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

the physical dying, as experience fails him, but generally assigns short periods of time to the process—attended by obvious and great functional loss.

The physician defines the dying patient very differently. First of all, he does not step quickly into the mind-body duality. He will concede, if pressed—or sometimes he will spontaneously offer the same concept as the layman—a dead mind in a living body, but it is not quick to his lips. The physician bases his definition upon the prognosis of the disease from which someone is dying. In so doing he is basing the definition upon his own ability to do something about it. By his own, he means literally his own, but also the collective ability of his profession. His definition of the dying patient is, therefore, dependent upon his knowledge and his technology.

To return to the two type cases again, the physician views them differently. Case one, the 42-year-old man with acute leukemia, is seen by the physician as dead the moment the diagnosis is made! It does not matter whether the patient knows or not—to the physician he is a dying man. On the other hand, the patient with the numerous myocardial infarcts around whom the many physicians and their machines are crowded *is not dying until he is dead!* The response of a surgeon clarifies the point: "A dying patient is someone that I can't help."

The difference between layman and physician in the definition of the dying patient is striking, and we begin to sense that the two may be speaking of two distinctly different states, two different kinds of being. To go further, it is necessary to examine more closely what the layman really means by the mind-body duality and the word dying. Several quotes are useful.

The first comes from a 38-year-old psychiatrist speaking of his own father. (He went on to make the usual physician's definition later in the interview.) He said: "My first thoughts are about withdrawal of interest, of cathexis—to use my fancy words—from the world. My father died way before he was dead, you know. He died when he stopped listening to the Brooklyn Dodgers' baseball games—months before he was dead."

The second quote is from an interview with a 29-year-old woman. "A dying patient? Oh dear! I guess somebody who has given up the will to live and doesn't have any energy." A little later in the interview, she says, "There are those things that you really get sick with that can kill you—well, like we had this dog that was a perfectly healthy dog for nine years and my mother came home and he was dead—I guess he had a stroke, or something. But I guess he was never dying."

Thus the process of *being dying* may precede the process of *being dead*—or it may not ever occur. Being dying may not be present in someone about to be dead or may be present in someone not about to be dead. Doctors, then, have two distinct processes with which to deal: 1) the process of being dying, a non-physical process, and 2) the process of becoming dead, a physical phenomenon.

The physical aspect—the process of becoming dead—has classically been the province of physicians and constitutes the manifest content of their work. The science that underlies our understanding of the body is a model of analytic thought. Over the centuries that have been occupied in the development of scientific medicine, doctors have, in essence, taken the human body apart bit by bit. It has been dissected into its parts with ever smaller discrete units being discovered as technology advanced. In the last century, to the previous anatomic dissection has been added the physiologic and chemical dissections of function. Each piece has been examined and understood in the belief, accepted by all, that by understanding the parts in their most minute detail, an understanding of the whole would be achieved.

In the course of this, physicians have learned to think in body terms. They see disease in the same terms, as altered units of structure or chemistry. But for our purposes it is important to conceive of the physician at the bedside thinking in *body* terms and to know that this is thinking in analytic terms. Whether the body is really best understood in these terms is not central to

this discussion, but it is important. There is a certain circularity to the process. Analytic thought having been the thought mode in which the discoveries about the body were made, it is the kind of thought required to understand the results of the discoveries. In fact, there are problems in thinking about the body the way we do. We tend to conceive of the organism as sets of static states, altered or otherwise, rather than to think about the transformation between states. In practice this means that we have difficulty thinking in terms of function and think more easily about what may be less important—alterations in structure. This has been phrased, in other fields, as a distinction between being and becoming, and analytic thinking brings one primarily to states of *being*.

Whatever difficulties may be presented by analytic thought, it has for physicians the advantage that it is depersonalized. Part of the paradox of our subject is the constant opposite pull upon the doctor's mind. Depersonalization is destructive, but without depersonalization there is not the objectivity essential to caring for the body. *To understand physicians you must picture them straining in fascination to understand what is happening within the body beneath their hands.* The process of becoming dead occurs in the depersonalized body. But what do we mean by depersonalized?

