
A GOOD DEATH

BY PYTHIA PEAY

Lost in the heated debate about assisted suicide is the question of how we all can help one another with the spiritual work of entering life's final stage.

Like a lightning bolt that sears the sky with illumination, my father's death changed my relationship to life forever. Sitting at his bedside the moment his breathing stopped, I felt I was witnessing a sacred event. As I continued to keep watch, allowing his soul time to depart, I was awed by the transformations in his body: the deep relaxation that smoothed his furrows, the look of pained concentration that slowly changed into wonder, the pearly translucence that softly radiated around him.

However, just as a storm is announced by rumblings of thunder and dark clouds, my father's dying did not happen suddenly. Ten months before he became bedridden, my siblings and I had begun to sense that something in our eccentric and difficult patriarch had changed. Despite his doctor's reassurances that, even with prostate cancer, he had years left, each of us knew instinctively that the end was in sight. We also had a strong hunch that, as in Dylan

Thomas's poem, my father would not "go gentle into that good night."

A lifelong drinker and smoker, my father had made it clear that if further treatment became necessary, he would not enter the hospital. If he was going to die, it would happen his way: in bed, with the TV on and a cigarette and a drink nearby. I steeled myself for the worst, imagining that he would die a lonely alcoholic's death or that he would shoot himself if the pain got too severe, as he had often said he might. I relinquished the idea of a funeral because of his hatred of Catholicism, so there would be no end-of-life resolution, I thought sadly—more likely anger, perhaps relief.

But a miracle happened—in fact, a host of them. When my father died, he was at home surrounded by a loving family. He had made his peace with estranged relatives and with God. He had completed his will, reconciled with the Church, and even helped plan a funeral after all. He had spent long hours recalling scenes from his youth, and a steady stream

of dreams and hallucinations had opened up for him the possibility of an afterlife. His dying became a kind of party—sending out for his favorite foods, socializing with family, enjoying a few last drinks and cigarettes. And although my father and I did not say all the things to each other I had hoped we might, we walked his very last mile together—and that brought a lasting healing to our relationship.

The miracle of my father's dying occurred not thanks to a divine angel but through the human agency of hospice workers—a chaplain, a social worker, and a nurse—as well as a priest with a soul of gold and a family who maintained a vigil until the end. My father did not die in pain, because he had been treated with morphine; he did not die in fear, because he had confronted his anxieties; and he did not die alone, because, as best he could, he had been helped by counselors to reach closure with those dearest to him.

But as the reaction of friends who had also lost parents made clear, my

father's dying contrasted dramatically with the cultural norm. The difference, it seemed, stemmed from the hospice support my family had received, so unlike the more clinical treatment in hospital setting. As a result, I began to wonder whether our society's neglect of the metaphysical dimension of death contributes to the suffering that surrounds modern-day dying.

American culture contrasts sharply with that of ancient Egypt, whose enigmatic civilization revolved entirely around the mysteries of death; medieval Europe, with its Christian contemplation of the suffering, crucifixion, and resurrection of Christ; and Tibet, which produced a *Book of the Dead* that mapped out richly detailed landscapes of the afterlife. Aware that death was a central organizing principle of inner and outer life, these cultures did not expect the dying to make the final passage unaided. Instead, priests, priestesses, monks, and nuns provided spiritual and psychological assistance. Such skilled guidance, however, has all but vanished in modern-day America. What was once a royal road traversed by saints and sinners, the powerful and the humble alike, has become a narrowly defined passage involving only the physical dissolution of the body.

Much of our society's crisis around death could be said to stem from a lack of awareness of the dying process as a stage of growth. Just as different steps must be mastered in childhood, adolescence, and adulthood, dying presents its own challenges. Borrowing from the theories of developmental psychologists such as Jean Piaget and Abraham Maslow, Ira Byock, M.D., author of *Dying Well: The Prospect for Growth at the End of Life* and president of the American Academy of Hospice and Palliative Medicine, has conceptualized the landmarks in end-of-life growth: completion of worldly affairs, closure of personal and professional relationships, learning the meaning of one's life, love of oneself and of others, acceptance of the finality of life, sense of a new self beyond personal loss, recognition of a transcendent realm, and surrender to the un-

known. When looked at from this perspective, says Christine Longaker, a Buddhist teacher in the Rigpa Fellowship—an international network of centers that follow the teachings of the Buddha—"dying becomes another stage of living, a very vital stage that can allow us to conclude our lives well."

