

When death has no power anymore: considerations on a work by Elisabeth Kübler-Ross

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Abstract

This paper is aimed at analyzing the contributions of the work About death and dying by Elisabeth Kübler-Ross in order to problematize the human condition in patients with terminal illnesses. After conducting a seminar on death and dying for many years, the author developed with her students a theory regarding personal stages that patients and their relatives go through when death is near. This approach provides possibility conditions not only to clarify many possible reactions patients may have when facing death, but also to understand how current societies are not structurally ready to face this subject. Such perception is consolidated with analyzes of the bioethics ramifications of the author's contribution relating them with recent biopolitics researches of Giorgio Agamben.

Key words: Inpatients. Death. Adaptation psychological. Public policy.

Resumo

Quando a morte não tem mais poder: considerações sobre uma obra de Elisabeth Kübler-Ross

O presente trabalho objetiva analisar as contribuições da obra Sobre a morte e o morrer, de Elisabeth Kübler-Ross, para a problematização da condição humana em pacientes com doenças em fases terminais. Após a realização, durante anos, de seminários sobre a morte e o morrer, a autora desenvolveu com seus alunos uma teoria a respeito dos estágios pessoais que um paciente e seus familiares passam nas circunstâncias de proximidade da morte. Esta abordagem fornece condições de possibilidade não só para esclarecer várias reações possíveis dos pacientes que se defrontam com a morte, mas também de compreender como as sociedades atuais não estão estruturalmente preparadas para encarar essa temática. Tal percepção consolida-se com a análise dos desdobramentos bioéticos da contribuição da autora, relacionando-os com as recentes pesquisas biopolíticas de Giorgio Agamben.

Palavras-chave: Pacientes internados. Morte. Adaptação psicológica. Política social.

Resumen

Quando la muerte ya no tiene poder: consideraciones acerca de una obra de Elisabeth Kübler-Ross

Este estudio tiene como objetivo analizar los aportes de la obra Sobre la muerte y los moribundos de Elisabeth Kübler-Ross para problematizar la condición humana en pacientes con enfermedades en fase terminal. Después de la realización de un seminario sobre la muerte y el morir durante años, la autora ha desarrollado junto con sus alumnos una teoría acerca de las etapas personales que un paciente y sus familiares pasan en condiciones de proximidad de la muerte. Este enfoque proporciona condiciones de posibilidad, no sólo para aclarar distintas reacciones posibles de los pacientes que se enfrentan con la muerte, sino también para comprender cómo las sociedades actuales no están estructuralmente preparadas para enfrentar esta temática. Esta percepción se consolida con el análisis de las repercusiones bioéticas de la contribución de la autora relacionándolas a las recientes investigaciones biopolíticas de Giorgio Agamben.

Palabras-clave: Pacientes Internos. Muerte. Adaptación psicológica. Política social.

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Few people are prepared to die. Not even within the group of those who are part of a religion or philosophy that believes in life after death individuals face the fact of dying naturally, that is, as part of life itself. Who gives us some empirical findings on this popular impression is the Swiss psychiatrist Elisabeth Kübler-Ross. In her book "On death and dying", published in 1969, debates on *what the terminally ill have to teach doctors, nurses, religious and their own relatives*.

In her observation of terminal stage patients with incurable disease, the physician found, among other things, that: *patients who had religion seemed to differ just a little from the ones who hadn't. (...) However, we can state that very few extremely religious people, of deep faith (...) that would release them from conflicts and fears [of death]* ¹. In this sense, with the exception of those who idealize or try suicide for different reasons, we can affirm with certain accuracy that nobody wants to die. Even those who believe that life continues after death, or that will meet with God Himself, people do not want to go through this experience so early.

After this first finding, the question that immediately emerges is: what is the cause of this phenomenon? What contributes for people to seek with all their strength and resources to postpone death? The merit of Kübler-Ross work is to answer these questions, among other considerations of equal relevance: *from the psychiatric point of view, this is quite comprehensible and may be better explained by the basic notion of, in our unconsciousness, death never be possible when it comes to ourselves* ².