In discussions by laymen, theologians and philosophers, one can commonly hear the belief and fear that doctors unnaturally extend or prolong the dying life toward their own ends or toward the ends of their science rather than act in a manner best serving the needs of their patients. These discussions somehow imply that there is a distinction between doctors and other men; between the doctor and the man within the doctor—between "medical" values and "human" values.

It is an extremely interesting implication which seems to flow naturally from the distinction we have just noted between doctors and other men. But when doctors (or "medical" values) are said to be different from other men (or "human" values), it is more an accusation than a simple statement of fact (in contrast, for example, to the statement that poets are different from other men).

Let us, then, look more closely at the statement as an accusation. To do so we must return to the bedside. The setting which gives rise to the fear might be as follows. A 74-year-old man has been ill for a long time. In the beginning he had been stubbornly independent, and despite considerable pain and discomfort, carried on his life, making light of his illness. Recently the pain had become almost constant, his appetite failed, and his clothes hung on him. His once constant wit gave way to depressed silence. He moved into his daughter's house so that she could watch over him; even reading the newspaper seemed to require more effort and interest than he could spare. Finally, no longer eating, he was admitted to the teaching ward of a hospital. Soon he was part of the familiar scene of intravenous feedings, injections, and arduous diagnostic studies—all grinding on almost oblivious of him and his family. The pace of treatment hastened as he sank into coma. The family was at first grateful that the burden had been lifted from them, but they became increasingly angered at all the young doctors doing so much to the patient but giving them so few words. The family was angry, too, at the machinery clustered around his bed, and the bottles and tubing and wires connected to him. It was especially distressing because the patient himself had resisted going to the hospital, saying he didn't want to be "an experiment for them."

It would be common, in commenting upon this scene, to say that the family was upset because the doctors were so impersonal. To put it more strongly, we might say that the doctors had depersonalized their care of the old man: they were acting as if he were not a person, but an "it"—a living piece of flesh toward which every effort had to be extended to keep it alive. Seen in that manner (and, not infrequently, one hears people speak of physicians in those terms), the depersonalization has extended to include the patient himself. He too, although alive, has been

depersonalized. In a mythical sense, a dehumanized object has been created that lives and breathes like a human being but is not perceived as a person.

Every act of the doctors is rational and follows implicitly from their present understanding of the disease process, the effects of treatment, and the workings of the body. The system of thought employed is clearly analytic reasoning. Remaining solely within that mode of thought, although there might be some—even quite wide—variation in individual acts, it would be difficult to conceive of any basic decisions that would have been essentially different. To have produced basic change in this hypothetical case would have required changing the very foundation of thought about the problem. Such change does not come easily.

In this case, at least in terms of the fear aroused in laymen, the analytic mode of thought (science) produced a monster. The case described here and the many similar ones that have given rise to present public distress are entirely creatures of current medical science, i.e., they were not possible even a few decades ago. It is of some interest to note, however, that although only present-day reality provides concrete example, the fear of a depersonalized living body is not new. The Frankenstein monster, Dr. Jekyl and Mr. Hyde, vampires, and a host of other fictional or mythical characters provide similar examples. The *golem* of Jewish mythology is a very old and well known example of a living body without a person within. Common parlance might say that these are creatures without souls.

From what has gone before and from this case we get a clue that the analytic thought mode may be essential to thinking about the body and, at the same time, antagonistic (reduced to its ultimate) to that mode of thought concerned with non-body, "human" values. Further, the possibility begins to emerge that the *body itself,* and "body values" in the setting of the dying patient, for example, may be antagonistic to non-body, "human" values. If so, we begin to see that the conflict between "medical" and "human" values and the conflict between the doctor and the man within the doctor is at a level so basic that it involves the very mechanics of reason and conflicting states of being.

