LIVING WITH DEATH: THE MEANING OF ACCEPTANCE

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Summary

The emerging debate about what is a "good death" and whether individuals have a responsibility to die well usually calls attention to the evils attendant upon either participating or not in active forms of killing. In this article the author argues that we should avoid another kind of evil, that of an excessive reliance on medical concepts and values to define the dying process and the resultant image of death as the enemy. The author discusses a possible foundation for an obligation to accept death and develops related constructs: readiness to die, knowing when it is time to die, and the will to die. The last section argues for a shift from a commitment to prolonging life to an affirmation of dying, a more balanced view that values confronting the experience of and making choices in the face of finitude and death.

The emerging debate about what is a "good death" and whether individuals have a responsibility to die well highlights issues related to active forms of killing (Hardwig, 1997; Humber & Almeder, 2000). Advocates of a strong sense of duty to die try to show how hastening death can avoid the evils of dehumanizing the dying and victimizing caregivers and society. Opponents charge that individuals will become victims of society's drive to conserve

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resources. In this article I explore a background issue that has not received as much attention. I argue that another evil should be avoided: the excessive reliance on medical concepts and values to define the dying process and portray death as the enemy. We need a more balanced view of dying. As existential psychologists such as May (1996) emphasize, the human condition includes confronting the experience of and choices in the face of finitude and death.

In the first section of this article, I argue that we can identify an obligation to accept death that is at the heart of learning to live with death. The idea of acceptance of death seems to describe the underlying meaning implied in all deliberate attempts by individuals to facilitate or cooperate with the dying process. I discuss briefly the possible foundation for such an obligation and then analyze three of the most basic elements of this construct: readiness to die, knowing when it is time to die, and the will to die. This analysis may provide us with a convincing way to clarify individual choices that emphasize the value of a good death. Acceptance, in effect, signals a shift in thinking that may serve to temper the strong presumption of modern medicine in favor of prolonging life, sometimes regardless of the person's wishes and condition. The last section explains what it might mean to shift from a commitment to prolonging life to an affirmation of dying.

GROUNDING THE IDEA OF ACCEPTANCE OF DEATH

We are accustomed to various arguments that show how moral obligations derive from life itself, sentience and rationality, special roles and relationships, or certain performances such as promise making. I argue that death, the fact of human mortality, grounds an obligation to accept death.

It may be difficult to define precisely the exact moment life begins or ends, but empirical evidence after the fact makes it clear when life has begun its trajectory, and at the other end when life is over. The end is part of the life continuum not only as an end point but as a haunting dimension throughout the life cycle. Death is an intrinsic condition of being (Feuerbach, 1980) or an ontological structure or mode of being (Heidigger, 1962). At the cellular level, from the very beginning we are dying and replenishing life continuously. And even though the life cycle as a whole exhibits more

growth in the earlier years and then decline in the later, in some fundamental sense not only is the possibility of death ever present, but dying is ongoing. Each individual is dying right now and always dying. Biological life and death are intimately connected. Death is an immanent dimension of human life as well as its termination.

The beginning of one's own life obviously cannot be the focus of an obligation. But the end of life can be, because individuals can imagine it as part of their life continuum and anticipate it as unavoidable. According to Feifel (1969), this awareness distinguishes human nature: "It is man's excelling capacity to conceptualize a future—and inevitable death—which distinguishes him from other species" (p. 292). This unique ability seems to imply a unique responsibility. Dying as a dimension of our living now, our vulnerability to death at any time, and death when it actually comes, are universal parameters of human life that seem to demand a response from each individual: to search for moral meaning in this phenomenon (Frankl, 1963), "to fully choose one's finitude" (Koestenbaum, 1976, p. 11).

Philosophers and religious writers throughout history take up the challenge in developing theories for understanding the meaning and place of death in life and recommend morally appropriate behavior. Behavioral and social scientists have tracked various ways that humans cope in real life with the fear and anxiety that often accompany death. Some theorists try to articulate the dimensions of healthy fear and others, like Freud, imply that all fear of death is neurotic, but "treatable" to some degree. Some chronicle the many ways that the challenge to search for meaning is avoided: by ignoring death, minimizing it, repression, displacement, depression, or denial (Becker, 1973; Lonetto & Templar, 1986; Niemeyer, Bagley, & Moore, 1986; Simpson, 1979).

