

The Meaning and Value of Death

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INTRODUCTION

AS A CLINICIAN it seems disrespectful to discuss the “meaning and value” of death. The preciousness of life underlies all clinical disciplines and preservation of life is a paramount clinical goal. Understandably, for clinicians death is the enemy to be conquered, and when it occurs, it represents defeat and failure.

Phenomenologically, death is nonbeing. The essential nature of life entails activity, purpose, and making order from disorder. Death is the antithesis of life. Nonlife is inactive, and despite its stillness, death is chaos. Life generates its own meaning. In contrast, on its face death appears devoid of meaning and value.

Because philosophically I cannot know anything with certainty about death, I must accept that death itself may (or may not) be meaningless. Nevertheless, it is apparent that the fact of death profoundly impacts our understanding—and experience—of meaning in life. Although it remains unknowable, death’s relationship to life is essential and as profound as the relationship of darkness to light. Death need not illuminate life, it is sufficient for death to provide the background against which the light of life is seen. It is from this perspective, both clinically and philosophically, that the question: “What is the meaning and value of death?” becomes relevant and approachable.

Inquiry into the meaning and value of death can be approached from cultural, individual, and communal perspectives.

DEATH AND THE MEANING OF INDIVIDUAL LIFE

If death represents ultimate ego annihilation, it is no wonder that people have an aversion to thinking and talking about death. Thanatologist Herman Feifel quotes seventeenth century French writer and moralist, La Rochefoucauld, “One can no more look steadily at death than at the sun.”¹ Contemplating nonbeing is a Gordian knot and attempting to understand death is inherently frustrating and can provoke considerable anxiety. Indeed a number of psychologists, including Freud, have considered death to be the root source of all human anxiety. It is interesting, however, that it is equally frustrating, although less anxiety provoking to contemplate nonexistence before one’s conception and birth than after one’s death.² It may not be the absence of one’s being that causes emotional pain, but the loss of having been. The anguish of anticipated loss of relationships to others and the world is not evoked by contemplating people and the world before birth.

The human capacity to conceptualize time and, therefore, to conceptualize the future underlies the meaning of death.² We can only speculate on other species’ understanding and orientation toward death. Ethological observations reveal that animals flee from perceived threats to life instinctively, although these instincts can be overridden in special circumstances—dare we say, for “a higher purpose”?—such as the defense of young offspring.

Although lower animals may not be able to

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Presented at the W.K. Kellogg Foundation National Leadership CGA Seminar *Future End-of-Life Care: Best Ideas, Practices & Policies*, Airlie Conference Center, Warrenton, Virginia, November 18–19, 2000.

conceptualize the meaning of death, it seems humans have no choice but to try. Anthropologists have long posited that humans are inherently "meaning makers." Biologic evidence for an innate drive to make meaning include split-brain experiments with people born without connections between the two cerebral hemispheres or who have had the corpus callosum of their brains severed to control epilepsy. Presented with disparate images shown to the right and left halves of their visual cortices, such individuals reflexively strive to interpret and explain the unrelated images as a meaningful whole.

Particularly when a problem cannot be overcome, it is a trait of human nature, individually and culturally, to assign it a meaning. Faced with the ultimate problem and unalterable fact that life ends, human beings impulsively strive to recognize some meaning in death.

Awareness of death confronts us with questions that go to the very nature of existence. What is the nature of life? Is there continued existence beyond life? Does life have meaning? What is the meaning of my own life? These questions, asked in an infinite variety of ways, are part of the human confrontation with death. Such questions define our place in the world and our relationship to others. They hold profound relevance to human life—individuals and collectively, as families, communities, and societies. A society's and culture's orientation toward the meaning of life and death underpin moral values and ethical norms of behavior.

Although inquiry of this nature is familiar to philosophers and theologians, most people actively avoid the subject of death. However, even for the least introspective among us, the ever-present fact of mortality constantly threatens to wake us from the dream of life.³ When sudden death, serious injury, or terminal illness strikes our family or circle of friends, the foundation of our world is shaken. From the moment an individual is diagnosed with an incurable illness, death becomes the alarm that will not stop ringing. Even during remissions or times of relative health, its distant ring can be heard.