The process of *being dying,* in contrast to the process of *becoming dead,* is an intensely personal, non-physical process. In what part of us does the process of being dying take place? The primacy of the body in serious illness is clear, but as we listen to our patients when they are well and when they are dying, it would seem that trapped within the ever-narrowing confines of the body becoming dead may be a person whose life continues on (our respondents clearly tell us this) and to whom the body is largely irrelevant—as is the case in health. Health, at least in part, incorporates the ability of the self to soar; allied with but unhampered by and unaware of the confines of the body. In a sense, illness, and certainly death, represent a defeat for the self within the body. Bodies can be conceived of as dying, but persons cannot.

On the other hand, as in the cases of the respondent's sister-in-law whom she could see dying "because her whole interest was gone" or the psychiatrist's father who "died way before he was dead" as he withdrew interest from the world around him, the self can also be seen as dying independently of the body.

No richer picture of the destructive effects on living that result from an injured relationship between self and body comes to mind than that so beautifully written by Lifton[4] in his study of the survivors of Hiroshima. There, in those unable to transcend it, the self remains shackled to a body seen as somehow already dead or permanently tainted in some inexplicable way. The interrelationships of the two independent but inseparable parts of being—the symbiotic halves of existence—humble us by their mystery and complexity.

But the two are so intricately bound together in the sick and the dying that if we are to care for them, we cannot rest in awe before the mystery. The concept itself is so urgent that it insists upon being understood. For that understanding, analytic

[4] Robert J. Lifton, *Death in Life* (New York: Random House, 1967).

thought seems inappropriate. Although several generations of research on the mind and on social interaction, done increasingly in the analytic mode, have provided ever greater comprehension of aspects of thinking, the intimate nature of being remains elusive. In fact, the more analytic investigation becomes, the further "being" retreats. For the personal nature of being, synthetic thought seems more appropriate. However, synthetic thought is infinitely more difficult to comprehend. Perhaps that is the first characteristic of synthetic thought that strikes us—its seemingly inexplicable nature. It is that same characteristic that seems to make it, in this age of science, unacceptable for public discourse. It is the thought of Socrates' *daimon;* the flash of problem-solving in Kohler's ape, Sultan; the substance of insight, creativity and intuition; the basis of "sudden illumination." We see it from the outside; we know that it exists within us and in others, but we do not know what has taken place or how. It is clearly integrative thought—drawing upon and integrating into one response material from different levels of mindfulness, such as experience, the results of analysis, beliefs, feelings, insight, intuition, unconscious resolution, and so on. But the formula for the integration, the different values given to the parts of mindfulness that make up the synthetic thought remain a mystery to us, even as we have the thought. Unlike analytic thinking, in which we can, together, trace the path of our common thought, here the detailed path of thought is closed and only the result may be apparent.

Lévi-Strauss, in *The Savage Mind*[5] shows us, in considerable detail, how the two modes of thinking interact. As the notion is dispelled that the primitive mind is occupied *only* by synthetic thought, we can see some reason why our own synthetic thinking has become, in part, relegated by us to the primitive, the child, and the savage within us.

[5] Claude Lévi-Strauss, *The Savage Mind* (Chicago: The University of Chicago Press, 1966 [date of translation]).

By now it must be clear that analytic thinking and synthetic thinking cannot be valued one above or below the other but are better seen as two necessary and inseparable companions in the mind, just as self and body are companions in existence.

Because synthetic thought draws its results from so many levels, both personal and universal, it is the thought mode of human values and moral action. One cannot arrive at human values by analytic thought. In the same manner it is the mode of thought of shared human experience—of empathy. The mystery of it draws us on, as it has so many others over the ages until we begin to believe that the self *is* the totality of thinking.

However, for our purposes in understanding the dying, the following should be clear: Synthetic thought is real, and because it is integrative in nature, it is the opposite of analytic thought. It is the thought of human values and of shared human experience. Finally, in part because of its present low status, but mostly because of its private nature, its operation is not consciously manifest—we do not know we are thinking it. Further, the two processes—the physical process of *becoming dead* and the non-physical process of *being dying*—are represented, broadly speaking, by two different kinds of thought.

We can see that the doctor, in caring for the dying, is using two competing systems within himself to render care (as distinct from caring). However, although the two processes are distinct, they are so intimately entwined that if the doctor confines himself to dealing only with the process of becoming dead, he creates the depersonalized technological spectre with which the philosophers and the rest of us are concerned. But further, he gives up his function as a healer in favor of his function as a curer.