Denial of death in the contemporary Western world, especially the United States, may constitute a relatively new cultural phenomenon (Becker, 1973; Mitford, 1963). Advances in medical science and technology in the 20th century may have contributed to the growth of denial by exaggerating the power of dramatic, high-tech life-saving weaponry to overcome the "evil" of death (Choron, 1964, p. 8). This approach has influenced Western societies to view death as an enemy to be fought to the bitter end. Or, at best, death is seen as the ultimate challenge blocking medical science from extending biological existence indefinitely. Perhaps it is only a

matter of degree of denial, but earlier cultures, primarily the Egyptians, mummified the body so it would be available for immortal existence in the next world. Medical science acts as if it were possible to attain immortality in this world.

By contributing to a new form or degree of denial, medicine seems to have aligned itself with those attitudes and philosophies that recommend facing up to death only when it is imminent and can no longer be resisted. This is consistent with the mission of medicine to preserve life. But the impoverishment of such an approach is that it admits to the default position of accommodating the reality of death only when life is about to run out, and thus when there is less opportunity for reasoned reflection and informed choice. Or worse, the implication may be that one should choose to resist to the bitter end and never accept death. Individual and cultural differences can lend credence to such thinking. But on the whole, the history of human responses to death seems to reveal an enduring realization that biological death is a necessity that one must acknowledge, at least periodically, if only to find the perspective and tools necessary to cope with the fear of it.

The biological necessity of death may serve as the foundation for an obligation to learn to live with death, or what is called in this article "acceptance." The inevitability of death presents human consciousness with a unique challenge: to find meaning in that which is necessary. By contrast, even life itself is not viewed as a necessity by the various worldviews that support the idea of a duty to live. Such a duty is rarely viewed as an absolute because other duties may take precedence under certain circumstances. For example, duty to live must give way to other duties such as to protect others for whom we are responsible, to show loyalty to the demands of our religious faith, or to defend significant causes. As Kant (1963) said, "To live is not a necessity; but to live honorably while life lasts is a necessity" (p. 152). The duty to live requires that the individual will to live and take appropriate action, and refrain from other actions, in order to promote continued life, and to know when other values take precedence over life. Kant suggested that our philosophy of life should include what we would die for. A distinct duty to accept death also makes sense not only as a way to express the meaning of death under unusual circumstances that threaten significant values but, more importantly, as a way to come to terms with death under ordinary circumstances, when death has to be viewed as a natural, biological part of the human condi-

tion. Death is the preeminent reminder of the radical contingency of life. To what extent death is viewed morally in a positive or negative light depends on the meaning systems constructed to deal with death.

Consider another situation in which the demands of duty, in this case based on a particular role related to the beginning of life, involve determination of meaning and planning ahead. We would expect a pregnant woman and partner to reflect together on the significance of childbirth, under ordinary circumstances when there are no complications expected and also when medical history or current diagnosis indicates there may be problems. The implication is that participating in conception imposes a duty on prospective parents to be reflective about how to deal responsibly with childbirth and what follows. Individuals do not cause their own mortality any more than their birth, but the fact that the prospect of death refers to the last chapter of one's own created life story imposes on every individual an obligation similar to that of parents: to be reflective, ready, committed, and in this case to learn to deal with one's own dying. Parents too often shrink from responsibility by waiting until just before the child is born to begin thinking about parenting. Similarly, those who wait until the bitter end, when death is imminent and unavoidable, and only then begin to think about dying have lost sight of their obligation to accept death. Acceptance implies taking time, if not lifelong then at least for an extended period, to prepare for and participate as much as possible in a meaningful death.

The inevitability of one's own dying is the foundation of an obligation to learn to accept death. The foundation is unique. The duty to live requires that as long as one lives there is an obligation to live well. But one can choose not to live. Or as long as one is a parent there is an obligation to be a good parent. Again, one can choose not to be a parent or can provide for alternative parenting. By contrast, it is not possible to choose not to die. Consequently, it is difficult to see how this obligation could be replaced or overridden by other moral considerations. One can ignore death but not opt out of it. (Spiritual continuation/immortality is another matter.)