The intrusion of death forces us to look at the things we want most to avoid. Hitherto philosophical issues that seemed abstract and avoidable acquire concrete relevance and immediacy. Existential concepts such as the "aloneness" of each individual in the universe become all too real when faced with the approaching and in-

evitable loss of everyone we know and love. The person living with progressive illness directly experiences the profound implications that issues of meaning and value of life hold for the way we live, individually and collectively.

CULTURE AND THE MEANING AND VALUE OF DEATH

Our cultural and individual orientations toward death are intimately interwoven. We are at once a product of our culture and a participant in its ongoing evolution. It is well recognized that denial, or perhaps more accurately, suppression are psychological defense mechanisms that mark the orientation of Western culture toward death.⁴ The culture tends to avoid serious consideration of death and avoidance behavior is readily documented.

Even when confronted with unsettling news of the death of someone they have known, contemporary Westerners typically avoid questions that search for some meaning in death. Instead, in a manner that deflects deeper inquiry, typically people seek to ascribe a reason for the specific death. We hear people ask, "Was he a smoker?" or, "Was she wearing her seat belt?" as if in assigning an explanation for an individual's demise, one's distance from death can be preserved. On the surface, the numerous examples of violent deaths in contemporary films, computer games, and other types of pop culture might seem inconsistent with this cultural trait. However, such fascination with violence and gory death more likely represents an array of defense mechanisms such as reaction-formation or desensitization than any sort of mature effort to incorporate death within our individual psychological or collective cultural makeup.

If avoidance of death is so deeply rooted in our individual psyches and culture, it may be presumed that a world without death would represent a Utopia. Kastenbaum⁵ conducted a simple, but intriguing experiment that suggests otherwise. In a two-phase written survey, 214 university students enrolled in a course on death-related topics were asked to express their feelings about living in a world without aging and death concisely. The assignment was given prior to any readings or course work. Initial responses were 88% clearly positive. Typical written comments were, "You bet! Does it start now?" and "I love

it! This makes my day!" Students were then given a written homework assignment with specific instructions to consider and list (1) "the effects a world without death would have on other people and society in general," and (2) "the effects a world without death would have on the way you live and experience your own life."

The initial survey question was then repeated. The result was a dramatic reversal of frequencies with 82% giving negative responses and 18% positive. Expressed concerns about the absence of death on society clustered around issues of overcrowding, mandatory birth control, loss of rules governing human relationships, the conservative influence of massive numbers of elderly, the potential for economic systems to falter ("Kids wouldn't get their inheritances . . .") and the erosion of religious beliefs. Worrisome impacts on individuals' lives included, loss of ambition, loss of meaning, loss of heaven, and less need to be responsible. Under the category, "loss of meaning," Kastenbaum⁵ reports the following quotes as characteristic: "I just cannot think of myself going on and on, and things not coming to an end. I'd have to ask myself what life is all about, and I don't know that I can answer that question." "I have a real hard time imagining what it would be like to live in this kind of life. To be honest, I don't know what life would mean to me if I knew it was just going to go on and on . . ." ⁵

Of course, the implications of this thought experiment are limited. Two hundred fourteen university students who elect to take a course on death and dying do not constitute a representative sample of the human population. Still, the consistency and dramatic reversal of responses warrants consideration. Perhaps, as theologians, philosophers and poets have long suggested, life without death would be so monotonous and devoid of intensity, pathos and joy as to render the human condition meaningless. Indeed, it is not necessary to say that death gives life meaning to note that death may be necessary for life to have meaning.

HUMAN DEVELOPMENT THROUGH CONFRONTATION WITH DEATH

Rich empiric evidence from the biographic and medical literature has established that an individual's confrontation with death can serve as a stimulus for personal growth.⁶⁻¹⁴ In an essay

written about a year after his diagnosis of esophageal cancer Dr. Bill Bartholome eloquently described his own personal adjustment to living with the knowledge of death's approach.

