow a new biomedical discovery may bring the patient around.

Yet, even as more and more people die in the hospital, it is less and less considered to be an appropriate place to die. Other institutions called hospices have sprung up, to better serve the dying. Hospices are not yet so plentiful, however, that they can take over the dying from the hospitals. Physicians in hospitals are dedicated to the prevention of dying. Physicians do not define themselves as ministering to the dying. So long as physicians maintain their authority in hospitals, dying patients will be kept from death by available technology.

Yet dying patients do eventually die, and for some this may take a long time. How does the hospital, particularly the attending physician, deal with this? Not very well, according to medical ethicist and sociologist David Moller. Applying a sociomedical perspective to complement the biomedical perspectives of hospital physicians, Moller critically examines medical folkways in the hospital with respect to dying. He finds that physicians see no purpose in dying. He argues that if we understood more about dying we would gain in our power to "design personal and social systems of living, that are creative, constructive and meaningful." By way of the intensive, scholarly study he reports here, Moller has become an advocate of the dying, seeking to reduce their socially enforced isolation.

Dying is not only rejected by hospital physicians as a condition they feel prepared to deal with professionally, but is also neglected in the larger social sphere. How does society respond? Dying is avoided as a subject for conversation. Attention is directed to doing physically possible things. We are lacking in socially acceptable routines in dealing with dying. There are no standards, guidelines, or codes. The subject is suppressed as being too depressing. It becomes a totally private phenomenon with which few of us are prepared to deal. Technological concerns displace or, at least, dampen social and emotional involvement. Dying is a reflection on the failure of technology; and modern medicine is nothing if not technology.

Lest he be misunderstood as attacking how physicians respond to dying, Moller does not single out modern medicine as unique or even peculiar in its technological orientation. Rather, he places it in the broader society with its technological emphasis. Technologizing is one of two major social forces which has led to the isolating and falsely hopeful experience of the dying. The second is the cultural value of individualism as manifested in the human potential movement. These two powerful and pervasive social forces are merged in the managing, packaging, and containment of dying as an individual experience subject to unrealistically indefinite, technological postponement. The dying role decimates individual dignity and identity, converting the individual to the "low status of a second-class citizen."

Moller calls for a more candid, open approach to dying which will recognize dying as a normal, social phenomenon as well as a deeply personal, individual experience. He counsels us to abandon technologic intimations of immortality. The creative efforts of individuals, heroic and moving as they may be when confronting dying, need to be buttressed by social legitimization in the form of "prescribed societal rituals, folkways and meaning sets." Individuals and their social networks should not be left entirely to their own resources in coping with dying. Moller wants social recognition of the meanness of dying, especially oncological dying in the hospital, the subject of his empirical observations, with its "experiences of alienation, stigma, helplessness, pain, suffering, normlessness and turbulence."

The current societal approach to dying is silent avoidance. Cultural variation in funeral arrangements is a social response to the actual occurrence of death, not to dying. There are no dying "images and themes" in ordinary social intercourse. This is a twentieth-century phenomenon, unlike preceding centuries. Dying is now shameful, dirty, improper, and a social evil since it is outside of technological control. It is disinfected by medicalization in the hospital technocracy. As Glaser and Strauss have shown, the reality of dying is hidden by conspiratorial interaction of doctors, nurses, patients, and their families [2].

Moller identifies dehumanization of medical care as a structural force, rooted in the way physicians are trained and perpetuated by the peer culture and organization of medical work. With Renée Fox he recognizes the importance of the human anatomy laboratory with its cadavers as the place where medical students learn detached concern, even callousness. In the case of the dying, physicians' priorities are activities which medically benefit patients. When doctors note that death is imminent, Moller observed "a formal and regular rush to move on to the next patient and on to another floor." He concludes that there is increasing normlessness with respect to how physicians should relate to dying patients. As medical technology becomes more rational, more uncertainty is introduced into interactions between physicians and dying patients, leaving this to individual physicians and patients.

The ultimate powerlessness of the dying is reflected in the behavior not only of the patient, but also in that of the physician and the hospital. Family and friends are limited in their experience with dying as a social phenomenon. Society has as yet failed to provide the necessary rules for processing the inevitable ultimate failure of science and technology to prevent what is, after all, a universal social as well as biological event.

