his deathbed and his whole life passed before his eyes in an instant, and he wasn't even in it. Is this an instance of T.S. Eliot's "hollow" man who passes his days in a "wasteland"? In the very first sentence of Ernst Becker's Life Against Death, he writes, "The prospect of death, Dr. Johnson said, wonderfully concentrates the mind." Why must our minds be concentrated, if we are to avoid being found "missing in action" when our life passes before us at our final hour on this earth?

Yes, indeed, brushes with death can wonderfully focus our minds on the essential lessons of living, but glancing in this mirror we rapidly turn away and quickly forget what we have seen. The fragile lessons we learn when faced with death are soon forgotten, scurrying into the shadow regions of our souls as we plod along our mundane ways, once again oblivious of the Grim Reaper. The compulsion to forget the lessons taught by our brushes with death may well be what Freud was pointing to with his theory of the Death Instinct. Linked to the compulsion to repeat, this self-destructive instinct blindly compels us to forget the lessons we must learn if we are to live our life to the full. Heidegger insisted that we can live abundantly and authentically only when we remember that we are on a journey toward our own death, or as he would say, we are "Be-ing-toward-death."

Our refusal to remember—this existential repression—springs from a peculiar fear of living and hatred for life. In an exchange of letters, Why War?, between Einstein and Freud, they concur that whoever hates life loves death. Death reminds us constantly that we must own our own life, take responsibility for it and resolutely refuse to hand our life over to any other. Heidegger sees our human situation as a perpetual flight from the summons to own our own life. Only "Thought-fullness" can save us from losing ourselves in the things of this world, in the impersonal mass—the herd, the crowd—and public opinion. Repression of death thus takes the form of "Thought-lessness." If I give away my very own self by absorption into the "they," what they think and what they do, then I live a Thought-less life by repressing both my fully living and my fully dying. Whoever said that if I am not for myself, who am I, and if I am only for myself, what am I, had it just right. Only if I have owned my own death by having fully lived my own life can I speak in any sense of a good death. Otherwise, it is as the Bard said, mere sound and fury signifying nothing.

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Hope

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Our approach to the issue of hope at the end of our lives is to view it through the plight of one determined woman. Jane Coyle's decisions and language illustrates how personal experiences and self-image can work in concert with the medical community. This is a skill that medical providers and patients must nurture in the face of medical technology.

Jane Coyle grew up in a large family and married early. She lived in Pittsburgh and raised six children. When her husband died, Mrs. Coyle remained in her community, becoming even more active in her church, local charities and cultural institutions. When she had a stroke at age seventy-one, her life changed dramatically. She became partially paralyzed and was only able to walk with the assistance of a walker. It left her with vocal cord paralysis, which caused her to have difficulty swallowing. Although she was unable to do much of her volunteer work, she devoted her energy to her rehabilitation and recovery. Initially she responded well to speech therapy and ate safely for

several years. However, as she aged, her swallowing weakened, as did many other muscles in her body. Slowly she developed more frequent pneumonias. She began to spend more time in the hospital, with her doctors, and discussing her health with her children. There were frequent conversations with Mrs. Coyle about how she would survive if she could not swallow and what the future might bring. When her doctor or family talked with her about her future care, she would only say, "Where there is life there is hope. Everything possible should be done to stay alive." As it turned out, this answer was open to multiple interpretations and almost caused Mrs. Coyle personal indignity, pain, and potential medical complications.

What Is Hope?

Mrs. Coyle was hoping to live. She was a fiercely independent person with tremendous pride. She had a very personal definition of what it meant to stay alive, but with this came a threshold where it no longer would be bearable or beneficial to accept limitless medical interventions. Many patients with chronic aspiration have physical hopes regarding their health and swallowing abilities. Mrs. Coyle may have believed her muscles could strengthen enough so that she could eat and keep food out of her lungs. Other physical desires may have included staying out of the hospital, never developing further pneumonias, avoiding pain and living at home.

In the medical community we discuss the physical hopes, but ignore the emotional hopes that drive these discussions. The hope that our bodies will remain at our emotional and intellectual age is often what drives aggressive medical interventions.

Mrs. Coyle had seventeen grandchildren and wanted to see how their lives would develop. Maybe she wanted to reconcile relationships, or regain independence. Mrs. Coyle likely hoped for everything discussed. However, when she envisioned herself with her grandchildren, she did not envision herself infirm. She hoped for a chance to eat what she wanted, laugh, love, dance, and actively participate in life. Although not possible, she wanted to remain vibrant and strong, watching the generations of her family mature and find happiness.