It's been little over a year now since I discovered I have a fatal disease. In trying to explain to family and friends what having this period of time has meant to me, I have found it helpful to characterize it as a gift. . . . It has allowed me time to prepare my family for a future in which I will not be physically present to them. It has given me the opportunity of tying up all the loose ends that our lives all have. I have been provided the opportunity of reconnecting with those who have taught me, who have shared their lives with me, who have touched my life. I have been able to reconnect with those from whom I had become estranged over the years, to apologize for past wrongs, to seek forgiveness for past failings.

But even more than all these, this gift has provided me the opportunity of discovering what it is like to live in the light of death, to live with death sitting on my shoulder. It has had a powerful effect on me, my perspective on the world and my priorities . . . I like the person I am becoming more than I have ever liked myself before. There is a kind of spontaneity and joyfulness in my life that I had rarely known before. I am free of the tyranny of all the things that need to get done. I realize more than I have ever before that I exist in a web of relationships that support and nourish me, that clinging to each other here against the dark beyond is what makes us human . . . I have come to know more about what it means to receive and give love unconditionally . . .

. . . To live in the bright light of death is to live a life in which colors and sounds and smells are all more intense, in which smiles and laughs are irresistibly infectious, in which touches and hugs are warm and tender almost beyond belief . . . I wish that the final chapter in all your stories can have a chapter in which you are given the gift of some time to live with your fatal illness.¹⁵

The stimulus for personal development that occurs in response to an individual's confrontation with death arises from questions that define ex-

istential and spiritual realms of life. What is the nature of existence? Who am I? Who or what or where was I before I was born? Will "I" exist after death? Forced to live with knowledge of impending death, such questions assume poignant relevance. Some people experience severe spiritual or existential distress while others develop a seemingly paradoxical sense of "rightness" that characteristically involves realms of inner life. A number of clinically reported accounts of positive subjective experience with life's end document a transition through a sense of spiritual or existential distress to a sense of "wellness" despite full acknowledgment that death is near.^{7,16-19} Recognition of these poles of human experience engendered by death's approach—from severe distress on the one hand to a profound sense of wellness on the other—and the demonstrated potential for some individuals to move through suffering, make it imperative for clinicians who care for dying people to understand something about spiritual, existential and religious experience as they relate to life's end.

The inherent mystery of existence is at once awe-inspiring and terrifying. In responding to that mystery people seek to discover some meaning within their own lives and within life in general and strive for a sense of connection to something larger than oneself that will endure into the open-ended future. Listening for one or more of these themes has been helpful in understanding people's expression of profound distress on the one hand and seemingly paradoxical sense of personal well-being on the other.

In clinical evaluation and end-of-life research, I rely on a working definition for spirituality comprised of three themes: response to mystery, connection to something larger than oneself which endures into an open-ended future, and an experienced source of meaning. Religion and spirituality are distant constructs. In the context of the present inquiry, religion may be considered a subset of spirituality. Religion refers to a coherent set of beliefs, values, eschatology, knowledge, techniques, rituals, customs, and practices toward fostering a sense of connection and meaning and a way of dealing with the mystery of existence. Religions often involve specific beliefs related to a deity or supreme being, but this is not a requirement. Religion is a principal way through which human beings have reached out to one another—in community and across generations—to provide guidance and support in confronting death. Not surprisingly, people who

have a religious faith often find it provides a deep well of strength and source of comfort in dealing with illness, caregiving, death, and grief.

Existentialism arose in reaction to theistic religion. A contemporary dictionary defines existentialism as, "A philosophy that emphasizes the uniqueness and isolation of the individual experience in a hostile or indifferent universe, regards human existence as unexplainable, and stresses freedom of choice and responsibility for the consequences of one's acts."²⁰ It might well be presumed that existentialism and spirituality are opposites, mutually exclusive ways of approaching reality. In fact, an existential perspective may not obviate spirituality—and even religion in the broadest sense. Recent advances within physical and theoretical sciences, including chaos theory, suggest that within the haphazardness of reality there may be an underlying pervasive order. Even if there is no master plan, the intricacy of patterns and "laws" of mathematics, astrophysics, quantum mechanics, and molecular biology reveal a subtle, esthetic intelligence within the very fabric of physical reality.