In sum, acceptance includes developing honest awareness of one's responsibility for being prepared and a realistic commitment to exercising control over the dying process that is consistent with one's basic philosophy of life. Acceptance defines the general framework of meaning and values within which a person makes

specific decisions about death and dying. Acceptance represents an acknowledgment that biological death is a necessity and that persons should be willing to learn to deal with their own death in a responsible way.

The focus of this article is on demonstrating that each individual should develop an acceptance of death. Whether this individual duty or obligation places demands on others to perform certain actions or make certain decisions is the topic of another article.

READINESS TO DIE

A key element in the concept of acceptance derives from this sense of a need to prepare for the inevitable. This may be a more developed or acute sensibility depending on life circumstances, the fragility of life, and how different cultures ritualize death events. For most people, past and present, the daily reminders of death stimulate awareness of needing to be ready to die. In preindustrial cultures, getting prepared could involve training to achieve nonordinary states of consciousness. The means could include various spiritual practices, rites of passage, mysteries of death and rebirth, shamanic methods, and books of the dead (Grof, 1994, 2000).

In the contemporary Western world, however, especially the United States, this sense of preparedness needs to be cultivated because of all the death-denying practices and institutions that have evolved in the 20th century. But if the necessity of death weighs on our consciousness at some basic level, then preparation is demanded of us. Preparation for death is certainly as imperative as preparation for other life events such as childbirth, initiation to adulthood, and marriage. In one sense, the appeal is to common sense. Readiness to die, as with preparation that contributes to the success of other major life projects, should be an essential ingredient in being able to die well. As a 17th century German Augustinian monk put it, "The man who dies before he dies, does not die when he dies" (Grof, 1998, p. 151).

And dying well and living well are interconnected. This is part of Plato's wisdom in the *Phaedo* and from one contemporary model of a good death, Morrie Schwartz (Albom, 1997): "Once you learn how to die, you learn how to live" (p. 82). And conversely, when we try to avoid death we may end up avoiding life.

> This incapacity to die, ironically but inevitably, throws mankind out of the actuality of living. . . . [T]he result is the denial of life. . . . The distraction of human life to the war against death, by the same inevitable irony, results in death's dominion over life. The war against death takes the form of a preoccupation with the past and the future, and the present tense, the tense of life, is lost. (Brown, 1959, p. 284)

Learning how to face up to death seems to require the development of a philosophy of death, or at least having more than rudimentary ideas that grapple with the meaning of death and its connection to life and whatever is beyond biological death. Perhaps an adaptation of Nietzsche's famous line, "He who has a why to live can bear with almost any how," captures the possible value of developing a philosophy of death. A person who has an understanding of death, one would hope, through responsible decisions can bear with almost any form of dying.

Conceptualizing the ideal death also may be an important part of readiness. Ongoing reflection about the ideal, what constitutes an appropriate death (Weisman, 1978), or a peaceful death (Callahan, 1993), or dying with a calm and detached state of mind (Miyuki, 1978), or a task-completed process (Corr, 1992), for example, certainly can help us prepare for death, at least to the extent that death is predictable and is within our grasp to plan for and control. But the underlying intentionality of acceptance must be simpler because it must encompass controllable but also unpredictable, surprise deaths as well.

The Stoics and various religious traditions suggest that the basic focus of readiness is an overall attitude that the individual must develop over a lifetime as a means of accepting death in all its guises. Such an attitude may function as the general form that represents a kind of unity and balance of the individual's holistic response to the reality of death.

The role of readiness may be similar to that described by various authors of the concept of ethical integrity, one's overall moral stance in life (McFall, 1987; Taylor & Gaita, 1981; Williams, 1981). The idea of ethical integrity, however, is much broader than what I am describing as readiness. Also, these authors tend to deny that integrity presupposes any other more specific virtues. I believe that readiness, whether it can be described as a higher order virtue or not, does require a set of some specific virtues or moral principles or rules for guiding behavior and sustaining the overall attitude toward death. Such specific characteristics may include hon-

esty, courage, equanimity, and perhaps endurance and patience. Any such list deserves more discussion than can be given here. But if this account is plausible, then readiness defines the ideal of balancing in mind and behavior whatever can be identified as the core set of characteristics that facilitate accepting death. Readiness, then, may be one manifestation of ethical integrity in the larger sense, or of such notions as self-actualization (Maslow, 1968), wholeness (Rogers, 1980), authenticity (Bugental, 1981), integration (Mahrer, 1989).