The physician elucidates that it occurs because of the following factor: *it is unacceptable for our unconsciousness to imagine a real end for life on earth and, if life has an end, this will always be attributed to a malignant intervention out of our reach* ². In simple terms, none of us seem to be able to think about our death if not for the fact of being dead. It is inconceivable to our consciousness to face a natural death or caused by advanced age. *Therefore death in itself is associated with a bad act, a frightening happening, something that in itself calls for retribution and punishment* ².

Moreover, the general tendency to repel any thoughts about death and dying, under the sign of being something macabre to think about, is exacerbated by the endemic malaise that affects our contemporary societies: fear. As Zygmunt Bauman affirms, *in the past years, especially in Europe and its former dominions overseas offshoots, the addiction to fear and the securitarian obsession have made*

the most spectacular career in recent years. ³ And on another occasion the thesis asserts that: *[for] us who are on the other end of the immense cemetery of frustrated hopes, Fabvre's verdict seems – once again - remarkably appropriate and current. Ours is, again, a time of fears* ⁴.

Insecurity and violence in cities, looming wars and natural disasters, as well as fundamental and characteristic contingency of human life, make fear a distinctive feature of the inhabitant of this contemporary world. Regarding specifically the fear of dying, Bauman considers that: *only we humans are aware of the inevitability of death and so we face the terrifying task of surviving from this knowledge, a task to live with the fear of inevitability death, despite [the knowledge of it]* ⁵.

For these reasons, both from the sociological and psychological point of view, we can observe *societies in where people are increasingly 'kept alive', either by machines that replace their vital organs, or with computers that control them periodically to check if any physiological function needs to be replaced* ⁶ by electronic devices. For Michel Foucault, when debating about the transformation of sovereign power in the Modern Age, has identified the exercise of sovereign decision on life and death in Antiquity in the slogan *make die and let live* ⁷. However, Giorgio Agamben demonstrates that with gradual concern on the care of life and health of vassals on the concerns and calculations of power mechanisms, as well as the nationalization of the biological for biopolitical purposes, among the two following formulas of Foucault:

(...) Insinuates itself between the other two, which defines the most specific trait of twentieth-century biopolitics: no longer either to make die or to make live, but to make survive. The decisive activity of biopower in our time consists in the production not of a life or death, but rather of a mutable and virtually infinite survival. In every case, it is a matter of dividing animal life from organic life, the human from the inhuman, the witness from the Muselmann, conscious life from vegetative life maintained functional through resuscitation techniques, until a threshold is reached: and essentially mobile threshold that, like the borders of geopolitics, moves according to the progress of scientific and political technologies. Biopower's supreme ambition is to produce, in a human body, the absolute separation of the living being and the speaking being, zoe and bios, the inhuman and the human – survival. This is why in the camp, the Muselmann – like the body of the

overmatose person and the neomort attached to life-support systems today – not only shows the efficacy of biopower, but also reveals its secret cipher, so to speak its *Arcanum* ⁸.

The rising trend at the time Kübler-Ross wrote her book, cryogenics, is actually pointed out by Agamben as an epiphenomenon of a psychological structure maximized by a governmental biopolitical technology, resulting in processes of subjectification in which death and dying are not considered, devalued and relegated to the realm of the ineffable - in favor of a growing propaganda of an existence that is merely survival. As in the interesting description from Aldous Huxley in *Brave New World*: *children were used to/vaccinated against the fear of death by offering them their favorite candy while they were gathered around the bed of agony of your older relatives* ⁹ All our culture, disseminated by the mass media, rites, social myths and widespread narratives precisely seek to make death unthinkable, thus avoiding the fear of considering it as something close to us all.

Based on what was exposed, we shall ask: what is the result of all this in the popular imaginary of the inhabitants of our admirable biopolitical world? Perhaps this answer is one of the important contributions of Kübler-Ross for researches within this subject: her *famous scheme of five stages of grief when, for example, we find that we have a terminal disease* ¹⁰. We are informed by the Slovenian philosopher and psychoanalyst Slavoj Žižek that *later, Kübler-Ross applied these stages to all forms of catastrophic personal losses (unemployment, death of loved ones, divorce, drug addiction) and has emphasized that they do not necessarily appear in this order nor are all experienced by patients* ¹⁰ - in addition Žižek himself uses this scheme to dissertate about what he named social consciousness of apocalypse, demonstrating the profitability of the reasoning developed by the author.

