Supportive Guide

# FOUR WINDOWS ON THE END OF LIFE: PERSPECTIVES FROM CANCER AND HOSPICE PATIENTS IN THEIR FINAL JOURNEY

Donald Iannone, D.Div., Ph.D.

Donald T. Iannone & Associates

# Four Windows on the End of Life:

## Perspectives from Cancer and Hospice Patients in Their Final Journey

Don Iannone, D.Div., Ph.D.

April 1, 2025 (Revision 2)

---

*Our view of death profoundly shapes our view of life. If we see death as a terrifying end, we may live in denial, distraction, or fear, clinging tightly to control or avoiding deeper questions about meaning. But if we view death as a natural, even sacred part of existence, it can awaken us to the preciousness of each moment. Accepting our mortality can deepen our gratitude, sharpen our sense of purpose, and guide us to live more authentically. It reminds us that life is finite, and therefore urgent, not in a panicked way, but in a way that invites presence, love, and intention. How we relate to death ultimately reflects how awake we are to life.*

~Don Iannone

## I. PREFACE

This article reflects on the work my wife Mary and I did with individuals facing the end of life. After retiring from our main career fields at the end of 2016—Mary from healthcare administration and me from economic development and public policy—we spent seven years as contract employees at the Cleveland Clinic Cancer Center, working two days each week with cancer patients and their families. During that time, we offered a range of supportive services designed to bring comfort, presence, and care. Our work included gentle relaxation touch therapy, meditation, journaling, poetry therapy, and life coaching. It was, for both of us, a profound and humbling encounter with the human condition. This article offers a reflection on those years, focusing particularly on the varied ways patients approached their dying process, and how their beliefs, values, and inner lives shaped the journey toward death. *At its core, this article identifies four "windows" on the end-of-life.*

Our involvement in end-of-life care began earlier, from 2006 to 2008, when we served as volunteers at Cleveland's Hospice of the Western Reserve. I worked primarily with adults in their homes, while Mary supported both children and adults at the hospice facility. At that time, our thinking about death and dying was deeply shaped by Elisabeth Kübler-Ross's seminal work, *On Death and Dying* (1969). In her groundbreaking book, Kübler-Ross portrayed dying as a fundamentally human experience that requires understanding, compassion, and dignity. She introduced the now-famous five stages of grief—denial, anger, bargaining, depression, and acceptance—not as a strict sequence, but as common emotional responses to the reality of impending death. Her most important insight was that open, honest communication with dying individuals, along with attention to their emotional needs, can help transform the end-of-life experience from one marked by fear and isolation into one of meaning, connection, and peace.

While *On Death and Dying* remains an influential and widely respected contribution to the field, Kübler-Ross's five stages model is now regarded more as a helpful framework than a universal or linear process. Contemporary scholars and practitioners increasingly recognize that grief and dying are highly individual, shaped by personality, culture, spirituality, education, and life circumstances. Some critiques of the model point to its potential for oversimplifying the complexity of emotional responses or encouraging prescriptive expectations. In recent decades, theories such as continuing bonds, dual process models, and meaning-making approaches have deepened our understanding of how people experience and adapt to loss. Yet despite these evolving perspectives, Kübler-Ross's core message—that the emotional and relational lives of the dying matter profoundly—continues to guide compassionate end-of-life care today.

## II. IMPORTANT DEFINITIONS

*"It is not death that a man should fear, but he should fear never beginning to live."*

—Marcus Aurelius, *Meditations*

### Medical Definition of Death

Death is defined medically as the irreversible cessation of all functions of the entire brain, including the brainstem. This is commonly referred to as brain death and is considered legal death in most countries, even if cardiopulmonary function is maintained artificially.

Source: President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1981). *Defining death: Medical, legal, and ethical issues in the determination of death*. Washington, DC: U.S. Government Printing Office.

https://repository.library.georgetown.edu/handle/10822/559345

This influential report helped standardize the definition of death in U.S. law and medical practice, leading to the Uniform Determination of Death Act (UDDA).

### Medical Definition of Dying

Dying is the process of decline leading to death, marked by progressive loss of vital functions and increasing physiological instability. It often refers to the terminal phase of a serious illness when death is imminent and irreversible, despite medical interventions.

Source: World Health Organization (WHO). (2002). *National cancer control programmes: Policies and managerial guidelines (2nd ed.)*. Geneva: World Health Organization.

https://apps.who.int/iris/handle/10665/42494

The WHO emphasizes the importance of recognizing dying as a phase in which care should shift from curative to palliative, focusing on comfort, dignity, and quality of life.

The medical definitions of death and dying are closely connected, representing two points on the same continuum. Dying is understood as the physiological and functional decline that precedes death, a process during which vital systems gradually fail and medical interventions often shift from curative to palliative. Death, by contrast, marks the definitive endpoint of that process, defined as the irreversible cessation of all brain activity. Together, these definitions frame not only the biological reality of life's end but also guide medical decisions, ethical care, and the timing of emotional and spiritual support for patients and families.

### Medical Definition of End of Life

"End of life" refers to the final phase of a person's life when they are living with an illness that is advanced, progressive, and incurable, and when death is expected within a relatively short period, typically months, weeks, or days. During this time, the focus of care often shifts from curative treatment to palliative and supportive care aimed at comfort, dignity, and quality of life.

