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DEATH, MOURNING, AND MEDICAL PROGRESS

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ABSTRACT A number of changes can be observed in the way people are coming to think about death, mourning, and medical progress. The palliative care movement was initiated some 30 years ago to respond to widespread ignorance or neglect of pain relief for the dying, which was then coming to public attention and becoming a key part of the nascent hospice movement. Yet if an important feature of the latter movement was acceptance of the reality of death, in recent years there has emerged a blending of clinical treatment and hospice care, a kind of compromise with the idea of death as an inevitability. Meanwhile, the combination of real progress in forestalling death and the matching medical and media hype about past and coming victories over mortality mean that death itself is coming to be seen as a biological accident, a contingent event, not a fixed given. People die now because of bad luck, indifference to good living habits, unfortunate genetics, and the like, or because they have the misfortune of dying before a cure for their fatal disease is at hand. Mourning likewise is changing. The old custom of the deceased being laid out in their living rooms, followed by a funeral, has long given way to a movement away from public funerals to private ones followed later by a memorial ceremony. No more dead bodies on display to grieve over, but soothing ceremonies of remembrance.

IN HIS SPLENDID BOOK, *The Hour of Our Death* (1977), the French historian Philippe Aries noted “the persistence of an attitude toward death that remained almost unchanged for thousands of years, an attitude that expressed a naïve acceptance of destiny and nature” (p. 1). That attitude, he argued, created what he called the “tame death.” It was marked by the individual’s and the community’s acceptance of his unalterable fate and its domestication in rituals of

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mourning. Death was given a formal and acknowledged status in the life of human communities.

There was a “familiar simplicity” about death, to use Aries’s expression. It was not simply an individual, private loss but was taken as a blow to all those who survived, both family and strangers. Death required a public affirmation of human solidarity against a harsh and indifferent nature. It was not to be hidden: families should be there when death was at hand, and the door thrown open to neighbors and even those passing by in the street.

The “tame death,” Aries contended, has in modern countries—but especially in Europe and America—has been replaced by a “wild death,” with death to be rejected, evaded, rationalized, and hidden. Aries’s book took death up to the 1970s, and it was that era and its emerging attitudes and practices that he was trying to capture with the notion of a “wild death.”

THE TRANSITIONAL DEATH: REFORMING THE CARE OF THE DYING

I want to bring that story up to date. We are, I believe, now moving on to another stage, one marked by medicine’s de facto rejection at the research level of the ancient belief that death is inevitable, an immutable and unchangeable fact and human fate. It is a stage that simultaneously displays considerable ambivalence about the “hour of our death,” about appropriate modes of mourning, and about the place of death in the life of the community. Once again we are being forced to ask some old questions. What is the meaning and significance of death for us as individuals? How might it best be dealt with as a medical challenge? And what does death mean for our public life and cultural practices?

The 1960s and 1970s might well be understood as the transitional era. Death was, to use the cliché of the era, just beginning to come “out of the closet,” at least for public discussion. There was a rising tide of complaints about the way people died, often alone in ICUs, wrapped in a harsh cocoon of tubes and wires, their families denied admittance. By that time some 80% of people in the United States were dying in hospitals or nursing homes, and there was no shortage of personal stories of medical indignities, poor palliative care and deficient pain relief, and a chilling indifference to the sensibilities of anxious friends and relatives.

A Pulitzer-prize winning book by psychiatrist Ernest Becker, *The Denial of Death* (1973), well caught the spirit of the times. Out of those complaints came a number of reform efforts: better physician training in the care of the dying, the hospice movement, and a patient rights initiative aiming to give the dying a voice in their final care. But something was missing in most of those efforts. A deep and sustained discussion and consideration of death itself was all but absent. It was still assumed that we would all die, that nothing could be done about that, leaving it up to individuals to make of that reality what they would. The only

issue of public interest was how to legally and organizationally traverse the road from life to death.

As that development was taking place, there was a parallel movement as well, a shift in the care of the dead body and in rituals of mourning. In the mid-1940s I witnessed my dead grandmother laid out in an open coffin in her house, her wake open and convenient for all her neighbors. I did not realize that I had seen the final throes of an ancient practice and would never witness that kind of scene again. This being America—with a buck to be made, and many families no longer drawn to dead bodies in the living room—the modern funeral industry arose to tidy up and gloss over death. It did an effective job, embalming and beautifying the corpse, offering elaborate, expensive, and rot-resistant coffins, and a well polished therapeutic professionalism to cope with the mourning self and grieving relatives.