Taking lessons with those who face death

The research, as well as the work of Kübler-Ross, emerged in the fall of 1965, [when] *four students from the Chicago Theological Seminary asked my collaboration on a research project (...) on the 'crises of human life'* ¹¹. Those theology students were unanimous in recognizing death as the main crisis of human existence, once it is seen as the termination of life.

Even those who disagreed with this perspective - the very students of the theological seminary

- had no empirical data for their research: *"How one can research on dying if it is impossible to get the data? If they cannot be proven, neither be experimented?"* ¹¹. The solution to this methodological aporia was to base on a questionnaire to be used as guidance in the interview of patients with terminal diseases. It is clear that even this methodological approach has its inherent limitations, since the determination of a terminal state is relative, since *the survival rate has been varying from twelve hours to a few months. Considering the last visited patients, many are still alive, while others who were in serious condition felt better and returned home* ¹².

The interview was designed to be applied by small group, formed by *one or two students and the responsible physician, or with the hospital's chaplain, or even with both* ¹³. It should be succeeded by a brief presentation and communication, with no stalling, the purpose and time for the visit. It was said that each patient that: *we make part of an interdisciplinary group of the hospital that eagers to learn something from him. Then we make a pause, waiting for the verbal or nonverbal reactions of the patient. And only start after he invites us to talk* ¹³.

By the end of the interview, the person responsible for the visit goes back to the classroom, debating on *the incident with the listeners in the auditorium. Our own spontaneous reactions emerge without the concern to be fair or unreasonable* ¹². The various seminars presented showed that the debate was valuable for the participants to become aware towards the urgency to consider death as a real possibility, not only of others, but of himself.

The survey results were so useful that *two years after its creation, this seminar became part of the course in the School of Medicine and in the Theology Seminary. It is also attended by many visiting physicians, nurses, nursing and hospital assistants* ¹⁴, as well as by social workers, priests, rabbis, inhalation therapists and students from various college courses. According to the author, *the medical and theology students who attended as a regular course also participated on a lecture, given either by the author or by the hospital's chaplain, where all theoretical, philosophical, moral, religious and ethical issues are discussed* ¹⁴.

Despite this success, however, the beginning was hard. In fact, the author relates that one of the first results revealed by that research was the resistance of the physicians responsible for the terminally ill patient in dealing with the death of those who were under their care. She states: *the hospital staff felt a desperate need to deny that there was termi-*

nally ill patients under their responsibility¹⁵. This is the reason why, in general, physicians are reluctant to follow the work of the seminar on death and dying. Precisely because not only our society, but the course program of medicine itself tries to make its students to *learn how to prolong life, but get insufficient training or clarification about what 'life' is*¹⁶.

As the author warns, health professionals, in general, *are inflexible when saying that 'there is nothing else to do' and we drive our attention more to the equipment than to the facial expression of the patient, which can transmit more important things than any effective machines*¹⁶. This general evasive tendency of dealing with death, seen throughout all society, is potentialized by the presence of a small depth questioning about life in superior courses involved with the vital care of human beings. Those who should provide adequate understanding of living and dying in care only worry about prolonging life and avoiding death - although there are several initiatives in medical courses to include discussions about death and palliative care, the contribution of bioethics from a semester is dissolved into the two years of medical practice.

Not even the form of informing patients and their families about a bad prognosis is unanimous among health professionals: *we are impressed on how worried they are about the fact that if the patient can tolerate the 'truth'. (...) some physicians are supportive of telling the truth to relatives, but hides the reality of the patient to avoid an emotional crisis*¹⁷. What the hundreds of interviews with patients over the years have revealed to Kübler-Ross was that *they all had become conscious of their situation in one way or another, sometimes openly and sometimes not, but it would depend, in large measure, on the physician to give the news in a way that would be accepted*¹⁸.