Approached from the most coldly rational perspective, one cannot escape the implications of death on the meaning of life as individuals and, more particularly, life in relation to others. Earth is but a speck of rock hurtling through space. The circumference of the earth is 24,901 miles at its widest point, fewer miles than many of us drive each year. All of us are but tiny creatures, living precariously on its surface, held by the mysterious happenstance of gravity, hurtling through deep space on this speck of rock, with only a thin blanket of air to warm and protect us from the frigid ravages of the Milky Way's galactic void. Whether or not there is an active or watchful deity, human beings are still faced with the reality of living on this earth. The strictest, least sentimental existentialists, while decrying any notion of meaning within the puny, insignificant human condition, is nevertheless faced with the predicament of living together, for whatever time we each have. An overarching question remains, "What are we going to do about it?"

DEATH AND THE MEANING OF COMMUNITY

The impact of death on human life extends beyond the fact of our individual mortality. For although human beings are individuals alone, each

person also exists in relationship to others. Individuals do not live in isolation, but instead in families and communities. In common with most mammals, human beings are communal animals; we are inherently connected. Even the strictest of hermits depends on others for necessities such as food, clothing, and shelter from the elements, but at very least for emergency services at times of true crisis and from protection against others who might prey on them.

Indeed, humanness may have no meaning out of context of our connection to one another. This is not merely a philosophical assertion. There is ample evidence for a biologic basis for relationship and love—both in terms of a need for love and a drive toward it. In fact, empiric data suggest that human interaction, including physical touch, is essential for primate development—and human well-being.²¹

One etiology of pediatric failure-to-thrive syndrome—a condition associated with high mortality because of secondary malnutrition and infection and with universal developmental delay—is the deficiency of human touch and caring interaction. The naturally occurring experiment of foundling homes provided stark empiric evidence that even with adequate nutrition, shelter, and support for bodily functions, humans can become ill and die from a deficiency in human touch at critical developmental stages.²² The well-known studies by Harlow and Mears²³ demonstrated a similar syndrome in juvenile primates engendered by absence of a responsive mother.

Here again, death informs our understanding of human life. Our shared mortality poses fundamental questions of our relationship to one another and our essential responsibilities one to another. Bartholome's observation that, "Clinging to each other here, against the dark beyond, is what makes us human," may be literally true.¹⁵ Perhaps, in addition to our opposable thumbs, 46 chromosomes or specie specific genome it is how we are with another in the face of death—including how we care for another—that confers our humanity.

The presence of people with advanced, incurable illness who are experiencing physical distress, disability, and physical dependence in the process of dying confronts communities with the need to respond in some fashion. What services should communities and society as a whole extend to people who are dying? How, and how much, should individuals and their families pay for such services? Are certain services so basic

that they must be available for all? Should the availability of other services be based solely on one's ability to pay? What responsibilities do we have to those who are dying: our family members, friends, neighbors, and those we do not know? What responsibilities do we have as individuals, and collectively as a society? And what, if any, responsibilities do the dying—all of us—have to those we leave behind? A culture's orientation toward these questions underpins moral values and ethical norms of behavior.

In a 1978 article entitled, "The Ethics of Terminal Care," Harold Vanderpool asserted:

These four fundamental features of human worth—respect for the individual, inclusion in community, concern for the body, and considerations of a broader purpose—are offered as ethical guidelines for terminal care.²⁴

Ethicist Laurie Zoloth-Dorfman has written:

Cleaving to another, recognizing that the other is the bone of the bone and the flesh of the flesh that is given in common, locating the mutual body as the site of the moral gesture is fundamental to ethical reflection . . . it requires a radical rethinking of all that occurs to the other. All of the yearning, all of the loss, is in fact, my loss. This responsibility for the narratives great and small, for the dreams of the other, for the temptations of the other, for the responsibility of the other, creates a mutual commandedness. The encounter is intensely personal. The death of the other, the illness of the other, her vulnerability, is your own.²⁵

What Zoloth-Dorfman is describing here is a covenantal relationship of people within community. That each of us will die is inevitable. What has come to be miraculous is to die in fellowship. The vision she offers is one in which people are being born into the welcoming arms of community—and dying from the reluctant arms of community.