In a previous essay (*Commentary,* June 1970), I have discussed the function of healing as being concerned primarily with taking care of the non-disease elements that make up sickness, and the present tendency of physicians to flee the greater personal burden of being *healers* for the lesser intellectual burden of merely

curing. Curing is a technological pursuit, healing is a non-technological pursuit engaging primitive and as yet largely unexplored areas within patient and doctor.

The healer provides a connection between the shrinking world of the sick and the larger reality of the well. He offers his own personal intactness to protect the sick person from the danger of having lost his sense of personal invulnerability. The healer's system of reason encompasses illness and offers the security of knowing to the patient for whom sickness is the fearful unknown. The healer provides a surrogate control of the world to the ill person whose own sense of mastery over his destiny may be slipping. And all of this is usually buried below words and unavailable to conscious processes.

But in all the ill there is a larger battle, the battle with death. No matter that it is probably not an unknown like death that we fight but rather, helplessness, whose fearful impotence we have all experienced in infancy. What matters is how large the fear. That battle is the healer's province. In our culture the picture of the physician doing battle with death is so well known as to need no elaboration, and the image goes back to well before the present era of therapeutic achievement. For the physician-healer the process is emotionally demanding and draining; the more challenging, the more draining the battle. For this reason he must save his energies and try only to engage where success is possible. Where success is not possible, healing gives way to the duty simply to "comfort and company" the dying.

Separating the physician-healer from the physician-curer is, of course, essentially artificial since there is no such absolute separation among doctors themselves. But it is not hard to recognize the validity of the concept and apply it to reality, where, indeed increasingly, doctors lean toward the less demanding, primarily intellectual function of physician-curer. The physician as curer does battle with blood counts and electrolytes. Freed from the very real constraints of healing, there is no limit to his field of battle.

Thus the human and ethical problems are, in part, created by the separation of the functions of healing and curing. However, as we have seen earlier, these two functions of physicians can be seen to occur within opposite and competing modes of thought: the analytic mode used by the curer and restricted by its nature to the physical process, the synthetic mode of thought more important in the function of the healer. We saw before how in the dying patient himself the two systems compete.

But the body *does* have ultimate sovereignty, and that is the basic dominion of doctors. The physician cannot enter the field of dying without being part of what can be seen as the battle between the body and the self within the body. We want the doctor, we require him, to take the part of our body—if he does not, he fails us. But if he *only* takes the side of the body, he also fails us.

Thus, to the previous dimensions of the function of the healer we must add the resolution of conflict between self and body in the sick and the dying. *It is essential to any understanding of doctors to realize that they, and they alone in society, are responsible to both the body and the self within.* And within the physician himself, if he is really engaged in caring for the dying patient, the same battle between body and self must be raging. This is the price of caring for the dying—the more so in this day when the analytic mode of thought is so well developed within doctors whereas the language of self lies largely unacknowledged and underdeveloped.

To summarize, we have seen how modern science can create a living body shell whose self is gone. But further, although literally a creature of today, the fear of the empty body goes far back in history. With that knowledge in addition to what we hear patients express about death and sickness, we see increasingly the validity of conceptually separating these two parts of being.

We have also seen how the two parts of the duality seem to be represented by two different kinds of thinking, and in physicians by two different functions, healing and curing. For un-

derstanding we must see the two parts for what they are, but for man to be whole, the two must blend.

"But O alas, so long, so far,
Our bodies why do we forbear
They are ours, though they are not we,
We are
The intelligences, they the spheres
We owe them thanks, because they thus,
Did us, to us, at first convey,
Yielded their forces, sense, to us
Nor are dross to us, but allay.
On man heavens influence works not so,
But that it first imprints the air,
So soul into the soul may flow
Though it to body first repair.
As our blood labors to beget
Spirits, as like souls as it can,
Because such fingers need to knit
That subtle knot, which makes us man."

From *The Ecstasy*
John Donne