The possibilities for black humor were numerous, and British writers Evelyn Waugh and Jessica Mitford made great fun of it all in their books *The Loved One* (1948) and *The American Way of Death* (1963). More solemnly, Geoffrey Gorer's book *Death, Grief, and Mourning in Contemporary Britain* (1965), described the goal in that country as the banishment of death altogether from the public sphere, aiming to make it invisible. He could have been talking about the United States.

SHUTTING THE CLOSET DOOR ON DEATH

Mourning started on a parallel track in America. While the funeral industry has continued, large church funerals and graveside rites began to decline in the 1970s, at least with the more educated portion of the population. Private funerals, insistently for families only, increased. Open caskets with visible bodies started going out of fashion, and then—as cremations increased—even closed caskets with intact bodies. There was one final step down that road: a steady rise of memorial services, with no bodies at all. Their aim is less to mourn a death than to celebrate a life. A small minority, even more sophisticated, made clear to one and all that there should be no ceremony of any kind; even a scattering of ashes at sea by a few friends would be going too far. In a word, dear friends, keep your grief to yourselves. The ancient notion of a public death and collective mourning was thus finally turned on its head by these successive developments.

Now I am speaking of trends only, first visible in the 1970s and 1980s, and many traditional wakes and funerals still occur. But the direction seems clear, and what was at first a small trend seems now to have gained momentum. Yet that is not the end of the story, either with death or with mourning. By the 1990s still more changes surfaced, opening up a new chapter on both. The change has at least three important elements: a gradual shift in the palliative care movement, a more aggressive medical and scientific campaign against aging and death, and a growing confusion about mourning.

THE CHANGING FACE OF PALLIATIVE CARE

The palliative care movement got its initial impetus as a response to a great deal of evidence and anguished, sometimes angry, complaints that pain was often badly managed with the dying and that physicians were poorly trained in relieving pain. A fear of killing patients by excessive use of opioids, and thus some legal threats, did not help matters (though the threats were more fantasy than real). The physician Eric Cassell made an important contribution to the debate with his book *The Nature of Suffering and the Goals of Medicine* (1991) which noted the importance of distinguishing between pain and suffering, too often conflated, by physicians as much as by laypeople.

As the scope of palliative care was broadened by that distinction, it gradually became clear that palliative care was appropriate for all patients, not just with end-of-life care, or only in hospice care. At least in the early reform years, it was understood that a dying patient needed palliative care addressed to both pain and suffering, but also that a key to a good death was its acceptance by patients. As time went on, however, many hospice providers concluded that not all patients can or will accept death, thus breaking with the Aries paradigm of a tame death. Indeed, good palliative care requires careful management of dying patients for whom the inability to accept death is itself a source of suffering.

As palliative care was broadened beyond dying patients, the idea emerged that for some patients—particularly those whose condition is on the borderline between potentially treatable and terminally ill—it would be appropriate to team up a clinician and a palliative care specialist. An analogous problem was identified in hospice care, which had long contended with the fact that too many terminal patients got into hospice much later than would have been ideal, often only during the last week or two of their lives.

An unwillingness to accept the coming of death is usually a prime reason for the delay. Doctors and families are often unable to accept the fact that a patient is dying. But it is also a reflection of the difficulty of discerning a clear borderline between living and dying. In retrospect, it is often possible to say that a patient was over-treated and should have been allowed to die earlier. But it is becoming harder and harder to determine in advance just which patients those are.

MEDICAL UTOPIANISM: THE WAR AGAINST AGING AND DEATH

The present period might best be characterized as a revolt against death itself, and with that a revolt against the aging that has gradually become death's most common predecessor. Death is gradually being transformed from a fixed and unchangeable biological and human inevitability to a contingent event, even accidental and manipulable. Where death was once thought to be natural and therefore unchangeable, the very notion of "the natural" is vanishing from our vocabulary, or at least from the vocabulary of aggressive medical research.

As William Haseltine, the colorful CEO of Human Genome Sciences, put it a few years ago, “death is nothing but a series of preventable diseases” (Fisher 1999). That statement verges on the ridiculous, but the international biomedical research agenda has targeted every known lethal disease for conquest. With time and adequate financial resources, the belief goes, all of them can be conquered. The leading argument in favor of the \$3 billion Human Genome Project, completed a few years ago, was that it would reveal the ultimate genetic source of disease, opening the way for decisive cures. It has not worked out that way—proteins may be more important—but along came stem cell research to stake a new claim of opening the door to a massive saving of lives. That has not quite worked out yet either, but hope springs eternal these days about the potentialities of medical research, as necessary to drive the economic engine of research as it is to sustain critically ill patients.