Given the lessons that the seminar on death and dying provided to the author, we realized that there is an argument within the cultural conceptions in general, as well as in the activities of chaplaincy and treatment of terminal patients, that is, death is not a part life, before that it is something external to it and which needs to be avoided anyway - even if life is transformed into mere survival. This conception, which understands death as something artificial and violent towards life, functions as a minimum common multiple within different ideas about dying in the common sense.

Even not stated, this discomfort towards the imminence of dying is present in certain tradition predominant of medical activity that aims, at any

cost, to avoid or defer death at the most; the difficulty that health professionals, religious, relatives and even patients experience when dealing with a disease in terminal stage; and our own sepulchral image. Precisely for this reason, the greatest contribution that the seminar provided for the researcher was the theory of the five stages of grief, which aims to refine and adequate the communication among all involved with a patient in terminal stage regarding all the negative attitudes towards this natural and unavoidable phenomenon of every human being.

The main chapters of the book *On Death and Dying* are an attempt to *summarize what we have learned from our moribund patients in order to deal with various mechanisms during an incurable disease*¹⁹. Yet that at no time did the author hold that the stages occur in a sequence, we will follow the same order of Kübler-Ross. The first presented stage is the *denial*. This is the most primary response of all patients when receiving the news from the physician or family about his incurable disease: *all of our patients have reacted almost the same way with respect to bad news (which is typical not only in cases of a fatal disease, but it seems to be a human reaction to the strong and unexpected pressures), that is, with shock and disbelief*²⁰. Such mechanism of reaction is typified in sentences and thoughts such as *"this cannot be happening, not to me,"* in other words, it is simply a refusal to accept the fact. This first reaction of denial could last from a few seconds up to many months²⁰.

Even if it takes longer in some cases, or is absent in many others, denial gives way to the second stage of reaction to prognosis: *anger*. This emotion relates to the explosion of feelings towards the impossibility of denying the fact. Such a reaction can be *enhanced by the reactions of care team and family, an almost irrational anger in many times*²⁰. An expression that exemplifies this stage is the recurring thought *"how could this happen to me?"*, questioned either by the patient or his relatives, who may even feel guilty: *"How could we have not seen this before? Why weren't we faste to bring him to the doctor?"*

Anger may persist for a prolonged period during the treatment and is expressed in different situations. However, in some cases third stage may arise: *the bargaining*. Due to a phenomenon that will be further explored - all the patients keep until the end, some degree of hope -, amid anger, a desperate attitude of hope may be observed: *"If God decided to take me from this world and did not respond to my pleas of anger, perhaps it is more condescending if I appeal calmly"*²¹. In other words, it is the hope of postponing the diagnosis.

Kübler-Ross points out that this third stage is *less known, but equally useful to the patient, although for very short time*²¹. With regard to the fourth stage of reaction - *depression* - its duration is variable and often long. Although the name may suggest a pessimistic way of looking at the fact, this stage concerns a libidinal disinvestment, like: *"I'll die anyway, so why bother?"*. This stage can become dangerous for both the family and the patient himself, as the negative psychological states can significantly affect the biological response to disease, accelerating it up, for example.

Finally, the last stage identified: the *acceptance*. Some might argue that depression is a kind of acceptance, which is not, since the acceptance presents itself more positively, that is, a resignation regarding death. While depression is more closely linked to apathy, acceptance characterizes the patient to become aware of the fact and he starts preparing for it, as well as helping their families to do the same. It is worth noting what Slavoj Žižek emphasizes: *the stages do not necessarily appear in this order nor are all experienced by patients*²². Regarding that fact, Kübler-Ross notes:

*Family members undergo different stages of adjustment similar to the ones described for our patients. At first many of them cannot believe that it is true. They may deny the fact that there is such an illness in the family or "shop around" from doctor to doctor in the vain hope of hearing that this was the wrong diagnosis. They may seek help and reassurance (that it is all not true) from fortune-tellers and faith healers. They may arrange for expensive trips to famous clinics and physicians and only gradually face up to the reality which may change their life so drastically. Greatly dependent on the patient's attitude, awareness, and ability to communicate, the family then undergoes certain changes. (...) Just as the patient goes through a stage of anger, the immediate family will experience the same emotional reaction. They will be angry alternately with the doctor who examined the patient first and did not come forth with the diagnosis and the doctor who confronted them with the sad reality. They may project their rage to the hospital personnel who never care enough, no matter how efficient the care is in reality*²³.