RESPONSIBILITY IN THE MEANING AND VALUE OF COMMUNITY

What is the fundamental responsibility of communities, or society, to its members as death ap-

proaches? If one accepts that any responsibility exists at all, it is most generally, a responsibility to care.

The barest essential components of human care at the end of life would seem to be the following: The provision of shelter from the elements. In essence, we say to the other, "We will keep you warm and dry." The provision of hygiene. "We will keep you clean." Assistance with elimination. We say, "We will help you with your bowel and bladder function." The offering of food and drink and assistance with eating. "We will always offer you something and help you to eat and drink." The keeping of company, nonabandonment. "We will be with you. You will not have to go through this time in your life entirely alone." Efforts directed at symptom management, the alleviation of suffering. "We will do whatever we can, with as much skill and expertise as available, to lessen your discomfort."

THE MEANING AND VALUE OF DEATH IN CLINICAL PRACTICE

Instead of distributing collective ownership for these basic obligations and discharging them in a proportional fashion, modern society delegated almost exclusive responsibility for care for its dying members to the clinical professions. The conscious motivation was, of course, to provide the best care possible. It is, however, also true that professionalization has served as a mechanism by which society has manifest its cultural avoidance of death. One result of assigning official responsibility for care of the most ill, infirm elderly, and dying people to doctors, nurses, and hospitals and nursing homes has been to distance society's members from these potent reminders of our own inevitable illness, infirmity, physical dependence, and death. In medicalizing care for "the dying," individuals with advanced and incurable illness are objectified and an inherently messy process is sanitized. This transformation finds symbolic expression in the traditional white coats and uniforms that distinguish and separate doctors and nurses from patients and in the ubiquitous rubber gloves of postmodern medicine. After death, the person officially becomes a corpse and, in many places by law, the body is sent to a mortuary.

Recognition of serious existing deficiencies in end-of-life care and the ongoing debate over pro-

posals to legalize physician-assisted suicide have included harsh criticism of doctors for reinforcing patients' denial of death. Although some degree of criticism is warranted, contemporary clinicians have been placed in an awkward, and in some circumstances, untenable position vis-à-vis death. Physicians, particularly, have been assigned a shamanesque role within society as cultural defender against death. Doctors are trained to do battle with death; selection processes at all stages of medical training favor warrior traits. This is particularly true for specialties most likely to encounter dying patients such as surgery, emergency medicine, internal medicine and its subspecialties, and critical care.

Medical training is concentrated in hospitals, which in our secular society symbolize temples of death denial. Within them are the *sanctum sanctorum* of death denial, the operating rooms, emergency departments, and intensive care units in which the most powerful and prestigious medical specialists, such as surgeons, cardiologists, pulmonologists, oncologists, and intensivists, perform the rituals of life-prolongation. They do so wearing special garb and communicating with one another in esoteric language. In these places an unrelenting opposition toward death is modeled and rewarded. Medical students, interns, and residents learn early on that straight talk of death is interpreted as weakness, equated to a student giving up, or not having the wherewithal to know what to do next.

Until quite recently, physicians who worked in hospice and palliative care risked subtle ostracism within the medical profession for seeking to care for dying patients, as if the proximity to death tainted the individual clinician. When hospice was first introduced in the United States, it was considered to be within the domain of nursing. (As with all nursing, hospice was considered to be "women's work," undoubtedly a factor that contributed to its diminished status within the culture of medicine.) In the early 1980s, while attending an emergency medicine conference, I mentioned in passing that I worked as a part-time medical director for a hospice program to a group of physician colleagues. One of the group reacted by abruptly taking a step back and asked, "Why would a doctor do that?" His expression conveyed how distasteful and unseemly the notion was for him. Of course, things have changed and palliative and end-of-life care have begun to enter the mainstream of medicine.²⁶

Over the past 20 years society in general, and the caring professions in particular, have begun to culturally acknowledge and integrate an acceptance of life's end. Fueled by the aging of the baby-boom generation and the infirmity of their parents and by documented, widespread deficiencies in care²⁷ and in the midst of the assisted suicide debate, society has begun asking a second layer of questions: What value is there in the last phase of life? Can there be any meaning and value in the process of dying? Can there be value in grieving? Can there be value in caring for people as they die?^{23,11,14,28}

The disciplines of hospice and palliative care continue to make critical contributions to this process of social and cultural maturation. It is, of course, proper for the caring professions to shoulder the technical components of society's fundamental responsibilities toward its members as they die. Clear communication, ethical decision making, meticulous, competent, and when necessary, intensive management of symptoms are basic standards and reasonable expectations for care.