Moller is not content with phenomenological description and analysis. He further provides us not only with social diagnosis, but also calls for social prescriptions. Social rules and behavior need to be invented for the social phenomenon of oncological dying and put into practice in order to respond to:

- the sense of isolation of dying patients and loved ones
- the feelings of powerlessness of dying patients and loved ones
- the devaluation of the dying experience
- the downward path of pain, suffering, and deterioration experienced by the dying person
- the stigma of dying
- the hopelessness, helplessness, ugliness, anxiety, and frustration of the dying process
- the unrelieved pain of oncological dying
- the feelings of vulnerability when emotional and social needs are inadequately met
- the feelings of self-blame, guilt, and dependency
- the feelings of rejection as a sexual being
- undignified dying patient behavior, such as anger, cantankerousness, and behavioral expression of private, negative feelings
- romantic, sentimental, and overly-inflated expressions of grief.

Such social rules and behavior could, according to Moller:

- re-introduce a peaceful sense of harmony between dying people and the process of dying
- provide the support of community participation in dying rituals
- be a force for the harmonious acceptance of the coming of death as ordinary and natural process as opposed to a social evil
- emphasize the comforting roles of fellowship, ritual, and ceremony
- facilitate, even mandate, the notion that dying should be a culturally shared community experience
- culturally legitimate the pain and suffering that often typifies the experience of dying
- provide a common base of participation and sense of belonging; attach the dying person to the community of the living.

This prescriptive catalogue of social rules and behavior could, in David Moller's view, transform and retrieve the process of dying from a medicalized technology to a natural social experience. As plausible and rational as his analysis, diagnosis, and prescription seem, it remains to be seen how compliant society will be. In any case, he has vividly reminded us that dying is a social phenomenon as well as an individual event; and that attention to its social components may provide us with social dignity when faced with an inevitable biological occurrence.

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Jack Elinson

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Introduction

> There is no love of life without despair of life [1, p. 56].
>
> *Albert Camus*

A man in his mid-fifties sat on the edge of his hospital bed, holding onto his IV pole. He had extensive involvement of cancer in his kidneys, and his healthy cell tissue was rapidly being replaced by the accumulation of water in the abdominal area. The twenty or twenty-five pounds of fluid which had accumulated in his stomach provided an absurd contrasting image to his otherwise frail frame. His oncologist walked into the room in midafternoon and found him disoriented, slightly hallucinatory, in danger of falling out of bed and toppling over onto his IV connection, and very much alone. The bed-tray had been pushed to one corner of the room, where it remained with medicines that were not administered and with food that had not been eaten.

When the oncologist returned later that evening, the man's wife had come to visit him after work. The patient was lying securely in his bed, but his bed-tray was still full with uneaten food and unadministered medicines. The doctor began talking to the man's wife, telling her that her husband would not be released over the weekend. He told her that she simply would not be able to manage him at home, so it would be best if he stayed where he was. He also commented that they would have to wait and see how he was progressing, and then begin to think about letting him go home during the middle of the following week. (The physician, however, had fully anticipated that this patient would die sometime over the weekend, if not that very night.) He also expressed his belief that the patient should have someone attend him around the clock. While voicing some concern over whether or not this could be managed financially, he felt it would be best for the patient's safety, given his worry about the patient's disorientation and newly-developed inclination of trying to get out of bed. The patient's wife responded that if it needed to be done, she would go ahead and make the necessary arrangements with the hospital cashier. The oncologist informed the wife that one of his associates would be making rounds over the weekend and he wished her good night.

The physician, upon leaving the patient's room, summoned one of the floor nurses and gave her verbal instructions (which were also appropriately written into the patient's chart) on what needed to be done for the patient, including making sure that his medications were fully administered.

In this brief case example, there are many ordinary processes related to modern dying that are taking place. There are no medical heroics involved, there is no extraordinary machinery in place, and the patient was admitted onto a general medical floor. In a certain sense, the situation of this dying patient is quite normative and commonly found in modern hospital settings. The patient had been treated for his disease for nine months, and he had been in and out of the hospital several times. He was still getting chemotherapy, and was receiving additional medical treatment for the symptoms that occurred from his disease. At this point, the patient was basically in an "auto-pilot" situation, a medical holding pattern where his symptoms would be actively treated, and a wait-and-see attitude had developed on whether he would live for days, a week, a month, or die very soon.

Death, of course, is present in this holding pattern, but then again it is very much absent. In terms of physician interaction with the patient and his wife, the idea or possibility of death—not to mention the reality that the patient was dying—was never discussed. Indeed, dying was isolated from conversations that took place, and the conversations which took place steered attention away from death. It was clear, though, that the issue of dying was very much in the heart, mind, and tearful eyes of the patient's wife. However, the physician masterfully orchestrated the course of interaction away from dying and guided it toward practical, technical, medical matters. It is in this way that dying becomes very difficult to detect; it is disguised as the need for physical management and symptom treatment, and thereby is excluded from the regular, ongoing flow of doctor-patient, doctor-family interaction.