Some attentive readers could draw our attention to the fact that there is a state among the set given by the author that does not connive to the

general argument of facing death as something unnatural, the stage five: acceptance. But this is not the case. According to the researcher, *whatever the stage of the disease, whatever the mechanisms of acceptance used, all of our patients maintained until the last moment, some form of hope*²⁴. As she states, all of them have kept hope even those who somehow had accepted death.

This fact, despite confirming the fundamental argument of unconditional rejection of death, also points to the need that hope is taken into consideration by all the involved in the care of these patients: *it is well for us to remember this! It may come in form of a new discovery, a new finding in a research laboratory, a new drug or serum, but it is this hope that should always be maintained whether we can agree with the form or not*²⁵. In this sense, diseases, even with no cure, are not synonymous of death.

The physician who can provide a diagnosis without leading to death, while the result is inevitable, is someone who is acting appropriately. However, if he does not feel comfortable for this kind of discussion, he may ask the chaplain or priest and ask him to talk to the patient. *They may feel more at ease having passed on the difficult responsibility to someone else, which may be better than avoiding it altogether*²⁶. The malaise of health professionals when facing the theme of death must be discussed as Kübler-Ross suggests: *the physician should first examine his own attitude toward malignancy and death so that he is able to talk about such grave matters without undue anxiety*²⁷.

In summary, the theory of the five stages outlined by Kübler-Ross confirms their more general perceptions: we are impressed that death has *always been distasteful to man and will probably always be. (...) Therefore death in itself is associated with a bad act, a frightening happening, something that in itself calls for retribution and punishment*²⁸. This conception is responsible for offices, churches, pastoral offices and families to witness *increased fear of death through unfamiliarity, the rising number of emotional problems, and the greater need for understanding of and coping with the problems of death and dying*²⁸. Considering such finding, is there anything that could be done? We are aware that there is vast literature on the subject, including works from the own Kübler-Ross that were not analyzed in this work. However, not pretending to exhaust the issue, we would like to present a contribution to the problem mentioned.

Value life as resistance to the power of death

The research emerged from the seminar on death and dying is not just about this finding. The psychiatrist and her students involved in it *have written meaningful papers about this topic* ²⁹, not only about what occurs in the lives of all people involved with patients of incurable diseases, but also in alternative paths to it. There was, therefore, a deep interest in dismissing this power that death has acquired throughout history. For such purpose, the method chosen was precisely to attack the base argument that we showed to be the least common multiple of our vision about death. As argues the author:

(...) I feel strongly that this should be the case. I do not feel it beneficial that a psychiatrist be called each time a patient-doctor relationship is in danger or a physician is unable or unwilling to discuss important issues with his patient. (...) Our goals should not be to have specialists for dying patients but to train our hospital personnel to feel comfortable in facing such difficulties and to seek solutions. I am confident that this young physician will have much less turmoil and conflict when he is faced with such tragedies the next time. He will attempt to be a physician and prolong life but also consider the patient's needs and discuss them frankly with him. This patient, who was still a person, was only unable to bear to live because he was unable to make use of the faculties that he had left. With combined efforts many of these faculties can be used if we are not frightened away by the mere sight of such a helpless, suffering individual. Perhaps what I am saying is that we can help them die by trying to help them live, rather than vegetate in an inhuman manner ³⁰.

It is then clear what Kübler-Ross has in mind: a proper posture of those who are involved with terminal patients or their families. According to her, the way to deal with the diagnosis of an incurable disease is not to simply refer the patient to a technician, such as a psychiatrist or chaplain. All people need to learn to cope with serenity these difficulties and seek, by themselves, the solution through their own continuing education.

