

On Death and Dying

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DR. J. RUSSELL LITTLE, Chief, Division of Infectious Disease, the Jewish Hospital of St. Louis and Associate Professor of Medicine and Microbiology, Washington University School of Medicine: Our guest this morning is Elisabeth Kübler-Ross, MD. Dr. Ross has become something of a celebrity since the feature story in *Life* magazine (Nov 21, 1969, p 36) concerning her and her work and the appearance of her recent book entitled *On Death and Dying*.¹ The book provides a fascinating account of an experiment in teaching and therapy concerned with the emotional problems of seriously ill and dying patients. We have decided to dispense with the traditional case presentation today even though Dr. Ross could discuss any of our hospitalized patients with a terminal disease. Instead we shall turn over the entire hour to her discussion of her approach to the emotional problems of dying patients.

DR. ELISABETH KÜBLER-ROSS, Medical Director, South Cook County Mental Health and Family Services, Chicago Heights, Ill: I was asked this morning why this topic on death and dying has taken such a long time to come into public awareness. Dying and dignity have been with us for as long as there has been mankind. Why is it now that we have to give seminars and workshops on death and dying? Has it taken us all these decades to begin to be aware that we are finite and that we have to treat dying patients?

Psychiatric Basis

I believe I shall talk like a psychiatrist for about five minutes and try to explain what death means and what the fear of death really represents. In terms of the unconscious, we cannot

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conceive of our own death. This is very important to understand. I believe that it shall happen to everybody in this room, but not to me. If I am forced to conceive of my own death, then I can only conceive of it as a malignant intervention from the outside. I cannot possibly conceive of dying of old age at home in my own bed. If I have to die, in my unconscious, I can only conceive of it as being killed. I am not afraid of death per se, but rather the destructive catastrophic death that hits me from the outside when I am not prepared. Perhaps the most complicated thing to understand is that I cannot differentiate between the wish and the deed. In the Bible it says somewhere that to lust after your neighbor's wife is as bad as actually doing it. In terms of my reality, testing this is actually absurd. I can have all sorts of fantasies of what I would like to do, but as long as I don't do it, that is satisfactory. In terms of my unconscious that is not acceptable. If you understand this, then you can see what is relevant and what is important to understand, especially in the death of a parent of a young child.

Little children have a peculiar concept of death. They regard death not as a permanent happening, but as a temporary happening. Every normal 4- or 5-year-old child who is angry at mommy wishes mommy to drop dead. That is very normal behavior. Children think of it when they are angry, when they feel small and impotent and helpless, and they wish mommy would drop dead only to make her get up again when they are hungry and they want a peanut butter-and-jelly sandwich. The trouble is that the little 4- or 5-year-old boy may really lose his mother by death, separation, or divorce. He then feels that he has actually contributed to her death. This thinking shows that he cannot yet differentiate between his wish to kill mommy and whether he has actually done it. If we understand this,

then we appreciate many of the complications of dying patients who sometimes, decades later in their old age, moan and groan and cry and have a lot of somatic complaints which we cannot understand medically. When we talk to these people, we see that they have a peculiar sense of guilt; they feel that they have committed a crime and they have to be punished before they die. These patients suffer far beyond our medical understanding.

Our Death-Denying Society

Why is dying different now? People have the same kind of unconscious thoughts and fantasies that they had years ago. What has changed, I think, is our society, which has become increasingly a death-denying society. Half of our patients now die in hospitals, as compared to 50 years ago when people died at home in a familiar environment with a little bit of chicken soup instead of transfusions, with their families around them instead of interns, residents, and laboratory technicians. People who are dying in a hospital are attached to several pieces of monitoring equipment and we, as physicians, pay a lot of attention to these gadgets. Sometimes we feel very uncomfortable when a dying patient looks at us and would like to ask a question in regard to dying or to some unfinished business or to fears and fantasies. In Switzerland, where I am originally from, there is no embalming. They do not have drive-in funeral homes such as we are beginning to have in the United States where you drive up in your sports car, look through a glass window, sign a guest book, and take off. All of this is an attempt to deny that people die. We have a society where we deep freeze people and promise at high cost to defrost them in 50 or 100 years. We have had questions from widows about whether they are eligible for social security, or if they are allowed to get married

again. In this sense, people use denial that their next of kin are really dead.

