BEING AND BECOMING DEAD

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BASIC to understanding the problem of caring for the dying is an awareness that with all its mysteries and ultimate questions, death is a concrete event, mostly smelly and mean, preceded and followed by pain.

The conflict of these two spheres of human thought—that concerned with being and meaning, and that concerned with the body—while finally resolved for the dying person, is brought into the open for those around him. In the physician who regularly attends the dying, the conflict finds constant, if subliminal, expression and is responsible for much of what troubles him in the care of the dying patient.

It appears that the modes of thought, the very mechanics of reason on which physicians have depended for generations and which have been so useful for understanding the body, may lead away from an understanding of dying. In other areas of medicine and science there is also a growing awareness of some of the inadequacies of analytic thinking (atomistic, particular, reductionist . . . that method of thought which reduces things into their parts in order to understand them). Nowhere is the failure so poignant as in death. Physicians are not alone in having accepted analytic thought as the only kind of reasoning "proper" for public usage and professional discussion. As science won its battle with theology far beyond A. D. White's[1] fondest hopes, a whole culture has accepted that the path to ultimate understanding lies in analysis—dividing, breaking into parts, holding still. Meanwhile, synthetic thought, the other kind of thinking, (integrative, intuitive, magical . . . the mythical thought of Lévi-Strauss, the dialectic of Sartre . . .) innately appropriate to other parts of the human condition, has sunk into the privacy of each of us. Though atrophied by disuse, that necessary kind of reasoning continues to trouble the surface of comprehension.

[1] Andrew D. White, *A History of the Warfare of Science with Theology in Christendom*, 2 Vols. (New York: Dover Publications, 1960). (Original appeared in 1896.)

In death and dying the two opposite kinds of thinking, the one (analytic) open and robust, the other (synthetic) private, and in this day, underdeveloped, bring conflict and paradox onto the scene.

Throughout this discussion we will see paradoxes and problems which I believe are best understood as dichotomous ways of thinking and states of being. Seen in this manner the care of the dying becomes more comprehensible. Hopefully, in examining this problem we will achieve clearer understanding of the two kinds of thought and their meaning to us.

Traditionally, in our culture approaches towards death have been religious or philosophical, but as in so many other areas, with the growth of technological society the voices of religion and philosophy have become remote. Not only do religion and philosophy seem distant from the bedside but their questions seem tangential in terms of modern physicians and what actually goes on. But how can it be that questions of morality and human values, so basic to the care of the dying, seem remote, "strange," or tangential in the actual setting of care?

To start answering that question, it is necessary now to address ourselves to death as a real event. It seems reasonable to start by defining what we mean by dying. Laymen, when asked "How would you define a dying patient?" generally divide death into physical and non-physical states. They say that someone can be dead in his mind. It is a concept quite familiar to us, and the connotation is unpleasant. Some quotes will illustrate:[2]

[2] The quotations come from taped interviews in the author's office.

Interviewer: "When do you consider somebody to be dying?"

Respondent 1: "A person dies when the mind stops thinking."

Respondent 2: "I had a sister-in-law who was a fantastic person . . . and led such a full life, and for everybody, and I just adored her. And she had a second marriage which was terrible—it demolished her, really. Just before, the day before she was going to go to a psychiatrist, she committed suicide. Yet I could see her dying, because her whole interest was gone. Is this what you mean? Is this what you're asking me . . . ?

Interviewer: "I'm asking you how you feel about it. In other words it is possible to be dying without having a disease?"

Respondent 2: "That's right, yes, yes. This is what I'm saying."

Generally, the death state of mind is considered sad. Under special circumstances, however, it is seen as making physical dying easier;[3] take, for example, patients with terminal disease who know they are going to die and withdraw interest from the world around them. But for this discussion, the essential fact is that the non-physician sees the mind-body duality and usually considers a dead mind in a living body to be a bad thing.

Physically defining a dying person seems harder for the layman and, in searching for a definition, he looks into his own experience. Where experience provides example, the temporal relationship between *dying* and being *dead* is generally considered short; where experience fails to provide information there is some hesitancy, but again, the time between being dying and being dead is quite short. It is interesting that for many there is considerably greater confusion about physical death than about non-physical death. While many factors may enter into this confusion, from denial to simple ignorance, I believe it is an area where, as in illness, the confines of reason do not provide easy answers to the questions.

Two type cases, however, serve to illustrate the layman's definition. Case one is that of a 42-year-old man who, feeling entirely well, was found after a routine blood test to have acute myeloblastic leukemia, a disease whose prognosis is at best measured in months. Does the layman think the patient is dying? There is some doubt. Does the patient know? No, he doesn't and feels entirely well. Finally the respondents generally agree that he is not dying. If he knows, then he *may* be dying if he *thinks* he is, but confusion continues. Some quotes from respondents presented with this case illustrate the point:

[3] Elisabeth Kubler-Ross, *On Death and Dying* (New York: The Macmillan Company, 1970).

Interviewer: "Is he a dying man?"

Respondent 1: "I guess on one level, yeh, I mean, he must be."

Interviewer: "If you looked at him and knew he had leukemia, would you look at him and say there's a dying man?"

Respondent 1: "Probably not."

Respondent 2: "I think dying, real dying, implies a knowledge of death, of personal death."

Interviewer: "So that person, that leukemic is not a dying patient?"

Respondent 2: "No . . . I mean, if you mean his body is deteriorating, yes."

Interviewer: "If you looked at him would you see a dying person?"

Respondent 2: "No, no."

Case two is that of a man who has had four or five heart attacks. In his present one he is in an intensive care unit, unconscious. There are doctors and equipment surrounding him as in a scene from the most dramatic television show. Is such a patient dying? Again, some confusion—but it is generally agreed by laymen that such a patient is dying.

To summarize, the layman is quite clear about a mind-body duality in dying, and sharp and decisive in assigning the possibility of "mental" death. He is more confused and vague about