I will not take up the question of whether such claims are credible, whether in fact death as a biological phenomenon can be eliminated. But hope now has much the same kind of valence in research that medicine has always given it in the care of individual patients. Hope drives good medical care, for the physician and the patient, and now hope also drives the war against aging and disease. The trans-humanism movement, which includes many reputable scientists among its followers, eagerly foresees radically extended life expectancies, the cure of most diseases, and dramatically new power to alter human nature and the human condition. These are not widespread views, nor have they seeped far into the popular consciousness, but they are out there and gaining ground.

None of this might matter but for its spillover effect, or perhaps more precisely because of the way it dovetails with the steady, incremental gains being made in mortality reduction and increasingly long life spans. As a demographic matter, mortality in developed countries is declining because of a combination of improved socioeconomic conditions, disease prevention, behavioral changes, and the provision of organized health care. No end of that progression is in sight. Fewer and fewer demographers believe any longer that there is any fixed limit to average life expectancy, or even with individual life spans. That data has had the effect of encouraging utopian dreams—and who can say that those dreams are totally groundless?

However, I am convinced that the changing research perspective on death has a clinical and cultural corollary, affecting the way death here and now is thought about, or at least tacitly understood. At the practical, clinical level, constant technological innovation has made it increasingly hard to know when someone is dying; the line between living and dying has become steadily more obscure. Why is that? Whatever the lethal, terminal condition, there is almost always something technological that can be done to give the patient a few more days, or weeks, or months. Cancer therapy, with an endless number of experimental treatments, is a fine example. It is easy to persuade patients, their families, and their doctors not to give up hope: let's try it even if the odds are not good—and yet not impossi-

ble either. For desperate patients, worried families, and aggressively acculturated oncologists, that is too often an irresistible argument. I paid a last visit to an old friend a few years ago, a pioneer in bioethics who had taught courses for medical students on end-of-life care. He could not speak well, his mouth filled with sores. I asked him why. His doctors were, he said, trying one more round of experimental chemotherapy. "Why did you allow that?" I asked with some astonishment. A bit sheepishly he answered, "Well, they talked me into it." He died a week later.

THE MEDICAL SCHISM

There is a profound schism now at the very heart of medicine. The palliative care movement has been working its way backwards in history, aiming to return to a tame death. In contrast, what I call the research imperative moves forward in time, implicitly aiming to conquer death one disease at a time. Few researchers will say that is their aim, but the logic of the medical research enterprise pushes it in that direction. Those of us who are skeptical of that venture have been given some names: we are called "mortalists" for accepting death as human given, and "apologists" for defending that awful state of affairs (Overall 2003).

The net result of the schism, pulling medicine in two contradictory directions, cannot fail to express itself at the bedside. One can see the tension at work in our ordinary language, where we commend both the person who dies with quiet resignation and the person who fights death to the end. Which stance are we supposed to take these days when a lethal disease comes upon us? Fight or give up?

In his book *Swimming in a Sea of Death* (2008), writer David Rieff describes the illness and eventual death of his mother, the writer Susan Sontag, from cancer, and her unwavering refusal to accept its inevitability. She lost the struggle but never gave up trying. Her story helps to qualify the widespread—and false—belief that hardly anyone wants an all-out effort to salvage life when death is on its way. In the 1970s, patients complained about doctors who would not let dying people die. Much more common now are the complaints of doctors about patients or their families who want everything possible done to save their lives. In Sontag's case, it was irrelevant to her that the available (and ultimately fruitless) treatments could themselves be a misery, and there may be a growing number of those who feel the same way.

Where does that leave grief and mourning? In a confusing place, I believe. If death is increasingly seen as a biological accident, a contingent and not necessarily fixed part of our human fate, then how are we to mourn those who die? How, that is, are we to come to terms with deaths that might now have been averted, but which also, even if not avoidable now, may well be so in the future? What is the meaning of death in a utopia-driven scientific age?

**HOW WE DIE AND HOW WE MOURN:
LET ME COUNT THE WAYS**

I want to get at those questions by noting the various ways in which death comes upon us, particularly centering on disease in comparison with other forms of death. Until I began developing some lists, aiming for a kind of typology of death, I had not realized how varied its forms can be, and how equally varied our response to them can be. I will quickly run through my list, which could, with a bit of imagination, be made even longer.