Yet the vision of a "good death" in the company of loved ones has been eclipsed by a stormy debate concerning an individual's "right to die" by euthanasia or physician-assisted suicide. The Supreme Court's recent ruling that physician-assisted suicide is not a constitu-

"As a national community," says hospice physician Ira Byock, "all of us need to say loudly that we do not consider people undignified or abhorrent because of their physical frailty or dependence."

tional right but should be decided by state governments means that the issue is unlikely to vanish. Some call it the abortion debate of the next century.

In part because of this controversy, there is a renewed commitment among many to encourage hospice and other forms of "contemplative caregiving"—those that attend to not only the physical but also the emotional and spiritual needs of the dying. Much as Baby Boomers transformed the way America receives obstetrical care, Byock hopes that, as they care for dying parents, friends, and even children, they will transform how Americans die as well. "We depathologized the concept of pregnancy and birth, saying that it was not a disease but a part of healthy living," he explains. "Similar things can be said about the end of life: that we need not pathologize people in order to acknowledge their

mortality. In fact, people can become healthy in their dying."

The Slippery Slope

Historically, observers say, society stands at an unprecedented juncture regarding end-of-life issues: the convergence of modern technology with ancient religious beliefs. On either side of this intersection, both medical doctors and "soul doctors"—psychologists, clergy, and meditation teachers—are pondering a set of moral riddles never before confronted. As medicine has advanced to extend life despite grave illness, the boundaries between a "natural" death and an artificially sustained life have become blurred: At what point should life support be removed? What are the limits of suffering, both physical and emotional, that an individual should have to endure? Do narcotics relieve physical pain but dull consciousness? What about "passive" forms of euthanasia that allow a person to die by refusing food and liquids?

As society debates these issues, caregivers are on the front lines tending to the needs of the dying. While not wishing to appear as apologists for assisted suicide, they hold a compassionate view with regard to those dying in intractable pain. Says Joan Halifax, founder of the Buddhist center Upaya in Santa Fe, New Mexico, and its Project on Being with Dying: "I have been with people who are in extreme states of mental and physical suffering. How could you not want them to be liberated from that suffering? [Physician-assisted suicide] really does not have to do with the Supreme Court. It's an ethics of the heart and the most intimate of questions."

Stephen Levine, an early pioneer in the death-and-dying movement and the author of *A Year to Live: How to Live This Year as If It Were Your Last*, voices a similar opinion. "What happens when you have no concentration left and you can't tolerate your suffering?" he asks. "If physical pain becomes extreme and untreatable—so that the person's life has essentially disintegrated and imploded—I very much understand the act of self-deliverance."

Yet despite the fact that intractable physical suffering has received the spotlight, it is just one facet among many that add to a dying person's discomfort. Principal among these are financial concerns and lack of proper physical care—critical issues in the current crisis around health insurance. Levine cites the hypothetical example of an 86-year-old man with severe cancer: Two long regimens of chemotherapy have used up his HMO coverage, and his family is broke. A third course of chemotherapy would leave his wife “a bag lady.” Under such circumstances, Levine says, a person is very likely to want to take his life. Or, he says, a person with AIDS may be dying without care because all his friends have died of the disease and he's cut off from family. The patient is “lying in a pool of material any one of us would die to get out of,” Levine says. “Blood and pus and urine and not being able to get back on his bed at four in the morning and no one to call. A person like that takes his life.”

A recent article in the *Journal of the American Medical Association* likewise concludes that the most common concerns at the time of euthanasia requests are not directly connected to physical pain; rather, it says, they are worries about such things as “loss of control, being a burden, being dependent on others for personal care, and loss of dignity.” Such research highlights what has come to be known as the “slippery slope” argument—namely, that if euthanasia were legal, people would request suicide for both nonphysical reasons and questionable physical ones, with the societal consequence of increased disregard for human life.

Dale Borglum, director of the Living/Dying Project in Fairfax, California, says that often someone with AIDS or cancer has asked him for help in dying. When he responds that he is legally forbidden

from such an action, it is not unusual, he says, that several weeks later that same person will say, “I'm so glad I didn't take my life, because there's been so much living and relating and understanding that's happened in the meantime.” Borglum says he has come to realize that much of the time when people ask to die, it is because “they don't have the proper support spiritually, or in terms of pain control or psychotherapeutic intervention. If you listen closely enough, what they're really saying is that they don't want to keep suffering.”



Healing Physical Suffering

When asked what he does as a hospice physician to help people work on the spiritual aspects of their lives, Byock says that he first treats their physical pain. “I help them deal with their bowels,” he says. “If they don't do it, trust me, they won't be thinking about what meaning their life had; they'll be worried about their bowels. Only when he or she is comfortable enough can a dying

person's attention be drawn to end-of-life issues.”