Joseph Matthews has provided a beautiful description of the death-denying society and if you will bear with me I will read just one page to give you an even better description of what I mean by a death-denying society:

To symbolize the dignity of the father's death the family decided to clothe the father in a pine box and rest him in the raw earth. Having been told that caskets ranged from one hundred to several thousand dollars, they asked for the one hundred-dollar coffin.

"What \$100.00 coffin?" replied the astonished undertaker.

"Why, the one you mentioned."

"Oh no, caskets begin at \$275.00."

"Did you not mention a \$100.00 coffin?" The persistent wishes of the family were met and the pine box was selected. Later Matthews describes his experience after his father had been prepared by the undertaker:

My father was 92. In his last few years he had wonderfully put chiseled wrinkles. I had helped to put them there. His cheeks were deeply sunken, his lips pale: he was an old man. There is a kind of glory in the face of an old man, but not so with the stranger lying there. They had my papa looking like he was 52. They had put cotton in his cheeks and had erased the best wrinkles. His lips were painted. He looked ready to step before the footlights of a matinee performance. I fiercely wanted to pluck out the cotton, but was afraid. At least the make-up could come off. I called for alcohol and linens and a very reluctant mortician brought them to me. I began the restoration. As the make-up disappeared, the stranger grew older. He never recovered the looks of his 92 years, but in the end the man in the coffin became my papa.

Later he describes his experience at the cemetery:

I say I smelled that fresh earth, but there was none to be seen. What I did see was difficult to believe. I mean that green stuff. Someone had come before us and covered that good raw earth, every part of it, with green stuff. Every scar of the grave was concealed under simulated grass just as if nothing had been disturbed here—just as if nothing was going on here, just as if nothing were happening. What an offense against nature, against history, against papa, against us, against God.

It goes on, but I shall stop here. You have to ask yourself why we have to conceal the grave, why we have to cover up that good earth with artificial greens, why we have to pretend that nothing is happening. You must

understand that the fear of death is the fear of a catastrophic happening, a catastrophic destructive force that destroys us from the outside.

Then we also have to look at death in the past and death in the present. In the old days death also came as a catastrophic happening in the form of epidemics. It erased populations of whole villages, but it was not man-made. In times of war you faced your enemy face-to-face and had a chance to kill rather than to be killed. These things have changed. In the past, epidemic disease was the killer; now we have developed antibiotics, vaccines, all sorts of things that can master the old types of death. In our fear of death we have also created weapons of mass destruction. We now have weapons that you cannot defend yourself against physically. We cannot see, smell, or hear an enemy and I am thinking of chemical warfare, bacteriological warfare, and means of mass destruction, all of which are man-made. We are afraid, we are guilty, and still hope "it shall happen to thee and to thee but not to me!" I think this is the reason why this society, especially at this time, is using such a mass denial. We live in the illusion that, since we have mastered so many things, we shall be able to master death too.

Physicians' Reactions to Dying Patients

How does this affect you as physicians? How does this affect our patients? I had a glimpse of this 4½ years ago through a chance happening. Some theology students knocked at my door and asked me if I would help them to write a paper on a crisis in human life. Several had chosen dying as the biggest crisis man had to face, but they were stuck. They did not know how to do research on dying. You cannot experience it, you cannot verify it. I suggested that one way that you could really collect some data and understand it was by getting close to dying patients and asking them to be our teachers. I had a similar experience some years earlier when I tried to understand what it is like to be schizophrenic. I spent two years in the state hospital where I sat with schizophrenic patients and asked them what is it like, how did it start, what are the changes, what does it

feel like, until I had the feeling that I really knew what it was like to be a schizophrenic from the patient's point of view. Because I had this good learning experience, I recommended the same kind of methods to my theology students.