There is *death from disease* (in childhood, adulthood, old age, and from preventable, curable, and unavoidable disease; and there is sudden or foreseeable death from disease); *death from natural disaster* (hurricanes, floods, drought, volcanic eruptions; and avoidable versus unavoidable risks); *death from war and political upheavals* (wars, riots, genocide, and holocausts); *death from criminal violence* (murder, gang wars); *death from suicide* (among the young, adults, the elderly); and *death from accidents* (auto accidents, falls, poisoning, fires, drowning).

Each one of those deaths can bring different kinds of grief and mourning. I give only some examples from my own life:

- the quick death of my 86-year-old mother from colon cancer with little suffering;
- the sudden and wholly unexpected death of my six-week-old son from sudden infant death syndrome (SIDS), a condition still with no known cause or cure;
- the deaths of three young friends and two colleagues from suicide;
- the death of three children of friends from drug overdose in the 1970s;
- the death of two teenage children of friends from auto accidents;
- the deaths of many old friends and acquaintances from cancer and heart disease, the most common diseases of the elderly;
- the death by murder of a college student daughter of a friend;
- the sudden death a day after giving birth of a daughter-in-law from a pulmonary embolism after a C-section.

The severity of grief in each of those cases was different, from mild to severe, and the length and intensity of mourning no less varied. One does not quickly get over the death of children or sudden, unexpected premature deaths. And people vary enormously in their resilience and in the meaning they attach to death. Which deaths are better and worse? The death of an elderly person from a common disease of aging seems far better accepted than the death of the young by violence. I can hardly imagine what it is like to see one's family and children tortured and then murdered before one's eyes in genocidal killing. Nor have I been able to get out of mind a recent news story about a father who accidentally drove over and killed his eight-year-old daughter playfully hiding in a pile of leaves in a driveway.

**WHAT MIGHT HAVE BEEN:
ITS IMPACT ON MOURNING**

But there are certain kinds of death that seem to torture people in a way particularly hard to endure. I will call them the “it might have been otherwise” deaths. By that I mean those deaths that might have been prevented, and I want to distinguish two types of such deaths. One of them is no doubt as old as human beings, that of the accidental death that could have been prevented: the parent who did not notice the small child getting too near the water or too near the fireplace, or the driver who took his eyes off the road a moment too long.

The other type has become steadily more common in modern medicine and bears on my notion of death as an accidental, contingent matter, no longer a matter of inescapable fate. I will call it the “it can be otherwise” death. Preventive medicine is now filled with examples. Colon cancer, which killed my mother at a time when there were no early diagnostic procedures, can now be readily detected by sigmoidoscopies or colonoscopies, and if detected early enough, it can be cured in most cases. Changes in unhealthy behavior, such as smoking, a lack of exercise, or a poor diet, can save thousands of lives. Drugs for high blood pressure and cholesterol can avert death from heart disease. The message from modern preventive medicine, in sum, is that if one takes care of oneself, makes use of available disease screening technologies, and uses the right combination of drugs, then death is not so inevitable after all.

The research imperative and the hope invested in it is another manifestation of deaths that could be otherwise. Advocates for stem cell research look to regenerative medicine to save many lives, from heart disease and diabetes to Alzheimer’s disease. When our 42-day-old child died from SIDS, my wife and I could do nothing but mourn and go on to have other children. It did not cross our minds 40 years ago to lobby the National Institutes of Health to create a research program to find a cure; for us, it was just something terrible that could happen to new babies, to be endured and accepted.

More recently, however, my wife was recruited by a much younger woman who had just lost a child from SIDS. She wanted help in raising research money for a cure, creating a small private foundation for that purpose. I don’t know how common it is in other countries, but it is striking now how many people in the United States who lose family members join advocacy groups to raise research money. The advocacy drive for stem cell research has been heavily financed by patient advocacy groups, intent on finding cures for lethal disease. Many obituaries now regularly carry a request that I believe was entirely absent when I was growing up: please make contributions to the American Heart Association or the American Cancer Society or some other disease-oriented advocacy group.

One advocacy group for stem cell research has talked of the possibility of saving 130 million American lives if it is successful. Such optimism is hyperbolic,

but there is much of it about. Disease ought not to be accepted, resignation is no longer acceptable—and fate is now in human hands. That is the new spirit.