Basing on the philosophy of Agamben to reflect upon bioethical issues, it is about the possibility of regaining sovereignty over your own life, and deciding for it. A patient with terminal disease in the waiting rooms of hospitals, awaiting for the

sovereign decision on their life or death, either from a doctor, family member or, indirectly, even the government (when regarding vacancy for hospitalization), characterizes as bare life. *Like every space of exception, this zone is, in truth, perfectly empty, and the truly human being who should occur there is only the place of a ceaselessly updated decision* ³¹.

It is only when we realize the operation of the life and death dynamics, *faced with this extreme figure of the human and the inhuman (...)* [which can achieve] *understanding [on] how they work so that we might, eventually, be able to stop them* ³². For that, the proposal of Kübler-Ross is the insistence on an honest consideration of death and dying, even recognizing that young physicians learn to prolong life but get little training or discussion in the definition of life ¹⁶. Actually, considering the above excerpt, the ideal would be the physician to sit down and talk frankly with the patient - which is still a human being with the capacity to make use of his abilities, even if weakened.

It also applies to family members of the terminally ill patients. According to the survey, *unfortunately, the tendency is to hide from the patient our feelings, try to keep a smile or a false joy on his face, liable to disappear sooner or later* ³³. *In this case, even when the patient dies, the problems remain, once the opportunity to work more appropriately with death was lost because of the insistence that the subject could be hidden* ³³. In this case, even when the patient dies, the problems remain, once the opportunity to work more adequately with death was lost because of the insistency of hide this subject. Even considering the possibilities of the patient, the best way to proceed would be the own patient to help his family members to face death. One of these modes is to *naturally share their thoughts and feelings to family members, encouraging them to do so also* ³⁴.

This example, very punctual, hides in its essence what we call in the title of the article as making death lose its power. All the fear and negative aura that seems to surround death and dying loses all its forces over our consciousness when there is no longer a focus on the mere extension of, redirecting us experience to exhaustion. The only way to death no longer have an effect on our lives is to develop a form of existence which exhausts all our potentials so that when death comes, there will no longer have more sense, because life was lived to the fullest.

No experience, no longing and no guilt holds our life, so death has no more power: it all came when

no longer made any difference. We no longer strive to deny or support the dying, but concentrate on living. As Kübler-Ross recalls, if the patient is able to face the pain and to show with his own example how to die peacefully, the family will remember his strength and will endure with more their own sorrow³⁴.

In turn, Bauman, reminding us of the Latin adage *memento mori* [remember your death], notes: *The memento mori warning, remember the death that accompanies the proclamation of the eternity of life, is an affirmation of awesome power that promise to fight the immobilizing impact of the immanence of death. Once the announcement has been heard and absorbed, and it has been believed that there is no longer any need to try (unsuccessfully, so to speak!) Forget the inevitability of death. No need to look away most of his inevitable arrival. Death is no longer the Gorgon, whose own vision could kill: not only can face death, but if you must do it daily, 24 hours a day, unless you forget the concern with the kind of life new that will foreshadow impending death. Remember the impending death of the mortal life keeps on course - giving it a purpose that makes all the precious moments lived. (...) Its quality, however, depends on how you live your life before you die. Can be heavy. Can be a bliss. And now to work ...*³⁵.

Perhaps the expression *memento mori* is the best synthesis of the lessons that the research of Elisabeth Kübler-Ross has provided. As if the inevitability of death, since then, seen as an integral part of life, makes us able to live so when death came, would no longer have a negative force upon us, since everything that had to be lived already happened. That is the original intent of Kübler-Ross: *to teach the young students the value of science and technology, teaching a time art and science of international human relationships, human and total care of the patient*³⁶. Only then we would witness real progress in our natural treatment when it comes to death and dying. *If there were misuse of science and technology in enhancing destruction, prolonging life rather than make it more human, the author ponders, as well as science and technology could walk alongside greater freedom for contacts of a person the person, then we could really speak of a great society*³⁶.

Final Considerations

What can be concluded from the argument from Kübler in her work 'On death and dying', rebuilt until then? At least, three things we may conclude.