The Lottery

The best investments are low risk and high payoff. When buying a lottery ticket there is little risk. For one dollar we dream about the gifts we will buy for others, bills paid off, good we will do. In reality, we know the odds of winning are miniscule. If we do not win the lottery we lose a dollar and enjoy ourselves. The downside of the investment is defined upfront and easily quantified.

What if we were gambling for life rather than money? What would we sacrifice in order to stay young and reverse the physical changes of time? Would we take the long arduous road including pain, indignity, dependence, institutionalization, bills, lost family time, lost wages for our families, and hospitalization? In this new scenario we would know that no one has ever won this lottery. Most contestants have died in hospitals or nursing homes, rather than at home surrounded by family.

What about gambling for time only, but, like Mrs. Coyle, we could not get well? We could gain more time, but would still have our stroke, pneumonias, dependence, the need for nursing care, and the fate of more illness in the future. How much would we spend to get the wish of time with disability and illness? This is the payoff when we hope against death.

Hoping against death is not like the lottery. Less than five percent of chronically ill older hospitalized adults survive and even fewer are discharged. None of those discharged from the hospital are as functional as when they were admitted. These people bet on curative therapy to live a long time, but pay the price of receiving invasive therapy and eventually die.

A Dignified and Serene Ending

Mrs. Coyle's children were distressed by the thought of their mother not eating enough. They questioned how she would be able to get well. After several hospitalizations, and because Mrs. Coyle had said to "do everything" to stay alive, her family felt that a feeding tube might be helpful. Although there is no evidence that feeding tubes prevent pneumonia or improve quality of life, the Coyle children could not help but try anything in the hope of keeping their mother alive. Mrs. Coyle said "Absolutely not!" when presented with this plan. She explained that what she meant by doing everything possible to stay alive, was everything she could do to stay alive, not what hos-

pitals and doctors could do. She felt she was already doing what she could do to help herself and she requested to go home. She agreed to hospice care, and after several weeks of speaking closely and personally with each of her children and grandchildren, died quietly and comfortably surrounded by her children in her home. When her children reflect on Jane's death they say that she died on her own terms. They all agree that she lived the last part of her life true to the independence and integrity that defined her whole life. They felt all her wishes had come true.

Higher Payoffs with Lower Investments

With realistic goals and hope intact, we can live a long and satisfying life accepting our illness while receiving supportive care. We can transition to supportive end-of-life care at the appropriate time and still wish for longevity. How do we do this? What can we really hope for? If we cannot live forever, if our true "wish" is impossible, how do we approach the hope that we have left?

Accepting that none of us can control illness and death is one of the first steps toward physical and emotional wellness. This includes our doctors and loved ones, and ourselves. Each of us has an emotional and spiritual foundation that comforts us and helps us to cope with adversity. When facing life-limiting illness, it is essential that we identify that part of ourselves and nurture it, as well as focus our faith, hope, and prayers that preserve that force.

Additionally, real risks that each of us fear accepting can be controlled and managed. We need to be clear about what these are. Given Mrs. Coyle's condition, what were those risks that she clearly wanted to avoid? Perhaps they were suffocation, pain, loneliness, incontinence, hunger, or any other number of difficult symptoms. Once Mrs. Coyle and her family had direct conversations about particular interventions, she was able to ensure that her values were understood and met during the last part of her life.

Our current language of hope is often counterproductive to meeting this goal. We routinely talk about fighting disease, battling illness, conquering cancer, losing battles, and withdrawing care. Using this framework we are all sure to die defeated one day. The reluctance to explore our fears and desires can actually cause more pain and suffering. People often feel that foregoing disease-modifying therapies is giving up. Can we be winners by setting realistic goals and hopes such as dignity, less pain, resolving unresolved issues, or saying things that seemed too hard before?

We all have the insight to explore our fears and hopes regarding death, if we desire. Armed with this insight and the ability to express it to our loved ones and healthcare providers, we can "save our own deaths" and bring meaning to the end of our lives.

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Fantasies of Death

Technoculture and Virtual Death

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The personal inner experience of the passing of time is developmentally connected with the sense of the passing of our own life and with the feeling of something irreversible concerning our existence. This fatal blow to the secure perception of one's life is consciously processed already at the preschool and early school ages. To guard one's integrity against the "bad" experience of mortality at the end of one's consciousness and one's lifetime, the child can recur to the fantasies and fictions of living in another time and place where death is not imminent. Such fantasies help master