Physicians and nurses cannot not guarantee that all symptoms will be fully controlled, nor that every person will die well. But on behalf of society, clinicians can commit to doing whatever is necessary to alleviate physical distress. We can commit to not giving up, to never abandoning patients. Whatever else we cannot do, we can commit to be present for another, this is the ground substance of human responsiveness. Whether or not society acknowledges a responsibility to provide organ transplantation, experimental chemotherapy or even physician-assisted suicide, we can acknowledge a social responsibility to provide the basic elements of human care and honor an inalienable human right to die accompanied, in relative comfort, and in a clean, dry bed.

MEANING MAKING: A GENERATIVE PERSPECTIVE ON MEANING AND VALUE WITHIN CLINICAL PRACTICE

To this point we have approached the subject of the meaning and value of death from the perspective of exploration, observation, and description. A complementary, equally valid approach exists. Because meaning and value are subjective human constructs, it is reasonable to consider whether meaning and value can be consciously, deliberately created.

Within a generative orientation toward meaning and value, notions of social and clinical responsibility to others are expanded. As beings in relationship to one another, human beings' response abilities extend beyond the barest obligations of meeting the physical or basic emotional needs of dying people. We also possess the freedom and human capacity of responding in creative, even loving ways to people who are dying, engaged in caregiving or in grief. The discharge of social responsibility is, ultimately, about our inability—and willingness—to respond to one another. For example, we have the capacity to bear witness, metaphorically saying to the other, "We will bear witness to your pain and your sorrows, your disappointments, and your triumphs. We will listen to the stories of your life and will remember the story of your passing." Bearing witness may not be an obligation in the same sense as other fundamental components of end-of-life care. However, it offers the potential for creating or strengthening relationships between individuals that are of profound value to the people involved.

Life review and the soliciting, telling, and receiving of persons' stories is another tangible example of components of care that extend beyond attending to basic biologic and emotional needs. Anthropologists suggest that peoples' stories play an important role in knitting the fabric of human community. The letters that concentration camp victims, passengers in planes headed for crash landings and, recently, the note to family from a doomed Russian naval officer trapped in the submarine Kursk, all give evidence of the importance of narratives in the human response to death.²⁹ Telling the story of a loved one's dying, and receiving the story of another, can both be creative acts. In telling personal stories of life's end people honor loved ones who have died and renew, refresh and sometimes reframe cherished connections. In receiving a story as inherently intimate as the dying of a lover, grandparent, parent, sibling, close friend, or child, new connections are made and each person's community expands.

LOVING CARE AT LIFE'S END AND ITS CONTRIBUTION TO MEANING AND VALUE

Human love is quite possibly the most creative response to the terrifying and awe-inspiring mys-

tery of life. The loving connection between two people creates something new in the world, something of inherent meaning and value to the people involved. Clinical care must be medically and technically competent. However, there is no reason to be found in law or ethics that prevents care from also being tender and loving. Beyond shelter, company, and competent symptom management, people can be cared for in a manner that treats them as one would treat an honored guest. Skillful clinicians can offer counseling for people who wish to reconcile strained or broken relationships before they die. Palliative care can encompass anticipatory guidance to facilitate bringing significant relationships to “completion” in the sense that people feel that there is nothing left unsaid. In providing care that assists people in strengthening connections with others, we can foster the creating of meaning and value.

I am not the first to suggest that the word “community” has properties more akin to a verb than a noun. The very nature of community has to do not only with some shared history and traits, but also with a mutual sense of belonging and in actions that reflect the recognition of some degree of shared “stake” in life. Community does not merely occur, it is created.