I promised them that I would interview dying patients, and that as they would become more comfortable during the interviews, I would drop out and let them continue the dialogue until they had enough data. A week later, after asking numerous people, there was not a single dying patient in that 600-bed hospital! There was just nobody dying. When I pushed, I was given all sorts of rationalizations. These patients were too sick, too weak, too tired, or "they don't feel like talking." Occasionally I was told that if I talked to patients about dying they would jump out the window. It was extremely difficult during the first year. It took an average of ten hours a week to get permission to see a single terminally ill patient. In all fairness I must say that I was new at the University of Chicago, and so the physicians had no assurance that I would not cause trauma or that I would be tactful. But this same kind of resistance I have also seen in Colorado; it was not associated with the University of Chicago alone. When we finally obtained permission to see a patient, he was an old man who was ready to talk. He put his arms out and said please sit down *now*. I told him, "No, not now," because my students were not with me. My needs as a teacher prevented me from seeing his needs. I described to the students the next day his outstretched arms, his pleading eyes, how he emphasized the *now*. The next day when I came with the students he was in oxygen, he could hardly talk, and the only thing he was able to say was, "thank you for trying anyway." He died about half an hour later. This was our first and most difficult patient, because of our own feelings, which prevented us from really listening to his needs.

We decided we would meet in my office and talk to each other about what we called our "gut reaction"—how we really felt about this type of work, about seeing these kinds of patients, and about the reception we would get from the patients. One of the students, who was as white as a

bed sheet, said, "Oh, I'm not afraid of death," and the other students questioned him as to why he was so pale. They wanted to know why he was the only one who denied his fear. He said that he had been the hospital student chaplain in a state hospital the year before and that he had been assigned to a ward where a patient was dying. He had walked into the ward and said (I am quoting him almost verbatim now): "I yelled at the peak of my voice, 'God is love, God is love' until the patient dropped dead." This was his proof that he was not afraid! I told him that when I was a little girl in Switzerland, I had to go down to the wine cellar to get a bottle of wine and the darker the cellar became, the louder I yodelled. That experience reminded me of him.

What I am trying to say is that after each patient interview, we tried not only to listen to the patient, but also to ourselves, to our own reactions; we tried to get to know ourselves better. In these after-interview discussions, we analyzed how we really reacted—when we had some tender thoughts, and when we had some difficulties. We also learned to become more sensitive, not only to the patients, but to ourselves and to our own needs. Dr. Wall described beautifully in his book on the dying patient how a social worker was faced for the first time with a dying patient and what her reactions were. He said every time she entered the patient's room, she felt strong feelings of guilt.

She was going to live, while he, of her own age, was going to die. She knew he wanted to talk to her, but she always turned the talk into a little joke or into some evasive reassurance, which had to fail. The patient knew and she knew because he saw her desperate attempts to escape: he took pity on her and kept to himself what he wanted to share with another human being. So he died and did not bother her.

We have interviewed more than 400 patients during the last four years. We have seen many times that patients want to talk and that they would very much like to share their thoughts with another human being. It is very difficult sometimes to try to do that. When we come in, we tell them that we would like them to be our teacher, that we would like to know what it is like to be very sick, and sometimes we use the word dying. Many of our patients respond

like we are opening flood gates. They share with us things that we were never aware of.

I think the most important thing that we have learned, and I am summarizing a bit now, is that all our patients know when they are terminally ill, whether they have been told or not. To me this is a very consoling thought. They not only know when they are seriously ill, but patients can even tell you the approximate day of their death, right up to their actual demise. They will tell you goodbye and you know this is the last time you will see them. This is also true for children. We asked our patients the question that we are most often asked, and that is, would the patient have liked to be told. Two-fifths of our patients had never been told, although they knew it anyway after a while. Our patients usually told us that they would like to be told if it is serious, but not without hope. Hope for the healthy and the living is a very different thing. We tend to forget that sometimes. Hope for the living is always associated with cure, treatment, and, if that is not possible, a prolongation of life and perhaps relief of pain and suffering. When a patient says to you, "I hope the research laboratories work on a new drug and I am the first one to get it and by some miracle I am going to walk out of this hospital," that is hope prior to the final stage. When the same patient then, suddenly, a few days later, looks at you and says, "I hope my children are going to make it," then you know that this patient has changed not to the kind of hopes that dying patients express, which are very reasonable, very appropriate, and not unrealistic. It is not wise at this point to tell them, "Oh, come on now, you are going to make it, you are going to get well." I think at this point we should support them, encourage them, and reinforce the hope that the patient expresses.