The humanistic assumption would be that the readiness characteristics, as dispositions to act in a consistent manner, also entail some positive affective dimensions. This is contrary to Kübler-Ross's (1969, p. 113) idea that acceptance as the last stage of dying is "almost void of feeling." But if wholeness or integration accurately circumscribes what I am describing as readiness, we would expect that in dying, as in other stages of mature development, there would be feelings connected necessarily with the other levels of existence: body and mind, soul and spirit (Rowan, 1998).

Various activities and situations, in turn, can serve to reinforce the strength of our intention to be ready to accept death now or whenever it comes: prayer and religious ritual, meditation (Boerstler, 1982, 1986), or other experiences inspired by the ancient knowledge that in recent years has been highlighted in transpersonal psychology and consciousness research, and thanatology (Grof, 1998). Near-death experiences seem to contribute to readiness by reducing fear and anxiety related specifically to dying (Groth-Marnat & Summers, 1998). Such experiences also can be transformative moments that enhance human development generally (Quimby, 1989), and presumably in the dying stage as well. More commonplace preparations and activities (in the West) can also play a role: obtaining life insurance, making out wills and advance directives, organizing documents and assets, making gifts, taking a long-postponed journey, repairing troubled relationships (Edwards, 1979), grieving the death of a loved one (Kessler, 1987), and even bringing a certain reflectiveness to watching the evening news that is often filled with reminders of contingency and mortality.

Parents and adults have an important role to play in planting the seeds of readiness in children (Widera-Wysoczanska, 1999). Adults should help children prepare to be ready later on to deal realistically with death. Open conversation about the meaning of

death, funerals, and so forth can make the child feel more secure and begin the process of building healthy attitudes toward death.

Finally, readiness to die seems to imply a willingness to die. This does not point to the presence of a death wish or an obsession with death, or any other form of neurosis. Rather, willingness to die points to a healthy realism about death, one in accord with the biblical wisdom that there is a time to live and a time to die.

KNOWING WHEN IT IS TIME TO DIE

At some critical point in an individual's life the acceptance of death seems to take on a special relevance because of heightened awareness of specific circumstances embedded with the real possibility of one's own death. The "weight" of circumstances, of course, usually involves an interpretation based on available facts but also individual perceptions and values. When there is time to reflect and sort out personal issues, many would demand, as an important indicator of when it is time to die, a medical diagnosis of a terminal condition with death as imminent regardless of what treatment is used. Others might be satisfied with a more open-ended diagnosis of a terminal condition that still recognizes the biological inevitability of death. Others would anticipate the impending loss of memory and ability to interact with significant others or, in the limit case, the permanent loss of consciousness. Pain and suffering that are resistant to palliative care would be sufficient for triggering self-conscious acceptance for other individuals.

One common element in these various perspectives on when it is time to die is the recognition that there are limits to human ability to control dying through whatever means. This realization does depend on historical context. For example, tribal and archaic societies of the past presumed that magic or evil intentions were the causes of untimely death. All death was untimely and yet bound to come at some time, despite countermeasures taken to ward off the negative forces. The contemporary dilemma in the West, as many perceive it, is that modern medical science and technology themselves have evolved into negative forces. They have the means to prolong biological life while simultaneously sacrificing quality of life beyond reasonable limits. Such prolongation can cause loss of dignity and unnecessary pain and suffering. The currency of such terms as "the right to die" and "death with dignity," the emergence

of natural death legislation and advance directives in the 1970s, and recent debates over physician-assisted suicide all signal a growing consensus that the ordinary person is the locus of responsibility for first, deciding that a limit to prolonging life has been reached and second, deciding not do everything that is technically possible to keep life going (Connelly, 1998).