Indeed, among the greatest problems cited by hospice caregivers is the lack of knowledge around pain management. There is a “huge gap” in the culture, says Longaker, author of *Facing Death and Finding Hope: A Guide to the Emotional and Spiritual Care of the Dying*, between the paucity of pain-management training among medical doctors and the hospice movement's research and expertise in ameliorating end-of-life pain. Long-lasting morphine pills, for instance, relieve “pain peaks,” and the morphine pump—often referred to as the PCA (patient-controlled analgesia)—gives individuals more control by allowing them to regulate their own doses. Even those kinds of pain that narcotics can't help, such as bone pain, Longaker says, have been found to respond to new treatments

Borglum's observation is at the very crux of what the death-and-dying movement has been attempting since its inception in the early 1970s under the pioneering work of Elisabeth Kübler-Ross: namely, to address all forms of suffering—physical, psychological, and spiritual—in order to make physician-assisted suicide unnecessary and a spiritually assisted “good death” possible. For while there may be individual circumstances that make physician-assisted suicide an understandable request, Ira Byock maintains that “at this time, in this country, legalizing physician-assisted suicide is the wrong response to a real crisis related to dying.”

Byock's central concern is the effect that legally sanctioned suicide would have on society in general. Should physician-assisted suicide be legalized, he warns, “it would not be

such as antidepressants combined with anti-inflammatory medicines.

According to Byock, the requisite medical knowledge and technology exist to control all forms of physical distress among the dying, but they simply aren't being applied. Fear of addiction is one reason. Paul Appelbaum, professor and chair of the Department of Psychiatry at the University of Massachusetts Medical School, says that for more than 20 years suicides have shown that "terminally ill patients who are in pain are systematically undermedicated, in part because of physicians' concern about addiction to opiates—a concern that has no basis in a terminal patient."

Religious attitudes toward suffering also play a role. According to Levine, the idea that people must suffer has been emphasized in the Christian, Buddhist, and Jewish traditions. There is a part of all of us, he says, that believes we deserve to suffer. But, he adds, "those who have felt the embrace of Jesus or sat in the lap of Buddha know that there is nothing in those beings that would do anything to extend suffering."

Sister Sharon Burns, R.S.M., Ph.D., chaplain of Stella Maris Hospice at the Cardinal Sheehan Center in Timonium, Maryland, tells the story of a young mother dying of cancer who, even though she was taking pain medication, "was in great spiritual distress because all she could think about was her own physical comfort." The woman confided in Burns that, like Christ who suffered on the cross, she felt she should be able to "offer her suffering up." Burns explained to her that there was nothing wrong in using "God's intelligence" in the form of painkillers to take away her pain and sorrow. She also reminded the woman that, even in the absence of physical pain, nothing could take away the pain she was feeling upon leaving her husband and two children. Such counsel eased the dying woman's anxiety; two days later she died at peace with herself and her family.

Another difficult task related to the physical distress of the dying revolves around deciding when aggressive medical interventions, such as life-support systems or chemother-

apy, should be halted. Psychiatrist M. Scott Peck, author of *Denial of the Soul: Spiritual and Medical Perspectives on Euthanasia and Mortality*, argues that important "soul work" may actually be going on beneath the guise of a coma, senility, or Alzheimer's disease. He warns in his book that making "life-or-death judgments" about the quality of another person's life is fraught with ambiguity—such as mistaking treatable depression for untreatable senility or prescribing further chemotherapy for the benefit of a brief remission. He points to ethics committees, living wills, and family discussions as important tools

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to help determine when and if treatment should be discontinued.

Still, Peck is generally against the use of heroic measures to prolong the life of a clearly terminal patient and in favor of "gently stopping" it. Likewise, many hospice caregivers complain that physicians unnecessarily delay referring their patients to hospice care until the last moment, thereby losing valuable time that might have helped the dying person conclude his or her life well. Longaker had this experience herself when her mother-in-law, who was "obviously dying" and in discomfort from her feeding tube, was detained in the hospital because her physician was reluctant to transfer her to hospice care. Although her mother-in-law finally ended up in hospice, Longaker recalls, she died just 24 hours later.