Stages Between Awareness of Serious Illness and Death

Patients go through five stages between their awareness of serious illness and their death, if they have a minimal amount of time available. Most patients respond with shock and denial when they are told that they have a serious illness. This may last

from a few seconds to a few months. Most of the patients we interviewed had dropped their denial; only three, less than 1% maintained it to the very end. Patients begin to see, when they are seriously ill, that the family comes in and does not know what to talk about and becomes estranged. Someone may come in with a red face and smile. Others may change their conversation a bit; they may talk more about a triviality because of their discomfort. Patients accept quickly that things are not at all perfect. When the patient cannot maintain his denial anymore, he will become difficult, nasty, demanding, criticizing; that is the common stage of anger. How do you respond to one who complains and criticizes everything you do? You may tend to withdraw and not deal with him anymore. What else can you do? You can avoid him, you can stick the needle in a bit farther—not consciously—but when you are angry you touch patients differently. We can measure some of these responses. In California some investigators measured the response time between patients ringing for the nurse and the nurse actually coming into the room. They showed that patients beyond medical help, terminally ill patients, had to wait twice as long as other patients for the nurse to respond. This behavior should not be judged; it should be understood. It is very difficult to remember that members of the helping professions, who work hard all day, may have a difficult job coming into the dying patient's room. In the first place, the professional is uncomfortable; second, she is worried that the patient may ask how long he has to live or all sorts of unpleasant questions, and then, if the nurse does something for the patient, he may begin to criticize her. The nurse comes in and shakes the pillow, and the patient says, "I just wanted to take a nap, can't you leave me alone." When you don't shake the pillow, the patient remarks, "why can't you ever straighten up my bed." Whatever you do is criticized. Such patients are very difficult to manage and the families suffer tremendously because, when they come in and visit, they are always too early, too late, or there are not enough people, or too many people. Someone has to do something for these patients, to facil-

itate life for everybody concerned. It is important to understand that these patients are not angry with the nurse or the family. The more vibrant the nurse is when she comes into the patient's room, the more energetic she is, the more she is going to get through to the dying patient. In a way she should be able to accept the anger as a compliment, because what the nurse reminds the patient of is functioning health, ability to go to work, to go for a coffee break, all those things that the patient is about to lose. Because the nurse reminds the patient of all these things, and because he is desperately attempting to deny that he is dying, he becomes angry and says in effect, "Why me?" But he is also asking, "Why couldn't this happen to Joe Blow or somebody else?" If the nurse can put fuel into the fire, if she can help him to express this anger, if she can permit him to ask the question, "Why me?" without the need to answer it, then she will have a much more comfortable patient almost immediately. We interviewed a young patient who was dying. She was in my office and looked completely numb and I asked her if she felt like screaming. She looked as if she were on the verge of an explosion. She asked if we had screaming rooms in hospitals. I said no, we had chapels. "No, this is wrong," she said, "because in chapels we have to pray and be quiet and I need just to do the opposite. I was sitting out in the car yelling at God and asking him, 'Why did you let this happen to me?'" I encouraged her to express this in my office and to cry on my shoulders. They never scream as loud as they think they will.

If you can help patients express the question, "Why me?" you can help them express their rage and anger; then your patients become more comfortable and ring for the nurse less often and stop nagging and complaining. Sometimes they even quickly become much more comfortable patients and we wonder what has happened to them.