In medical ethics in this century, the Catholic tradition was the first to formulate moral guidelines that provided space for the individual to admit limits and then say no to medical treatment. The distinction between ordinary and extraordinary medical treatment is given new currency by Pope Pius XII (1958). Extraordinary means of prolonging life are not to be considered obligatory if they offer no reasonable hope of benefit or impose grave burden, that is, cannot be used "without excessive expense, pain, or inconvenience," or if use of such means conflicts with superior, spiritual values (Kelly, 1957, p. 129). It is clear that this perspective identifies limit-setting as a moral judgment made by the individual and usually the family. The medical expert supplies information about the objective organic condition of the individual. But the individual is the one who is primarily responsible for synthesizing and evaluating such data, along with personal values, and then concluding, "I am dying" and "it is time." This awareness is ultimately spiritual and personal rather than empirical and medical. The realization that the limit is approaching or has been reached then entails concrete decisions about what actions or interventions are appropriate expressions of the individual's acceptance of death. Acceptance dictates a shift in emphasis away from the individual being concerned with preserving life and health and toward other moral and spiritual objectives such as reaching closure in relationships with others and God.

Is it possible from this discussion to shed light on the question of when it is time to switch full intentionality from a duty to live to one of acceptance or, in other terms, when duty to accept death should take precedence over duty to live? As posed, the question is misleading because it implies that there exist clear guidelines or objective signposts to be followed. On the contrary, the manifestation of acceptance seems to be more a matter of individual awareness and choice, a will to say "no more," that fits overall with the objective circumstances surrounding the individual as well as subjective feelings, values, and beliefs. Regardless of how we may eventually describe the psychological mechanisms that explain

the way that people recognize when it is time to die, the primary function of a duty to accept death may be that such a pervading mind-set, developed over time, disposes us to be on the lookout for objective signs and clues that give warning of impending death and allow for the natural emergence of an intuition that it is time to die. William James (1897/1956) described a similar state of mind as regards accepting the existence of God in his discussion of the role of expectation as one aspect of the will to believe. Acceptance of death suggests a certain clarity of awareness and vigilance that enables the individual to be more alert to biological signs of death. The absence of such a sense of obligation may be illustrated in the individual who is caught unsuspecting and surprised by the appearance of death.

To a certain degree one can prepare for being alert to signs of dying. Anticipating the exact circumstances of one's dying is difficult, of course. But the process of completing advance directives ("living wills" and/or durable power of attorney for health care documents) are helpful tools for reflecting ahead of time about one's choices in dying. Living wills enable the individual to instruct physicians to limit life-prolonging measures when there is little or no chance of recovery. Such measures may include, for example, cardiopulmonary resuscitation, intravenous therapy, feeding tubes, respirators, or dialysis. Durable power of attorney documents allow for designating someone you trust to make such decisions on your behalf when you cannot do so for yourself.

Advance directives have been in existence since 1976, when California passed the first natural death statute. They have been used with limited success since then. Only a small minority of people, including health care providers, actually complete a directive, and those that do fail to discuss it with families, proxies, or health care providers (Sehgal et al., 1996; Wood & Del Papa, 1996). Even when these actions are taken and the directive is part of the medical record it is routinely ignored by physicians (Marshall, 1995). The most recent studies indicate that advance directives do not improve the accuracy of surrogates' substituted judgment (Ditto et al., 2001; Tierney, Dexter, & Gramelspacher, 2001). They do, however, help establish a better climate for decision making at the end of life. Discussion of directives with their physicians contributed to patient satisfaction in their care and their general comfort level. These are important psychological benefits that improve the quality of dying. An addendum to advance directives might encour-

age even more awareness in the individual and inform discussions with family and physicians. I suggest that a statement of a philosophy of dying be attached to such directives. It could include various ideas about the meaning of death for the individual, for example, drawing on this and other articles and books on dying, and practical wishes about funeral arrangements. Developing a responsible attitude about expectations regarding the end of life should aid in recognizing when it is the right time to die.

THE WILL TO DIE

A third element in the concept of acceptance is the notion of taking full responsibility for one's dying. People who successfully confront their own mortality often experience positive consequences in their living (Koestenbaum, 1976; Moss & Moss, 1983-1984). I am using "the will to die" to focus on the experience of the positive consequence of dying well by taking responsibility in the final stage of living.