Once the decision has been made to allow nature its course, however, new dilemmas may present themselves, such as those around food. Hulen Kornfeld, a registered nurse who works with the chronically ill and dying and the coauthor with Richard Boerstler of *Life to Death: Harmonizing the Tradition*, says that aversion to food and drink often occurs naturally as the result of nausea caused by heavy medication or because of complications due to illness. Yet rather than prolong their lives through the use of feeding tubes, some patients may consciously choose to hasten their death through a form of "passive euthanasia" by simply refusing further nourishment. Some may even see the act as an opportunity to explore altered states of consciousness, as fasting can facilitate visions or hallucinations.

But a dying patient's refusal to eat can cause stress to caretakers who equate nurturing with food. Indeed, according to Byock, hospice workers have long avoided the topic of withholding nutrients when death is imminent, fearing that the act might be misinterpreted as assisting suicide. But, he writes in his book, "it is not suicide to refuse an operation when one can no longer swallow, nor is it suicide to decline food when hunger is a distant memory and death is one's immediate future." Rather than make patients feel obligated to do things that are contrary to what their body is telling them, says Kornfeld, she helps relatives and caregivers cope by teaching them spiritual forms of nurturing, such as enhancing the atmosphere with special sounds, music, or prayer.

Like fasting, another little discussed topic in the euthanasia debate concerns what is known as the "double effect," the administering of powerful sedatives, such as barbiturates, to help relieve the rare forms of severe physical pain that don't respond to ordinary analgesics. While not toxic enough to cause immediate death, these narcotics nevertheless hasten death by helping the patient relax more deeply, falling into what Byock described to one of his patients as a "twilight sleep" from which she would be unlikely to awake. In this particular case, Byock's

patient slept for 30 hours before dying peacefully; during that time, her loved ones bathed her, caressed her, and made their final farewells.

While most people may see only a fine line between sedation and euthanasia, Byock writes, it is in practice a "chasm." In fact, Peck says, few physicians are aware that the Catholic Church, which officially opposes euthanasia, has sanctioned the double effect. As Sister Sharon Burns explains the Church's stance, "[The double effect] means that the secondary effect of the intention is not willed. It's to relieve pain and give comfort and to give more dignity to the way of dying." Although approved by hospice as a necessary element of comfort care, Peck notes that physicians may not prescribe the drugs out of a fear of malpractice. In his opinion, the euthanasia debate would go a long way toward resolution if the courts would legitimize the double effect.

For many spiritual practitioners who have worked toward the goal of a "conscious death," pain medication can present a quandary. Most caregivers are aware that while narcotics may put a person to sleep, and may sometimes dull consciousness, pain may equally be a distraction from concentration or prayer. Longaker says that while it is not her right to impose upon others her ideas about what constitutes a spiritually "good" death, she herself would wish in the last days of her life to be weaned from narcotics. If she were to find herself in so much pain that she could not meditate, she says she might consider alternatives, such as being undermedicated enough to take the edge off her pain while still being "conscious enough to do spiritual practices and use the remainder of my life well."

Healing Emotional Distress

As difficult as it can be to ease the physical pain of the dying, most caregivers agree that psychological anguish is far more challenging to treat.

For some, it may be tempting to avoid treating the dying person's depression—after all, if the person is old or about to die, what's the use of uncovering buried wounds? But dealing with despair may prevent someone from taking his or her life too soon. It can also create an opportunity for hurts and grievances to finally be addressed. Discerning the specific causes of suffering, however, requires careful listening on the part of the caregiver. Often, societal expectations around what constitutes a valuable human being may contribute to a per-



son's wish to end his or her life. Especially in a society like ours, where independence, autonomy, and control are prized virtues, it is understandable that a person who is suddenly wholly dependent upon the care of others may suffer feelings of worthlessness.

Dale Borglum tells the story of a woman dying of a brain tumor who had made an agreement with her husband that if she got sick enough and wanted to die, he would help her. But when she decided it was time, her husband had changed his mind. Borglum was called in to mediate.

"When I asked her why she wanted to end her life," Borglum recalls, "she said it was because she was burdening those she loved. When I

asked her husband and her other caregiver if she was a burden to them, they both said it was a privilege and an honor to care for her and that they hoped she would live as long as possible. Then she started crying, realizing that it wasn't that she wanted to die but that she had felt like a burden. She died just two days later, but if her husband had given her the drugs he would have felt bad. This way there was a great deal of closure."

Loss of dignity is another cause of suffering for the dying. Such a fear, notes Byock, is a cultural problem. "As a national community," he says, "all of us need to say loudly that we do not consider people to be undignified or abhorrent because of their physical frailty or dependence." Byock compares caring for dying people to caring for infants. "We would not consider an infant to be in any way undignified by his or her complete physical dependence and incontinence. Even a colicky baby, who cries continuously, is not left in isolation. What do we do with that child? We respond with unconditional loving and care, not just as a family but as a community."