That is often when they reach the stage of bargaining. In the bargaining they may pray for another year to live; they would donate their kidneys or their eyes, or they may become very good people and go to church every Sunday. They usually promise

something in exchange for extension of life. Some of the promises are not made to God, but to someone on the hospital staff. We had a woman who asked to be relieved of some of her tremendous pain for one day so that she would not be dependent on injections around the clock. She said she would just love to go home one more day and the reason for this was that her favorite son was getting married. We tried everything, and finally we were able to teach her self-hypnosis to relieve her pain. She left the hospital and looked like a million dollars. She attended her son's wedding. I was curious about patients who only ask for one single day; how do they react when their bargaining time is up? It must be extremely difficult. I waited for her, she saw me in the hallway and she was not happy to see me at all. Before I could ask her a question, she said, "Dr. Ross, don't forget, I have another son." This is the most typical part of bargaining. Promises are never kept; patients say, "If I could live just long enough for my children to go through high school," and then they add college, and then they add I just want a son-in-law, and then they would like to have a grandchild, and it goes on and on. If, in the denial stage, they say "No, not me," then in the anger stage they say, "Why me," and in the bargaining stage they say, "Yes me, but." When they drop the "but," it is, "Yes me." Then the patient becomes very depressed.

There are two kinds of depression and it is important to understand the two different kinds. The first type is a reactive depression in which the patient cries when he talks about it, and mourns the losses which he has experienced. Later on he becomes quiet and depressed. When you enter his room, you see a man crying and he doesn't say what he is crying about. It is very difficult to accept such behavior over a long period of time. What does the physician do when he enters the room of a patient who is crying, especially if it is a man? This is one area in which men have a much more difficult time than women. The physician may be quiet. Many physicians go into the room and give the patient a pat on the back and say, "Come on, it is not so bad." We try to cheer them up because, as physicians, we cannot

tolerate crying patients very well. The reason our tolerance is low is not because of the patient; it is rather because of our own inability to tolerate depressed patients over a long time. Sometimes we request a psychiatric consultant, which is not appreciated by most patients. It is an inappropriate request because the patient's response represents normal, not abnormal, behavior.

If I were to lose one beloved person, I would be allowed to mourn and everyone here would respect that as being socially acceptable. But who has the courage to face not only the loss of one person, but the loss of everybody he has ever loved? It is a thousand times more sad, and takes much more courage to face. What we should be trying to do is to tell our patients that it takes a man to cry and that we mean it completely and willfully. We should help them express their grief, which, in fact, is a preparatory grief. It is not mourning and grieving over things lost; rather, it is a grieving and mourning over impending loss. The patient is beginning to separate himself from the people that he has to leave in the near future. This is what we call preparatory grief. If the physician can help his patient through a preparatory grief, the patients will ask once more to see the relatives, then the children, and at the very end, only one beloved person, who is usually husband or wife and, in the case of children, naturally, the parents. This is what we call the stage of decathexis, when the patient begins to separate; when he begins to feel no longer like talking; when he has finished all his unfinished business; when he just wants the companionship of a person who is comfortable, who can sit and hold his hand. It is much more important than words in this final stage. If the physician can help the patient express his rage and his depression and assist him sincerely through the stage of bargaining, then most patients will be able to reach the stage of acceptance. It is not resignation—there is a big difference. Resignation, I think, is a bit like giving up. It is almost a defeat. A stage of acceptance is almost beyond any affect. It is the patient who has said, "My time comes very close now and it is all right."

A woman who was always hoping

for a miracle drug that would cure her suddenly looked with an almost beaming face and said, "You know, Dr. Ross, a miracle has happened." I said, "What miracle?" and she replied, "The miracle that I am ready to go now and it is not any longer frightening." This is the stage of acceptance. It is not happy; the time is rarely ever right. People almost always want to live, but they can be ready for death and they are not petrified anymore. They have been able to finish their business.

Even children, depending on age, can show these stages, but to much less of an extent than adults. Very small children are only afraid of separation. They have no real concept of death yet. When they are a bit older, the added fear is one of mutilation. Later on they see death as a man whom they run from at night—a bad man; they want the lights on at night, as they are afraid of darkness. Later on they realize that death is not a temporary but a permanent happening. They begin to see it after the age of 9 years or so as a biological force, almost like grown ups. Sometimes children talk about death and dying, too—not in words, but in pictures. A little boy tried to paint what he felt like. He drew a huge tank and in front of the barrel was a tiny, little figure with a stop sign in his hand. This to me represents the fear of death, the fear of the catastrophic, destructive force that comes upon you and you cannot do anything about it. If you can respond to him by saying it must be terrible to feel so tiny and this thing is so big, he may be able to verbally express a sense of smallness or impotence or rage. The next picture he drew was a beautiful bird flying up in the sky. A little bit of its upper wing was painted gold. When he was asked what this was, the boy said it was the peace bird flying up into the sky with a little bit of sunshine on its wing. It was the last picture he painted before he died. I think these are picture expressions of a stage of anger and the final stage of acceptance.

