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Death and Dying: Has The Topic Been Beaten to Death?

AN EDITORIAL

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In 1964 one could find about 400 items in a world bibliography addressed to death and dying. By 1973, the scientific and clinical literature on the topic included over 2600 references. There are "courses" given in schools of all persuasions, from high school through postgraduate school. Clergy, sociologists, educators, social workers, psychologists (albeit with academic degrees, no clinical experience), funeral directors and even health counselors (gym teachers) give "instruction" as to how to deal with the death of others as well as one's self. Each, in his own way, is given to the role of "heavy" philosopher.

Why this explosive interest in death and dying? Why has it reached the proportions of a fad? One can only suggest some possible answers. The state of death is impossible to conceptualize, and the thought of dying terrifies. Since "being dead" cannot even be imagined, a void evolves to be filled with superstitions, fantasies and/or poetic creations. This leads to romanticizing death via intellectual discussions, *e.g.*, "death with dignity." Another possibility is interest motivated by fear: fear of the unknown; fear of death equating with fear of life itself. The hoped-for resolution of the particular fear through preoccupation with the theme would be mastery of one's own death. Another explanation might be the search for immortality to transcend our mortality. Suffice it to say that I agree with La-Rochefoucauld who wrote, "one can no more look steadily at death than at the sun (2, p. 4)."

Dr. Elisabeth Kubler-Ross, through her book *On Death and Dying* (1) gave great impetus toward popularization of the subject. Many consider it the bible in the field. The book is worthwhile, it should *not* be read, however, until after one has made his or her own observations. Otherwise, premature closure is effected. Also, an unfortunate ramification has evolved. Rather than observe the dying person vacillate between denial (intellectualizations) and frantic emotions, there are those who seek "stages" in a slavish and cultistic way. This applies particularly to the clergy, medical students and nurses, although there are M.D.s who are not immune to this. Thus the aura of a fad is intensified.

Recently, over 100 people attended a national workshop on curriculum design for teaching the subject. They represented many disciplines, medical, paramedical and nonmedical. Only a few had had intimate patient contact. The techniques for teaching were varied. Many used media (tapes, films, video). Some used classical literature. And some employed encounter groups. Utilization of direct exposure to the dying person as a core experience for instruction was not emphasized.

For the clinician in search of knowledge, there is no substitute for direct ongoing work with the dying person. It is our strong feeling that one can only learn by experience. Subtopics such as grief, euthanasia and understanding and management of the dying person are important,

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but the involvement in and with the dying person is crucial.

Much of what happens subsumed under "education" and "thanatology" consists of intellectualizations. The phrase, "death and dying" is in itself an euphemism. Death is an inherent part of a process, not an event, and the process is the reverse of what is implied in the phrase. That it has caught on, has done so precisely because it is euphonious. "Death with dignity" is another. Other than sudden deaths and the tired elderly who die quietly ("going home" equated with returning to the arms of Jesus), there is no death with dignity. Those of us who have seen pained patients with lines and tubes in all vessels and orifices know full well there is nothing dignified in this mode of exit. Can any dignity be squeezed out of being lifted, exposed, onto a bedpan? Can any dignity be gleaned out of the humiliation of incontinence? From regression and role reversal, from active to dependent? (In the early 1960s, we naïvely wrote pleading the cause of "death with dignity.")

There is another aspect to the problem that begs comment. There is nothing sacred about aging or dying. Implicit in much of the material being produced suggests that because one is aging or dying, one is "good." Nothing could be further from the truth. If one has been infantile, cantankerous or rigid, he should be expected to be the same as he grows old and dies. If he has been flexible during his lifetime, he will age and/or die with grace. He will age or die in the manner in which he has lived. This is not to say that the aged and dying should not be treated compassionately. They should be regarded as humans and as patients. This attitude demands that they be treated with concerned respect and appropriate therapy, and not necessarily with guilty reverence.

Rather than concern ourselves with thanatology on a cerebral level, we need to react emotionally along with the dying person. The approach should be an attempt at understanding the dying person, not the topic. As physicians, we have gone through training emphasizing the medical-biological model of and for death. Now we are going through a period of an intellectualized, philosophical-social-psychological model. Both models are necessary for understanding dying, grieving and gaining insight into our own feelings in this difficult area. But those who are experiencing losing and loss need ordinary, calm, unangry, unfrightened human contact, not pseudoscientific thanatologists. In this manner we benefit as much as we hope our dying fellow human will.

REFERENCES

1. Kubler-Ross, E. *On Death and Dying*. Macmillan, New York, 1969.
2. Quoted in Powers, T. Learning to die. Reflections/M.,S.,D. pp. 1–19, 1972.