Compounding feelings of depression and loss of dignity is the anguish that occurs when the dying look back on the negative aspects of their lives: the failure of relationships, the hurt inflicted upon others, the missed opportunities, the questions of identity and meaninglessness. Yet, say contemplative caregivers, dying consciously can bring insight into the true nature of personal suffering. For while too much physical suffering can halt soul development, bearing emotional pain can yield enormous spiritual growth. To help extract the gold from the dark of suffering, most religions have cultivated a body of wisdom that can be used to illuminate the soul work of the dying. Joan Halifax, who has studied several forms of Buddhism since the mid-'60s and is an ordained lay priest in Vietnamese monk Thich Nhat Hanh's Tiep Hien Order, draws a dis-

inction between pain and suffering: "Pain is the sensation of extreme discomfort, and suffering is the 'story,' or our feelings toward it."

As the emotional scars pitting every human heart attest, suffering is in great part related to the pain caused by interpersonal relationships. And the people who have hurt us the most, says Halifax, are usually those we love. But, she says, "meditation teaches us that we are in an ever-changing river of feelings, thoughts, and sensations. Relationships reflect this transient nature of reality: One day you love someone, the next day you're angry with them, and the next moment you're good friends. So to die feeling as though the condition of hurt or betrayal is permanent is tragic."

According to contemplative caregivers, meditations on forgiveness help prevent this kind of tragedy. In fact, forgiveness is considered one of the essential tasks in the "life review"—the reflection on the events and relationships of a lifetime—that is part of conscious dying. Often, forgiveness occurs naturally on the deathbed as what once caused anger dissolves in light of the bigger picture of death. Sister Sharon Burns, for instance, says that she has seen hospice patients reconcile at the last moment over the phone with estranged children or siblings.

Of course, often people cannot forgive others because to do so would be to condone unforgivable transgressions. But one needs to distinguish between an act and the person who committed it, says Levine: "The quality of forgiveness is never a quality of condoning. You never forgive an act such as abuse, theft, or mistreatment. But you can forgive someone whose heart, for that moment, could not see."

Perhaps one of the most tragic kinds of suffering the dying must grapple with is the feeling that their lives lacked meaning. In these instances, it is up to hospice caregivers not to provide pat spiritual answers but rather to listen unconditionally to the dying's life reviews. By asking questions, or simply reflecting back to the dying their own words, the caregivers may allow a pattern of meaning to emerge.

Burns tells the story of a 61-year-old dying woman who, although comfortable with her atheism, was deeply troubled by the question of whether her life had meant anything. "Could you say that the world has been left a little better because you've been here?" Burns recalls asking her patient. "Or that you've made a difference?" Immediately, the woman's husband chimed in about the many political, social, and community organizations she had belonged to, prompting his wife to reminisce about her marriage and children. Eventually, Burns says, the woman came to see that her life had indeed been worthwhile; having let go of her anxieties, she died at peace.

As some near-death testimonies indicate, the moment of judgment said to occur in the afterlife may have less to do with having done wrong than with having refused the gift of life.

Many of the dying, however, are unable to find anything of value in their life. Drawing on workshops he gave in Los Angeles, Levine describes in his book the poignancy of some participants with life-threatening illnesses who, as "out-of-work actors lost in the miasma of Hollywood hell," realized that they would never achieve their life's ambition. But caregivers stress that it is never too late to find meaning in life. All of us, Longaker writes, "yearn to do one noble act" before we die. She lists certain final acts that the dying person might consider, such as donating an organ, changing one negative pattern, asking forgiveness for past harm, or making offerings to religious or charitable organizations.

Another way to find meaning, even in the midst of anguish, can be found in the act of "dedication," a

concept found in many religious traditions, in which one's suffering and death are offered up for the benefit of others. In her book Longaker tells the story of a hospice priest who was having difficulty counseling an elderly widow bitter over how friends and family had mistreated her. At the same time, he was called in to help a young woman who had four small children and whose husband had died suddenly. When he next visited the elderly woman, he lost his patience and, relating to her the recent tragedy, suggested she offer up her dying as a way to help. By the priest's next visit, Longaker writes, the woman had been transformed, her whole being "infused with radiant love," and her thoughts focused only on how she could dedicate her dying as a way to alleviate the suffering of the bereaved mother. She prayed for the young woman and asked the priest whether there were other things she could do to help.