Recently, I had the opportunity of spending a day at Oregon State Penitentiary with 18 prison hospice volunteers, several of whom are convicted murderers. Each of these men have already been in prison for 5 to 10 years and described having “hit bottom” with depression during their early years of confinement. Each are facing long sentences and a number of them are “lifers.” As inmates they have little dignity and few rights. There is no material advantage to an inmate to participate in the hospice program. They do so without compensation and must maintain their regular 40-hour per week job. The training takes long hours and is emotionally charged. One after another, as they told their unique stories, these men expressed that being a hospice volunteer adds value and meaning to their lives. I felt like I was peering into the equivalent of J.B. Haldane’s “primordial soup” in which life was being formed. In this instance community, as in prison hospice programs around the country, we are witnessing creation of community at its most rudimentary, fundamental level.³⁰

Organized community-based efforts focused on improving end-of-life care and social support have begun to emerge. In my adopted home town of Missoula, Montana, we are engaged in a long-

term community-based research and demonstration project to study and improve the quality of life’s end. We are exploring what it means to be living “in community” rather than merely “in proximity” with one another with regard to the experiences of dying, caregiving, grief, and loss.^{14,28} And our community is not alone. Indeed, an increasing number of communities in the United States and Canada are communicating and collaborating in development of similar community-wide efforts.

The clinical professions—and the disciplines of hospice and palliative care in particular—have leadership roles to play in the continued maturation of our contemporary society and Western culture’s response to death. Care can be provided in a way that acknowledges the full range of human experience and potential within the people we serve, including peoples’ capacity to adapt and grow—individually and together—through the very end of life. It is possible to declare that people inherently have dignity. We need only act in a manner that honors the dignity of each person’s unique being to make the declaration come true.

There are profound advantages to clinicians and those they serve in this process. By providing care that is not only competent but genuinely loving, we invest even the most mundane aspects of clinical work with meaning and value. In so doing we can contribute to a sense of meaning and value in the lives of the people we serve.

RENEWAL AND PRACTICE OF RITUALS AS CREATIVE CULTURAL AND SOCIAL RESPONSES TO DEATH

Discussion of making of meaning in face of the apparent chaos of death would be incomplete without considering the role of rituals. Every religion, as well as every ethnic and regional culture, encompasses traditions, customs, and rituals in response to death. Since the early stages of the scientific revolution, public attitudes adherence with traditional customs and rituals surrounding death has steadily eroded. There has been a tendency to view such rituals as superstitious or somehow primitive.

There is now evidence that this trend is beginning to reverse. Organized, informal vigils within neighborhoods surrounding the impending death of a beloved individual may include prayers, singing, and placing luminaria along the person’s front walk. It has become fairly common for hos-

pice and palliative care programs to offer music as a means of soothing and honoring a dying person. Although traditional funerals and formal religious services may be on the wane, memorial services remain well attended. In addition to offering a chance for people to grieve together, contemporary memorials are often lively celebrations of the deceased individual, encompassing photographs and videos of the person along with music and readings that held meaning for the deceased or hold meaning for friends and family. It is possible to see that renewed interest and spontaneous generation of new ritual forms as a sophisticated, well-considered effort to respond to the tragedy of death by making meaning, investing shared time and activity with meaning.

CONCLUSION

Death is central to the meaning and value of human life as experienced by individuals and by communities. Death does not give meaning to life, but does provide the backdrop against which life is lived.

Fundamental responsibilities of human beings toward one another are defined by the need to respond to the facts of illness and death and contribute to the meaning and value of individual and communal life. Acting on behalf of society, the clinical professions bear critical responsibilities for caring for those who are dying and bereaved. However, overreliance on professionals as a means of denying or distancing ourselves from death and grief can diminish the fullness and richness of living and erode the experience of meaning and value in our lives.

Beyond acknowledging and honoring basic obligations, individuals, families and communities have the capacity to respond to the ultimate problem of death in a creative manner including the performance of rituals that reflect and advance values of human worth, dignity, and enduring connection. The clinical professions can lead by setting standards for excellence and by providing care that is not only competent but unabashedly loving. In so doing meaning and value is created by direct intention.

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