The absence of culturally established guidelines and moral codes to preside over dying leaves patients and loved ones confused and anxious. They frequently feel that they are inadequate participants in their own experience, often not knowing how to act or what to say. Physicians typically ignore the personal chaos experienced by patients and their families. They instead focus on technical and physical concerns. This process whereby the personal issues of dying are redefined into technical matters is not only consistent with their training and social organization of work, it also serves to reshape the human experience of dying into disease focus and treatment options. As we will see, this enables healthcare professionals to work each day in an environment where dying and death abound without having to deal with the emotions and social issues of dying and death. Dying, as a messy, complex, and profoundly meaningful personal experience, is consequently isolated in the private world of patients and loved ones. While patients and their loved ones are understandably concerned with the overriding question, "Is this dying or death?," the personal issues of dying are not an agreeable topic of conversation with physicians. Thus, patients, families, and physicians approach the experience of dying from sharply divergent perspectives. Patients and families experience deep personal and social implications of dying, whereas physicians adopt a preeminently technical approach in their patterns of care.

It is this pattern of interaction that invokes a deafening silence about dying and death, which is a penultimate source of social isolation for the dying patient. The emotional neutrality and objective-technical emphasis of the medical caretakers facilitate the isolation of emotional and social needs of dying patients. This often means that patients live in a private, personal, isolated, and encapsulated world. In this way, one of the major consequences of the technological management of the process of dying is to remand and banish the human meanings of dying to the private, isolated milieu of patients and their loved ones.

The theme of controlling the experience of dying through technological manipulation and through the social isolation of individuals is central to this book. I will explore how the American value of individualism and the widespread commitment to technology have given rise to particular forms of governing the process of dying that are unique to the professional dominance of death in the hospital setting. I will focus attention on how the values of technology in the broader society are applied in the framework of medicalized care of dying patients, and discuss the consequences this has for their lives. Additionally, I will analyze how the value of individualism, so ubiquitous in the broader society, influences the treatment of dying patients and their definition of the meanings of their own dying. In this way, I will show how the dominant values of the American cultural system are institutionalized in the medical treatment of dying patients.

My explicit purpose is to analyze dying and death in the cosmopolitan, modern setting. There is, however, an additional theme that is implicit in my analysis and observations. The portrait of dying, which is provided in the pages to follow, also tells us a great deal about life. It demonstrates that the foundation for the medicalization of death that piercingly shapes the life experience of dying persons and loved ones is a product of the ways of life in the broader culture. As emphasized in the Preface, the styles and patterns of dying and death are reflective of the styles and patterns of life in a particular historical and cultural circumstance. Indeed, the more I study and learn about death and dying, the more I am convinced that the way one dies is a reflection of the way one lives. This is not just relevant for the personal, private lives of individuals. It is also true on a societal level. In particular, the circumstances of an individual's private life—the quality of relationships, spirituality, personality characteristics, etc.—are significant to the unique way each person will endure his or her own dying experience. More broadly, the dominant patterns of life and socialization in the larger society will significantly shape and define the contours of the collective dying experience in American society. In addition, the values and institutional arrangements of the broader society significantly influence how individuals craft their own personalized meanings and response to dying. Thus, an interesting reciprocal relationship between life and death is apparent: the styles of death are a reflection of the ways of life, and the ways of life establish the styles of death [2, p. 236]. Hence, the study of death ultimately is a study of life.

It is precisely for these reasons that the study of death, which on the surface appears to be morbid, is one of the deepest pronouncements of the love of life. First and foremost, I have rarely witnessed more appreciation of life than I have observed in those individuals who are coming to the end of life. They truly are inspirational teachers about life and its joys. In addition, on a more scholarly level, the issues raised by the study of death are seminal to the study of life. Issues such as meaning, the significance of suffering, the need for social support and intimacy, integrity of the body, and yearnings for spiritual connection are not just narrowly related to death and dying. They are central to the human condition and are major issues defining patterns of life in America today.

The study of death also offers possibilities for transforming the conditions of life. The study of the suffering, agony, dilemmas, pain, and terrors of dying persons can lead to explanations and understandings that have the potential for improving their lives. In a corollary vein, the life experience of dying persons and loved ones is a signal indicator of how the quest for meaning, satisfaction, and joy in living is being fulfilled on a daily basis for all citizens. By approaching the study of dying as a cultural and structural reflection of living, we can obtain insight into dying and living which is sensitive to and affirms the value of life for all human beings—healthy, disabled, sick, or dying. If there was one dominant unspoken message which I read in the eyes of the dying patients whose lives and sufferings so enrich this book, it ran something like this:

> Tell your students, your readers that despite the incomprehensibility of our sufferings, this is truth, not fiction. Revel in the joy and goodness of life. For as we, the dying, thirst for health, normalcy, and a future those of you with all of these gifts at your doorstep owe it to us not to take life and its splendor for granted. Appreciate each breath that you draw, for someday soon, each of us is going to be dead for an awfully long time.