Such "redemptive suffering," as M. Scott Peck calls it, is the very nature of caregivers' service to the dying. Thus, a major portion of Joan Halifax's Project on Being with Dying centers around training physicians, nurses, and other professional caregivers and clergy from hospitals, church volunteer programs, and hospices in Buddhist mindfulness practices as a way of being "fully present" to the suffering of the dying. In her work over the years, Halifax says she has found that the resulting compassion and equanimity caregivers experience are the "two wings" capable of lifting up others out of suffering. "In order to sustain that experience of complete compassion," she says; "we need to have profound equanimity—a heart that is not partial to anything but holds itself true and open in the midst of all suffering."

What Comes After?

While there are many techniques and practices to help both the dying and their loved ones achieve acceptance and completion with regard to the conclusion of their life, what of the unknown future that the dying are about to move into? What, if anything, of themselves will remain? Not

knowing the answers to these questions can be a major source of anxiety and distress. Despite his belief in the afterlife, even Peck admits that "it's scary to go on an adventure where you don't know where you may be going." Peck says his outspokenness comes as a relief to many Christians who believe they should have no fear of death. "It's normal and healthy to be afraid," he says. "I would worry about someone who had no fear of dying."

While a fear of death should be respected, such fears should not prevent people from exploring their beliefs about the afterlife. Indeed, confronting what some call the "psychospiritual" distress around dying forms the last two of the developmental tasks formulated by Byock: recognition of a transcendent realm and surrender to the unknown. To help caregivers assist the dying in this process, psychotherapist Elizabeth Smith, an associate professor of social work at the Catholic University of America in Washington, D.C., has developed a "transegoic" model of intervention based on the work of transpersonal psychologists like Roger Walsh, M.D., and Frances Vaughan, as well as the late Swiss psychiatrist Carl Jung.

The psychological tasks involved in dying, explains Smith, are counter to the direction individuals have moved in all their lives—the construction of an individual ego identity that psychologists say is the definition of good mental health. But while strong attachment and identity formation may be the norm for healthy psychological development of the living, "ego disattachment" and the development of a "personal death perspective," she says, are the work of the dying.

In an article in the journal the *National Association of Social Workers*, Williams describes how clinicians can help patients move through the process of disidentification with the ego and reidentification with a transpersonal, or higher, self. Among

other exercises, patients practice letting go of the roles that once defined them and that are naturally falling away in death—lawyer, bachelor, mother, musician—then identifying with the "I" that remains and "just is." Or those who have trouble leaving behind an earthly talent, such as playing the piano, might conceive of carrying the essence of music onward within their spirit. Similarly, as the body disintegrates from the effects of illness, caregivers might ask their clients, "Are you your hair?" or "Are you your breast?" Cultivating con-



religious images of the person's own tradition—such as the Tree of Life in the Kabbalah.

Mostly, however, contemplative caregivers say they assist the dying spiritually by centering their work within the practices of their own tradition in order to create a sacred atmosphere. "There's not much you can explain," says Halifax, "but there's a lot you can be." When visiting a dying person, she says she leaves all her manuals, books, training, and ideas at the door and listens to "what their hearts know."

Longaker concurs: "Spiritual care is not a technique but a way of being. What gives confidence to the dying person is our presence, the compassion and wisdom we embody through our spiritual practice. The patient may never know the specifics of that practice—whether the caregiver is silently invoking and praying to Jesus, Buddha, or God—yet I've seen over and over again how they experience the benefits of our nonverbal spiritual support."

Thus, Buddhist caregivers may do the practice of Phowa, in which the clear light of divine presence is visualized suffusing and transforming the dying person's being; Christians may imagine caring for the dying body as the body of Christ, while Jews may recite certain chants or concentrate on the individual's *nefesh*, or soul. Like a lotus scenting a room with an atmosphere of purity and devotion, the perfume of the caregiver's particular attunement, most caregivers agree, serves to surround the dying person in tranquillity and peace, and helps usher the soul into the next dimension.

Appropriate, nonintrusive forms of music and meditative concentrations may help the dying make the transition to their next life; however, they don't stop when the person stops breathing. A much overlooked aspect of spiritually assisted dying concerns what to do for the deceased. In many traditions, the soul is thought not to leave the body immediately but to withdraw slowly. For

consciousness for what remains, they might then ask the client if she ever had a mystical experience of union with the universe or a sense of what her future might be after death.