WRESTLING WITH FATE

The perceptive political scientist Michael Walzer (1983) has well caught the essence of this new spirit. “What has happened in the modern world,” he writes, “is that disease itself, even when it is endemic rather than epidemic, has come to be seen as a plague. And since the plague can be dealt with, it must be dealt with. People will no longer endure what they no longer believe they have to endure” (p. 8)

Yet think a moment about the new configuration of death and its implications for grief and mourning. People have long believed, even against the depressing history of mankind, that war and the deaths they cause need not happen. Peace is possible, and in some places in the world it actually exists. Death from social violence is no less avoidable: some countries have a vanishingly low murder and violence rate. Good mental health programs can reduce the incidence of suicide.

Again and again the message is, death need not be. Even natural disasters are not wholly beyond human reach. If there is not much that can be done to stop hurricanes or tornadoes, droughts, or floods, sturdier buildings and similar measures can reduce the death rate and, in any case, people can move away from the most hazardous areas. If droughts cannot be stopped, humanitarian social policies can considerably reduce their deadly impact. What about accidents? Even there much advice is available on avoiding auto accidents, falls on slippery floors, and the hazards of leaving windows open when little children are about. So far as I can make out, accidents are an inescapable part of life, but that is rarely said in the literature and homilies on their avoidance—wholly possible, the safety literature implies.

Disease and the decline of the human body have almost become the last frontier of avoidable death. The premise of a tame death was that death simply is part of life, to be lived and died with—and to be suitably mourned along with the many other ways death can come to us. Now that frontier is being breached. There is no disease that is thought to be in principle incurable, no form of biological death that is not taken to be conquerable.

The “what might have been” of careful preventive foresight to avert death and the “what might be” of promising research have come together, leaving us in a new land. It is not quite a land where death is no more, and no doubt never will be, but it is one where the main ingredients of a peaceful death, acceptance and resignation, have been declared socially toxic and individually passé. We “moralists” and “apologists” are, so to speak, ought to be a dying breed.

MOURNING IN A NEW LAND

Where does that leave grief and mourning? It is surely harder, I think, to devise rituals of mourning in a world where less and less can be attributed to fate and chance, and where the scope of human causality, responsibility, and culpability grows ever larger.

The distinctive feature of the death of my mother at 86 was that it was treated as a natural event. Sadness was in order: she was loved and would be missed, but there were no tears, no obvious grief. Life is meant to go on. But that viewpoint will not be easy to sustain in a world of ever-improving diagnostic and screening possibilities: deaths like hers need not happen in the future.

There will be more space for regret about what might have been avoided, and more space for a mourning marked by anger that an avertable accident had happened. More space for the families of Alzheimer's patients to rage against inadequate research budgets, and more space for the families of those dying from congestive heart failure to resent the failure of cardiologists, however hard they tried, to keep their loved ones alive. But the test is not how hard one tries—only success counts. As Michael Ignatieff (1988) has acutely put it, "the modern world, for very good reasons, does not have a vernacular of fate. Cultures that live by the values of self-realization and self-mastery are not very good at dying, at submitting to those experiences where freedom ends and biological fate begins . . . their weak side is submitting to the inevitable."

If that is so, and if death itself is being removed from the realm of fate, then what are we supposed to do? We can simply reject the notion that the mastery of fate—if defined as full control of our lives, social and biological—is nearly at hand, or that it ever will be. We might agree that medical progress is an open, endless frontier while at the same time recognizing that death will still come whatever we do. It is thus no less certain that we will need rituals of mourning. Grief will never be cured by science.

Life improved greatly in the 20th century, from increased life expectancy to advances in almost every category of life: housing, recreation, income, education, scientific knowledge, and so on. Not only in the developed countries, but increasingly in most developing countries as well, life continues to get better. When I once asked my mother, born in 1895, whether life had improved since her childhood, it took her only a fraction of second to answer decisively: yes. But optimism about the human condition in light of those improvements needs a dose of reality: along with an overall improvement in quality of life, the 20th century witnessed the largest and worst world wars in history, as well as impressive scientific gains in the capacity to kill people in large numbers by use of the most advanced scientific knowledge, whether in physics, which gave us nuclear weapons, or biology, which has given us new tools for biological warfare. People, I have noticed, continue to die—later to be sure, but they are finally and irrevocably dead nonetheless—from all those preventable accidents and diseases and

from all of those potentially curable diseases, many of them, like AIDS, subject to the genius of constantly mutating viruses.