The first is that, even towards a global backdrop of imminent catastrophes, a strong insistence for people to protect themselves psychologically from any idea about their suffering and death, it is possible to face death more naturally. Not as an unavoidable fatality, but rather as a call to fully experience our potential, so that when death comes, it will simply lose its strength. Although it seems a paradoxical formulation, we will only become a society emancipated from the fear of dying when we focus on living and stop striving to only survive.

A second conclusion we could reach is that physicians, health professionals, chaplains and priests as well as the own relatives of a terminal ill patient must reconsider their own posture towards death in order to be useful in their activities. The doctor, for example, who cares so much about how he will share the news about a fatal prognosis, *should first examine your personal attitude towards malignancy and death in order to be able to talk about such serious matters without excessive anxiety, the second puts the author, should pay attention to the 'tips' that gives you the patient, enabling him to draw willingness to face reality*³⁷. Similarly, another class of people who need to position themselves alternatively towards dying are the religious people who provide chaplaincy service. Although the research was done in the 60s, these numbers are symptomatic for the issue. While 90% of physicians showed themselves uninterested in helping the research of Kübler-Ross, 90% of chaplains, rabbis and priests did not avoid the subject or were hostiles toward the activities of the seminar. Kübler-Ross confesses:

*(...) I was amazed to see the number of clerics who conformed to avail of a prayer book or a chapter of the Bible as the only means of communication with patients, this meant that they would no longer feel their needs, exposing themselves to hear questions that would not be able to respond or perhaps even wanted*³⁸.

The author considered that an effort to develop an alternative proposal to the negative imagery of death will be required from the officiating chaplain *who cared much for arranging funerals, to see what they would do before and after the funeral, but had great difficulty in actually dealing with only 38 dying. Only throughout the seminars, after several sections of interviews and discussions, the chaplains began to comprehend their own reluctance to face their own conflicts, and because it used the Bible and served the presence of relatives and medical orders as an excuse or rationalization to justify its non-involvement*³⁹.

Kübler-Ross conderates that to the similarity of family members and health professionals, while the officials of chaplaincy do not begin to consider the sincere and natural reservations about the die, the assistance they can provided to those who suffer will be considerably reduced. Only who has dedicat-ed a long time to the theme of death will never use empty words to find a terminal patient (...) because they had to face the prospect of his own death ³⁹.

Finally, it is worth remembering a third element that, in fact, is the bioethical aspect itself, which can be observed from Kübler-Ross' thinking and that are consistent to the recent research of Agamben. It is asserting that in an obsessed society and technologically devoted to the cryonics of mere life (bare life), as argues Agamben ^{8,31}, what is missing is precisely to address the issues about death and dying as a resistance to such biopolitics society. Far beyond the mere monitoring of a patient in terminal stage or from the palliative care, a serious treatment on death and dying may represent the fundamental attitude to affirm life. It would be as our fundamental mistake was the fact that we seek to prevent death to affect life, transforming it into survival (mere life) - when in fact we should be devoting ourselves to death and dying, transforming survival into an opportunity of living in the maxi-

mum. For Agamben, this task *is more urgent than taking position on major issues, about the supposed values and human rights* ⁴⁰. We believe that it is precisely in this sense that the contributions of Kübler-Ross are unique in the task of a bioethics that can address conflicts of death and dying in the context of a biopolitical society.

According to those who attended the seminar, *something can be done: not only face the patients with less anxiety, but feel good at the prospect of his own death* ⁴¹. The privileged path for this to occur, as Kübler-Ross insists, is precisely to invest resources and research in associations that address the issues and the perspectives about death and dying, encouraging the dialogue on the topic so that people can be helped to live with no fear until death comes - in equal or greater proportions to the efforts of our societies, dedicated solely to cryogenics, as Agamben argues. *We learn that death itself is not a problem for the patient, but the fear of death that comes from the feeling of hopelessness, helplessness and isolation that accompanies* ¹. Therefore, the work field for all of those dealing with terminal patients and their family members is not the natural fact of death, but rather the unpleasant and morbid aspects that escort it. Such care and attention will not fade death, but will considerably brighten life.

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Participation of authors

Pedro Lucas Dulci has worked in the conception, analysis and writing of this article. Carolinne Borges Alves has worked in the conception, analysis and critical revision.