Comment

DR. LITTLE: I wonder if I could urge you to tell a story that you told yesterday afternoon concerning the reaction of the nurse in encouraging

patients to achieve a state of acceptance of death.

DR. ROSS: Many people wonder whether all patients should die in a state of acceptance. Somebody once asked me that, and I said you try to elicit the patient's needs. One nurse in the audience arose very angrily. "I have been angry and a rebel all my life and I hope I can die that way." My answer to her was, "I hope they let you die that way and not sedated to keep you 'nice, quiet, and peaceful.'" It is very important to remember that the patients who have used denial all their lives may want denial and may die in a stage of denial. We should not project our own values onto the patient. The "stages of dying" affect not only terminally ill patients. You can apply these lessons to everyday living.

If a man loses a girlfriend, he may deny it at first; then he becomes angry at the other suitor. Then he sends her some flowers to bargain, and if he cannot get what he wants, he becomes depressed. Eventually, he reaches the stage of acceptance, when he finds another girlfriend.

DR. JEROME D. COHEN: Were there any differences between the patients who were told by their physicians about their fatal illness as opposed to those who were not? What guidelines would you recommend to physicians in determining whether the patient should be told or not?

DR. ROSS: I could tell after a while whose physician the patient was by the degree of comfort experienced by the patient. I did not even have to ask anymore. I do not believe the variable is whether or not they have been told. The variable is how comfortable the physician is in facing the dying patient. We had, at our institution, one surgeon who was particularly effective in this area. I think that he conveyed to them verbally or nonverbally the belief that he would stay with them until the end. The patients were able to pick this up. It is something that is more important than anything else. It is a conviction that the doctor is going to stick it out no matter what. He always did that. The patients knew that, even though there was no more possible surgery or medical treatment, he would still come to see them and care for them. Those patients had it much easier. In fact, we

hardly ever got referrals. We sometimes went to see them because we needed some "good patients" who were not troubled all the time. I am in favor of telling patients that they have a serious illness because patients accept that almost without exception, as long as you always allow for some hope.

A PHYSICIAN: What advice do you have for the families of patients who are dying?

DR. ROSS: That is only difficult if the patient or the family lags behind in the stages. We have patients who have already separated themselves from their relatives. In fact, we have a patient now at the hospital who is waiting to die. His family has stopped visiting him. The nurses are terribly upset because the wife called up and said that if her husband died, they should not bother calling during the night. She would call in the morning to check. This family has already separated itself and yet the husband is still alive and very lonely. When I went to see him, he expressed a lot of grief and asked if I would pray that it would soon be over. There is nothing much that he wants to do. It is more often true that the patient has reached a stage of acceptance and the family has not. That is the time when the family begins to run around and beg you for life-prolonging procedures. We have had one difficult case where a woman was ready to die. She had accepted it and was only concerned that her husband could not accept it. The husband was busy arranging for additional surgery, which was scheduled for the following Monday. The patient could not tolerate the thought of an additional procedure. She became very anxious and uncomfortable prior to surgery. She demanded twice as much medication for pain and finally, in the room outside of the operating room where she was prepared, she had an acute psychotic episode and became paranoid and screamed, "They are going to kill me, they are going to kill me." In her psychotic state she kept saying, "Talk to that man, talk to that man." When I talked with her husband and tried to explain what had happened, he said that he would rather have as a last memory his beautiful, dignified, wonderful wife than know that she was dying a

psychotic woman. When he was able to convey to her that he had accepted and acknowledged the fact that she was terminally ill and the surgery was permanently cancelled, she soon became nonpsychotic. She lived for about one week and she even went home one more time to help her husband turn the clock back a little bit.