What the will to die adds to readiness and awareness of the time to die is a sense of commitment to take appropriate action or nonaction in response to the possibility of death. Will to die includes the intentionality that is presumed as background for specific decisions that actively cause death or simply remove obstacles that prevent death being caused more directly by one's own biological condition. Will to die is implied in decisions that involve refusal of further life-saving interventions (e.g., surgery, medication, antibiotics, feeding), and certainly more active forms of killing such as suicide and euthanasia. Taking a lethal prescription illustrates this intention, but so do deliberate omissions and failures to act when it is technically possible to do more. Expressions such as "it is time for me to go," or even "Thy will be done," imply such an intention.

Reference to God's authority over life may seem problematical in this context. But examination of even this phrase, "Thy will be done," may illustrate the type of intentionality involved in acceptance of death. How do we unpack the meaning in statements some people make about God's will? The examples of decisions described above cannot be characterized as death resisting, as if the individual were fighting to stay alive until "God calls," because the decisions are known by the individual to lead to death occurring sooner

rather than later. And this is a primary reason for making such decisions. Another possible reading is that the individual intends to remain neutral as to outcomes, as if to say, "I accept whatever will come." The so-called doctrine of double effect is sometimes used to defend such a position. The doctrine distinguishes between directly intended death, where the will to die is explicit, and which is considered morally wrong, and death that is not willed but merely foreseen as a result of another morally justifiable action, and this is morally acceptable. This approach, however helpful in other health care situations, seems counterintuitive in cases in which an individual deliberately refuses treatment, stops eating, or requests pain medication knowing that death is inevitable and not just one of many possible outcomes.

Double effect has clearer application in war and self-defense situations, for example, in which it is never that obvious that defense of life entails certain death either for the enemy/assailant or oneself. There are too many variables present in most life-threatening situations to have firm assurance in this regard. Therefore, consistent with double-effect doctrine, individuals may directly intend to protect their own lives and foresee the possibility but not intend the death of others.

The intention behind the will to die, however, has more parallels with what must be present in the most controlled of killing situations: a suicide mission, execution, or death caused by an antiterrorist sharpshooter. In these cases, death is virtually certain and as such somehow must be folded into the killer's direct intentionality, as seems to be the case with the will to die as described above. Consequently, if we discount irrational behavior or debilitating fear or denial of death, all of which may prevent clear understanding of why one is making such decisions, it does not seem psychologically plausible that an individual, in all honesty, could make deliberate end-of-life decisions that hasten death and yet not have an underlying will to die. The same intentionality obviously underlies suicide and physician-assisted suicide, for example, though in these cases, more control is taken over the timing of death. But it may be more a matter of degree, morally speaking, than of kind if the same basic intention informs more direct as well as less direct types of dying that involve forgoing treatment.

This is not to say that acknowledging a basic underlying intention, a will to die, simplifies moral evaluation of actions at the end of life. Sorting out intentionality in active and so-called passive

means of dying will continue to challenge us (Hopkins, 1997; Rachels, 1975, 1979; Sullivan, 1977). We still need to seek justification for our specific actions by reflecting on what counts as proper motives and determine how to evaluate consequences that affect self and others. And clearly, the will-to-die concept does not help us settle matters of public policy related to distribution of health care resources (Battin, 1987; Callahan, 1995) or to determine whether others are permitted or obligated to assist another in dying, and the social ramifications of such policy (Henk & Keown, 1999).

But a common intentionality may help establish some common ground for different voices claiming the moral right to take more control of the dying process by deciding sooner rather than later that the end is near. This spirit is present in the Catholic tradition's defense of forgoing extraordinary treatment, the hospice movement's emphasis on palliative care, the Hemlock Society's advocacy of self-deliverance, and John Hardwig's (1997) exposition in a recent article on the duty to die. Hardwig's analysis argues in favor of active killing, including suicide. His underlying premises are broader, but he seems to use the language of duty to die to keep our attention focused on active methods for bringing about death.