Other caregivers, however, say they rarely bring up questions of the afterlife unless specifically asked. As a kind of religious protocol, they are respectful of not proselytizing or imposing upon the dying person their own beliefs. If they are asked, these caregivers are careful to inquire about the person's religious beliefs and to respond in ways that respect such beliefs: A Christian caregiver, for instance, would not talk about Jesus and the resurrection to a Jew but would encourage exploring the

example, in Tibetan Buddhism, Longaker says, it is believed to take anywhere from 20 minutes to 3 days for consciousness to leave the body. Therefore, according to their own beliefs—and within the limits of the law—caregivers and loved ones may want to continue the vigil they have maintained throughout the dying process. Reading spiritual teachings aloud to the dead and repeating special prayers or meditations are, in many traditions, considered essential to helping the newly released soul become free of suffering and find its way in the afterlife.

But it is difficult for the living to help spiritually support and guide the soul of their departed loved ones into the afterlife without some image of what that life might be. Indeed, according to psychotherapist Sukie Miller, author of *After Death: Mapping the Journey*, a more open dialogue about the afterlife is the “next step” for hospice and contemplative caregivers. Miller believes that the current denial within the movement to discuss the afterlife is “as big as the denial of death itself, a taboo as fierce as when Kübler-Ross began her work.”

Just as medical technology has radically altered the face of death, so has America’s multireligious society altered how contemporary society discusses the afterlife. In religiously homogeneous cultures, by contrast, taboos around the afterlife are rare. References to the next world are interwoven throughout the culture—such as the Day of the Dead imagery and rituals pervading Mexican culture or the spirit worlds of the South American rain-forest Indians—and are as familiar to the people as their indigenous food and clothing. The comfort provided by this spiritual safety net is missing for many Americans, who may have abandoned their childhood religious traditions and lived wholly secular lifestyles. Caught by surprise on the deathbed, they may even lack the language to ask the questions tormenting their souls.

This was my own father’s experience as he was dying. Because he had never been particularly religious, I sensed that he was frightened about where he was going, but I hesitated to say anything. In the middle of one

long and sleepless night, however, when I thought his death was moments away, I blurted out, “Don’t be afraid. You’re going to a better place.” Although he didn’t die then, this simple statement opened a door, and he began plying me with questions about my beliefs concerning the afterlife. An evocative and profound exploration of the possibility of different scenarios followed, as I read aloud passages on the topic. When my father finally died, it seemed that his soul was at rest.

While it is true that we can only speculate on what really happens after death, it is also clear that, on a cultural level, it is time to make more open discussion of the afterlife less prohibitive. In fact, few cultures ever

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of the heart.”*

imagined sending their loved ones into the next world without some kind of “map” to help souls find their way. As psychiatrist Stanislav Grof has researched in *Books of the Dead*, the landscapes encountered in the afterlife are richly described in such manuscripts as the Tibetan *Bardo Thodol*, the Egyptian *Pert Em Bru*, and the European medieval *Ars Moriendi*. Rather than actual places, Grof posits that these texts symbolically represent nonordinary states of consciousness (NOSC) experienced by spiritual practitioners, as well as those who have reported near-death experiences of the afterlife. These ancient texts, he writes, “are actually maps of the inner territories of the psyche encountered in profound NOSC, including those associated with biological dying.” These states include passing through hell, facing divine judgment,

being reborn, reaching celestial realms, and confronting memories from previous incarnations.

Similar to Grof’s research, Sukie Miller’s own far-flung explorations of various religious beliefs led her to discover four distinct stages common to all traditions in the afterlife: waiting (a calm place of rest before entering the next stage of reality), judgment (where souls review the results of the way they have lived their life on earth), possibilities (realms of paradise or heaven), and return (rebirth into the next life, or the Second Coming). In Miller’s opinion, dying patients should be offered the opportunity, if they choose, to become knowledgeable about these different philosophies of the afterlife.

To M. Scott Peck, one way to avoid last-minute discussions of the afterlife is to introduce the topic into mainstream culture through public education. Mandatory and credited courses on death and dying, he maintains, should be taught in every senior high school. The curriculum of such courses might include topics around mortality, Kübler-Ross’s stages of dying, and other religions’ beliefs such as reincarnation and karma. Children, particularly adolescents, Peck says, “are entitled to be exposed to the great ideas of civilization, some of which, whether there’s proof or not, have to do with God and the soul.”

What the Dying Teach Us

Despite the fears and confusion surrounding the euthanasia debate, it could contain within it a catalyst toward a collective spiritual awakening. According to Peck, America is gripped by the “disease of secularism,” which results in most Americans not taking religion, God, or their souls seriously. He wonders whether our “bland response” to euthanasia may be symptomatic of our having euthanized God from our lives.