We have had three instances so far where patients used psychotic defenses against artificial and extraordinary life-prolonging procedures. We have had some very traumatic cases where husband and wife could not reach the same stage at the same time. I think a golden rule for us as physicians is to know enough to stop the extraordinary measures when a patient has reached the stage of acceptance. When the patient has come that far, then I think many of us know that such interference is no longer therapeutic, and may only gratify our own needs.

A PHYSICIAN: Do you ever tell a patient he is dying?

DR. ROSS: You never tell a patient he is dying; never. You don't have to—you just tell him that he has a serious illness. You say, "It looks pretty grim," or "It looks pretty bad." Then you wait for and answer his next questions. He may ask you, "Is it going to be painful?" "Am I going to be alone?" "How long is this going to last?" You say you don't know, because the worst thing that we have experienced is people who tell time, for example, people who figure on six months, which is not correct anyway.

A PHYSICIAN: Have many of your patients been physicians, and if so, have they presented unusual prob-

lems?

DR. ROSS: We have had perhaps six or seven physicians and about the same number of dentists. I would say that they may have maintained the denial for a bit longer in spite or perhaps because of a better understanding of their diagnosis or of their illness. I think physicians have it much harder. We are trained to heal, to cure, to prolong life, and I think many of us feel that "if a patient dies on us," it is like a defeat or a failure, and so we do not talk about it. That makes it much more difficult. My big hope is that in time we will have more interdisciplinary seminars not only for medical students like we have in Chicago now as an accredited course, but for sociology students, nursing students, social work students, and members of the clergy.

A PHYSICIAN: Have you noticed whether or not the patient's religious orientation has affected his view toward resignation in the end?

DR. ROSS: Not resignation but acceptance! I have a peculiar patient population, or at least I tend to think so. I have very few really religious people. The few I have—and I mean those with a deep intrinsic faith—have it much easier, but they are extremely few. I have an even smaller number of real atheists who believe nothing, and they have it rather easy too. About 95% are somewhere in between. They are struggling at the end very desperately, but they would like to have the rock of Gibraltar and they only have a straw; they would like to enlarge that and get more faith, but it is somewhat too late. Many patients become more religious in the end, but it is not really effective.

Summary

Psychiatrically it is extremely important to appreciate that, in terms of the unconscious, we cannot conceive of our own death and that, in addition, we cannot differentiate between the wish and the deed. Although people today have the same kind of unconscious thoughts and fantasies about death that other persons had years ago, our society has changed and has become increasingly a death-denying society. We live today in the illusion that, since we have mastered so many things, we shall be able to master death too.

Certain generalizations based on interviewing more than 400 dying patients in the past four years can be stated. All patients know when they are terminally ill, whether they have been told or not. Patients usually state that they would like to be told if it is serious, but not without hope.

Most, but not all, patients pass through five stages (denial, anger, bargaining, depression, and acceptance) between their awareness of serious illness and their death, when they are faced with a potentially fatal illness. The knowledgeable physician, particularly one who is himself comfortable in facing the dying patient, can help these patients pass through one or all of these stages by appropriate verbal and nonverbal support—particularly the support engendered by the patient's realization that his physician will stay with him until the end.

Reference

1. Kübler-Ross E: *On Death and Dying*. New York, Macmillan Publishing Co, 1969.

Metrication: *What Is an Are?*—Effective January 1973, the present policy for AMA scientific publications for use of a mixture of metric and nonmetric measurements will change; the 11 journals thereafter will publish measurements only in a modified metric system (as described in Vawter SM, DeForest RE: The international metric system and medicine. *JAMA* 218:723-726, 1971).

In the International System of Units, wherein all measurements are based on the meter-kilogram-second (MKS) system, the basic unit for area is the square meter (about 20% larger than a square yard). It is used, for example, in building and construction. Small areas, however, are usually measured in square centimeters.

For land surveys, the hectare (about 2.5 acres) is used. One must not confuse an acre with an *are*, however; an are is equal to 100 square meters and 100 ares make a hectare. Thus, *ares* are units of area, and 1 are, the area of a square whose sides are 10 meters long, is only about 0.025 acre. The unit, are, is pronounced to rhyme with either "chair" or "far."