My concern in this article is to concentrate on the broader issue of what is the possible grounding for a variety of approaches, including Hardwig's, that recognize a need for deliberately cooperating with death, as it were, rather than taking combative action against death (Simpson, 1992). Those who tend to gravitate toward the ideal of cooperation exemplify respect for what I have called the obligation to accept death. But, contrary to Hardwig, this idea does not necessarily commit us to active self-killing or any other specific proposal for action or nonaction. The scope of acceptance is broad enough to include the full range of methods or strategies of dying. But broad in scope does not imply empty content. The core meaning demanded by acceptance of death is commitment to decisive action that hastens rather than prolongs dying. In this context, decisive action applies equally as well to forgoing treatment and to active killing.

Both of the terms "hasten" and "prolong," of course, bear the weight of accumulated meaning relative to modern medical interventions that can influence the course of biological life. For purposes of this article, I am using "hasten" to mean a quicker death than could be anticipated if life-saving technology and other medical interventions were used. In this case, the term takes on the

meaning of "willingness to use appropriate action" in order to let go (Boerstler, 1982, 1986) and not stand in the way of or postpone death. In the end, individuals must discover for themselves which path is best for them.

AFFIRMATION OF DYING

The goal of this article is to make a reasonable case for the existence of a distinct obligation to accept death. The moral basis for such a duty is a profound realization of the meaning of our mortality and the human condition, accentuated by the challenge of modern medicine. To never arrive at this realization, or to arrive grudgingly, by default, or only at the bitter end, seems to indicate a moral failing. Further mistakes in grappling inadequately with finding defensible motives, appropriate means, and realistic assessment of consequences can only compound the original failing. Or perhaps the lack of adequate grounding in the intention to accept death explains why the grappling is ineffective in the first place.

Acknowledging an obligation to accept death may have the effect of preventing egregious errors in end-of-life decision making. But its primary benefit, one that speaks to our age of modern Western medicine, is that it may lead us to err more on the side of relatively earlier discontinuance of life-saving interventions. It is hard to see how we can avoid error altogether given the uncertainties of medicine and fallible human nature. But, it is hoped, we may err less, as seems to be the problem today, on the side of overextended continuance of medical treatment in which dying is deformed and human dignity diminished.

An even stronger position may follow from this argument. A well-cultivated sense of acceptance, especially as a response in the age of modern medicine, may influence the individual at the end of life to self-consciously and deliberately shift away from the presumption in favor of life toward a more radical presumption in favor of good dying. This may translate into the practical rule, when in doubt about outcome, efficacy of methods of treatment, or impact on others, try to maintain focus on affirmation of the dying process and decide to let the duty to live slip into the background. At this point, the benefit of the doubt goes to experiencing well the last stages of living rather than extending the quantity of life. Paradoxically, an active, responsible, and skillful approach to letting

go is more life affirming than the self-deluding strategy of denying the imminence of death. Dying well is living fully up to the last moment.

This perspective brings us closer to a frame of reference that Aries (1981) described as "tame death," which he believes is far more typical of human experience throughout history than today's "wild death" that must be waged in the face of oppressive medical science and technology. This presumption is radical, then, only in the sense that it challenges the value of extreme commitment to prolong life in the culture of Western medicine. This presumption is reasonable because it represents a more realistic, balanced, and respectful view of the place of death in our individual and societal lives. This view neither depreciates biological life and the physical world around us nor seeks to magnify their importance. The former position has led tragically to death cults and ritual suicide, whereas the latter promotes life cults and ritual life saving that can be just as horrifying in the results.

CONCLUSION

The above discussion is an attempt to analyze the basic elements of the construct of acceptance and then suggest minimal performances that satisfy the obligation. The art of dying would take us beyond the minimum. In my view, the art of dying consists of having the ability to adequately understand relevant medical facts; the ability learned over a lifetime to listen to the wisdom of our bodies about biological decline and destruction; a developed character that responds with flexibility to the ups and downs of life and brings individual style and a sense of humor (Allport, 1961) to the last challenge; satisfying relationships that allow for authentic sharing of decision making in the dying process; a sense of individual closure in the lifelong pursuit of spiritual meaningfulness. And finally, the art of dying consists in having cultivated throughout life a sense of acceptance and the will, the intuition, and the prudence necessary to know when to fully commit to this duty at the end of life. Then the individual must choose means of death that are appropriate to deeply held ethical and/or religious beliefs. But acceptance should be the general frame of reference that informs awareness and guides any meaningful and responsible effort to encounter dying.

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