Peck’s point is somewhat borne out in the deathbed experiences of the dying. According to the testimonies of many caregivers, the dying often are gripped by regrets. Having invested so much of their lives in

secular pursuits—money, power, success—they find that these are not the things that matter the most. Instead, it is the nonmaterial dimension of life, including love both given and received.

Joan Halifax tells the story of a successful lawyer who was diagnosed with inoperable prostate cancer. With no background in any religious tradition, he arrived at Upaya depressed, his heart frozen, and “in absolute despair because he felt he had wasted his whole life in making money and on his vocation. Now that he was on the threshold of death, he felt that he had missed the boat because of how he had ignored the great spiritual questions of life.” Eventually, surgery slowed his cancer. Although he returned to work, his experience nonetheless served as a dramatic wake-up call, and he began to integrate the secular with the spiritual by attending meditation classes more frequently and by offering his services to the dying.

Not only is inattention to spirituality mourned on the deathbed, but the un-lived life is as well: the trips never taken, the undeveloped talent, the heart closed to love. As some near-death testimonies indicate, the moment of judgment said to occur in the afterlife may have less to do with having done wrong than with having refused the gift of life.

Burns says she was affected by the sorrow of one dying man whom she imagined to be suffering over some deeply spiritual matter. To her surprise, he confided in her his regret that he had never learned to play the piano. This struck a chord for Burns, as it had been one of her own lifelong desires. At age 69, she says she now practices the piano every day.

Such “death wisdom” is a secret that has been cherished throughout time by mystics of all faiths. In Buddhism, the practice of “being with dying” is considered an essential spiritual practice. The phrase “to die before death” is a familiar refrain found in one form or another among those saints and seers who recognized the value of becoming intimate with God now. Likewise, Peck says, the fabled shaman Don Juan taught his student Carlos Castaneda how to

live with death as an ally. In this sense, he says, death is a “fearsome spiritual power to be tamed and put on the left shoulder,” where one can continually benefit from its wise counsel on how to best use one’s time.

But perhaps, as stories of the dying filter throughout society, this precious death wisdom is already starting, like yeast, to raise America’s values from the strictly secular to the more meaningful. Byock, for example, has initiated a project in his hometown of Missoula, Montana, known as the “The Quality of Life’s End: The Missoula Demonstration Project.” The goal is to involve the entire community—from the mayor to local artists to schoolchildren—in providing humanistic end-of-life care. By doing so, Byock hopes to make Missoula a model city that can teach other communities how to transform death into a process of spiritual and psychological growth.

To those uninitiated into the mysteries of death, such a project may seem depressing. To those who serve the dying, however, it inspires. “The most beautiful Americans I’ve been around,” says Dale Borglum, “are people who are almost dead. That is because they’re not busy being lost in their identity—such as being rich, poor, fat, smart, needy, Buddhist, or the adult child of an alcoholic. Those things aren’t too important when you’re dying and you’re whittled down to an essential level of being. Thus, to the extent that we can carry our identities a little more lightly before death, so much the better. That’s what the dying teach the living.”

The poet Rainer Maria Rilke, says Halifax, perhaps summed up the mystery of death best when he wrote that “love and death are the great gifts that are given to us. Mostly, they are passed on unopened.” At the end of the 20th century, she observes, “we are called upon to look deeply into the nature of love and the nature of death and to enter those mysteries that are beyond language.”

Contributing editor Pythia Peay is the author of *Putting America on the Couch*, to be published by Riverhead Books in 1998. She is a columnist for Religion News Service.

Resources on Spiritually Assisted Dying

American Academy of Hospice and Palliative Medicine
P.O. Box 14288
Gainesville, FL 32604
(352) 377-8900
E-mail: ahp@ahp.org
Web site: www.aahpm.org

Learning Center for Supportive Care
Richard Boerstler and
Hulen Kornfeld, Directors
14 Orchard Lane
Lincoln, MA 01773
(508) 394-6520 or
(617) 259-8936

Living/Dying Project
Dale Borglum, Director
P.O. Box 357
Fairfax, CA 94978
(415) 456-3915

Missoula Demonstration Project
1901 South Higgins
Missoula, MT 59801
(406) 728-1613

National Hospice Organization
1901 North Moore Street,
Suite 901
Arlington, VA 22209
(703) 243-5900

National Hospice Helpline
(800) 658-8898

Rigpa Fellowship
Spiritual Care Education and
Training Program USA
449 Powell Street
2nd Floor
San Francisco, CA 94102
(415) 392-2057

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