The most important message of these dying patients was not about death. It was about life.

This book, with the landscape of modern life and death which it portrays, is devoted to understanding and honoring the lives and sufferings of all dying persons—both present and future.

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CHAPTER
1

Encountering Mortality: Preliminary Reflections

> And now lying and listening in the darkness, he understood his life [1, p. 15].
>
> *Herman Broch*

> Cholera! The thought flashed through Kitty's mind and then a deathlike feeling came over her; she was seized with terror, she struggled for a moment against the night that seemed agonizingly to run through her veins; she felt horribly ill; and then darkness [2, p. 151].
>
> *W. Somerset Maugham*

Death is the great instrument and facilitator of life! For it is death above all else which makes life precious and irreplaceable. Within the impossible knowledge that our lives will end lies both terror at the prospects of dying, and an opportunity for resurrection and renewal of life. It is ironic that death, which curdles the human heart with fear and constantly shadows each life with the possibility of extinction, is our unyielding companion throughout life's journey. For those who love life and yearn for its experiences, life cannot and does not exist independently from death. There can be no escaping the knowledge that life is temporary, and can be lost at any moment. In this regard, one of the most profound and universal challenges of humanity lies in our personal and collective confrontation with mortality. As we are summoned to meet this challenge, which is uniquely at the center of the human experience, it is important to recognize that the struggle for meaningful and fulfilling life must come face-to-face with the realities of suffering, of pain, of sorrow, and of death.

Perhaps the human spirit, with great influence from contemporary values and folkways, can avoid and "conquer" death through pretense and denial. This avoidance, however, is more illusion than productive accomplishment. In truth, we never fully escape the knowledge that we are destined someday to grieve the loss of loved ones as well as die ourselves. It is within this framework of knowing that a serious and successful passage through life must come to terms with death.

The mysteries of mortality are integral to the mysteries of life. The pursuit of self-knowledge and self-acceptance must reconcile the facts of death with the facts of life. It may be ironic that the process of nurturing and caring for life must include preparations for endings of life. The ongoing attempt to avoid the confrontation and encounter with mortality only serves to deepen our fears and heighten our anxieties. In this way, freedom from death in life is only obtained by active engagement with death throughout life. As Sherwin Nuland advises, it is only by frank discussions of the very details of dying can we best deal with those aspects that frighten us the most. It is by knowing the truth and being prepared for it that we rid ourselves of that fear of the terra incognita of death that leads to self-deceptions and disillusions [3, p. XVII].

Today, dying is filled with images of unmitigated suffering and horror. As we have progressed throughout the twentieth century, the styles of everyday life have become increasingly incompatible with facing the burden of mortality. Suffering, dying, and death have lost their presence in modern cultural life, and have been systematically separated from visible and public patterns of social activity. Of course, the confrontation with death remains an inevitable part of human experience. In the modern context, however, encounters with mortality have become increasingly concealed and privatized. Coinciding with this trend toward invisibility and privatization is the vanishing of norms and rituals that once helped to guide individuals through the dying process. In the contemporary milieu, where the cultural devaluation of death has given rise to pervasive patterns of avoidance, the human drama of dying is often sequestered in hospitals and redefined into a clinical and technological matter.

Images of denial have replaced images of familiarity and acceptance. Anxiety about the indignities of hi-tech, medicalized death continues to grow. In this regard, the intersection between the facts of modern life and the facts of modern dying has become increasingly strained and shaped by a gnawing sense of unease and confusion. Consider, for example, how difficult it is to talk openly and comfortably about death. Although very simple to pronounce, dying-death-dead are words which are difficult to say and to hear. When we must talk about mortality, our utterances are usually shrouded in euphemisms such as: "passed away," "kicked the bucket," "bought the farm," and "is with God now." Medically based euphemisms are also widespread, reflecting both clinical detachment and duplicity: "the patient has expired," "respirations have ceased," "the patient is no longer with us," and "the patient has gone sour." For many people, even more unsettling than talking openly about death is the actual confrontation with dying. Families are typically overwhelmed with unease and anxiety when witnessing a loved one die. They regularly complain about not knowing what to do or say. They frequently feel impotent and helpless in the face of suffering that seems so alien to the rest of their lives. And individuals, when faced with the diagnosis of life-threatening illness, are often paralyzed with fear upon receiving the news. We can only imagine the terror that grips the heart when a malignancy is discovered, as if the disease itself was an incarnation of evil. As we will see, not only does the