I live in an apartment full of elderly people, of which I am one. The disabilities of aging have been pushed back a few years, and high-technology medicine can get my neighbors through many episodes of a kind that killed their parents. But there they are by their 80s (and often earlier): no longer on the tennis courts, using canes and walkers, taking many drugs, enduring some kind of pain or disability (no one suffers from nothing at all), fearful when the elevators are not working that they may have to use the stairs, and of course many of them are already showing early symptoms of dementia. While the New York marathon seems to feature at least one person over 90 each year, those in our apartment house at that age rarely make it out of their apartments, and their dementia is more advanced. Whether that kind of life should be counted a medical triumph remains an open question.

**DEATH: LATER RATHER THAN SOONER,
BUT NOT ABOLISHED**

The fact that biological fate now comes later, with perhaps some of its harsh edges softened, is not the same as overcoming that fate. We cannot live here and now on promises for the future, all those diseases that will someday be cured. The trouble with nature, the source of our fate, is that it is ingenious in its gifts and its hazards.

That nature beyond our own gives us storms and droughts and disease, showing us that it can kill us just as effectively as the most well-organized genocide. As the surprising, unforeseen advent of AIDS made perfectly clear, nature is capable of throwing us curve balls. It has destroyed the reigning myth of the 1960s that infectious disease was all but conquered, and that the remaining chronic and degenerative pathologies of aging would be banished no less quickly. It turns out that as many people may now die of infectious disease as 40 years ago, helped along by AIDS, other new infectious conditions, hospital pathogens, and antibiotic resistance.

My modest conclusion about the present state of the human condition is that nothing will do away with death and the need for mourning. I use the word *need* to suggest three thoughts: we are better off if we do not try to explain away death itself as an accident; better off as individuals if we mourn the death of others; and better off when our mourning is public and nourished. Death is still a zero-sum game. To be cured of one disease is to be set up for death by another. To have our life saved from an accident or an earthquake, war or murder, is to increase the odds that we will then die from disease. "He can run but he can't hide," the boxer Joe Louis once said of an opponent before a fight, and that can be said of efforts to save lives as well.

It is surely better to have a longer rather than a shorter life, to die from cancer rather than murder, pneumonia rather than genocide, and to suffer from less pain rather than more. But all that just tinkers with and modifies our fate. Our fate is still death.

IN PRAISE OF MOURNING

If what I say is true, then it is important that we learn how to restore mourning to its rightful and sensible place, making death tame once again. The old-fashioned way makes more sense than the modern way. An open casket reminds us that the dead person was an embodied person. A funeral service, religious or secular, is better than a later memorial service. Time distances us from those who have died, softening our sense of loss and the sharpness of our grief. That grief fades is of course a blessing in the long run; enduring grief can be destructive. All the more reason then to catch it with a funeral when it is still sharply etched.

Our obituaries should be interesting and readable, as is the case with those in the better British press. Our deaths should bring us to life for those who did not know us. If we die in old age of some disease that most commonly afflicts the elderly, we should ask that contributions be made to groups and organizations helping the young. Flowers should still be acceptable. If we made it to old age, we had our goodly share of life. We should help the young to be so lucky.

Can we restore death as a public event? Not easily, but a few steps in that direction might help. We could begin by asking that no one should ask us to ignore his death, insisting that there be no funeral or memorial service. It seems to me an insult to one's own self-worth and self-respect to deny family and friends the privilege and comfort of grieving together, to ask in effect to be instantly forgotten—a strange kind of self-destructive narcissism.

At the least, we should recognize that once we have died, our problems and feelings have come to an end. That is rarely true with the survivors, and minimal decency seems to me to require that their needs be recognized. The famous Washington hostess, Alice Roosevelt Longworth, daughter of Theodore Roosevelt, left instructions that at her death there was to be no funeral, no ceremonies of any kind, and she got her way. A friend, however, felt that was wrong: "I think it was a great mistake . . . it was hard on everybody. . . . Maybe she did not want people to say pompous things about her. But I think when someone is not given a farewell you have a terribly uneasy feeling of their spirit hovering. It is as if a piece of music stopped before the final chord" (Felsenthal 1988, p. 268).

We could also usefully restore the practice of hanging black crepe on the door of the home of the deceased, announcing to all of one's neighbors that a death has occurred and that family and friends are in mourning. While an Irish custom I heard about as a child probably went too far—that of a wake featuring the deceased propped up in a chair at the center of the event—the idea had a certain mischievous charm. Beyond those ideas a final suggestion: keep those pub-

lic funerals and open coffins. Then hold a party on the anniversary of a person's death. Just have a good time in his or her honor. It will be more fun than most memorial services, and serious, shared grief will have been well served earlier.

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