Source: National Institute on Aging (U.S. Department of Health and Human Services).

https://www.nia.nih.gov/health/what-end-life-care

### Summary

**End of Life** refers to a period of time (sometimes months) preceding death, during which a person is living with a terminal condition and declining health. It is a clinical phase that may involve decision-making about hospice, advance directives, and comfort care.

**Dying** refers to the active process of bodily systems shutting down, typically in the final days or hours before death. It is often marked by observable physical and cognitive changes (e.g., reduced consciousness, breathing changes, withdrawal).

**Death** is the point in time when life ends, legally and medically defined as the irreversible cessation of all brain function or the permanent stopping of the heart and lungs.

## III. END-OF-LIFE RESEARCH REVIEW

*"Death is not extinguishing the light; it is only putting out the lamp because the dawn has come."*

—Rabindranath Tagore

Recent research across neuroscience, psychology, and hospice and palliative care has provided deeper insights into the human experience of dying. One groundbreaking study by Vicente et al. (2022) recorded the brain activity of a dying patient and discovered a surge of gamma wave activity in the 30 seconds before and after cardiac arrest, patterns commonly associated with dreaming, memory recall, and meditative states. This suggests the brain may retain conscious-like processing even during the final moments of life (Zacharopoulos et al., 2022).

Another important contribution comes from a 2023 scoping review by Leone, Miller, and Nissim, which examined end-of-life experiences (ELEs) such as visions, symbolic imagery, and mental clarity reported by the dying. The authors argue that these experiences are meaningful and underrecognized aspects of dying, calling for more systematic attention in both clinical practice and research. Their findings support the idea that the dying process is often rich with psychological and spiritual content, even when physical function declines.

Addressing existential suffering, recent studies have revisited the therapeutic use of psychedelics in palliative care. As reported in *The Times* and supported by a systematic review by Reiche et al. (2018), substances like LSD and psilocybin have shown strong potential in reducing anxiety, depression, and fear in patients with life-threatening illnesses. These experiences often induce a sense of peace, unity, and acceptance, suggesting that carefully supervised psychedelic therapy may become a valuable tool in end-of-life care.

A more traditional, qualitative perspective is offered by Sundqvist, Karlsson, and Heikkilä (2020), who interviewed nursing home residents about their thoughts on dying. Many participants expressed a desire for dignity, control, and open dialogue about their mortality. The study underscores how crucial it is to align end-of-life care with each person's psychological and relational needs, not just their medical conditions.

The 2022 *Lancet Commission on the Value of Death* led by Kellehear, Sallnow, and Smith offers a sweeping critique of how contemporary healthcare systems approach death. The commission highlights a paradox: some people experience overtreatment and aggressive interventions in their final days, while others die with inadequate access to basic care. It advocates for a reimagined model of dying—one that re-integrates death into family, community, and cultural life, emphasizing relational care and spiritual wellbeing alongside medical support.

This landmark study published in *The Lancet* examined NDEs in cardiac arrest survivors and found that 18% reported NDEs, regardless of medical, demographic, or psychological factors—challenging the assumption that NDEs are solely brain-based hallucinations.

The experience of dying is not uniform. It is as individual and varied as the lives we have lived—molded by our beliefs, values, fears, hopes, and the personal narratives we've formed along the way. In my work with cancer patients nearing the end of life, offering support through gentle relaxation touch therapy, meditation, mindfulness, journaling, and life coaching, I came to recognize four recurring ways that individuals made sense of their mortality.

These views are not rigid categories but distinct experiential landscapes. Understanding them can help us provide better care—not just physically, but emotionally and spiritually. Each view demands a different form of compassion, and each opens a doorway toward reducing suffering in a way that aligns with the person's core identity.

Near-death experiences (NDEs) are reported by individuals who have come close to death or were temporarily declared clinically dead and then revived. Common features include a sense of leaving the body, moving through a tunnel, encountering a bright light, feeling overwhelming peace, meeting deceased loved ones, or experiencing a life review. While interpretations vary—ranging from spiritual encounters to neurobiological phenomena—NDEs are remarkably consistent across cultures and have been documented for centuries. Research suggests that these experiences may be linked to specific brain activities during trauma or cardiac arrest, such as surges in gamma waves or altered oxygen flow. Though science cannot fully explain NDEs, many who experience them report lasting psychological changes, including reduced fear of death, a greater sense of purpose, and heightened spiritual awareness.

Together, these studies paint a complex and deeply human portrait of dying—not simply as a medical endpoint, but as a potentially meaningful process shaped by consciousness, connection, emotional needs, and societal values.

## References

### 1. Brain Activity at the Moment of Death

Vicente, R., Juan, E., Das, T. K., Chawla, L. S., Katyal, A., & Ifeachor, E. (2022). Enhanced interconnectivity and cross-frequency coupling in the dying human brain. *Frontiers in Aging Neuroscience, 14*, 813531. https://doi.org/10.3389/fnagi.2022.813531

Zacharopoulos, G., et al. (2022, February 22). First-ever brain recording of dying human reveals what happens as we die. *News.com.au*.

https://www.news.com.au/lifestyle/health/health-problems/firstever-brain-recording-of-dying-human-reveals-what-happens-as-we-die/news-story/6dc28b2a0275ab1ef4ecf804d95af2a5

### 2. End-of-Life Experiences (ELEs)

Leone, D., Miller, J. J., & Nissim, R. (2023). End-of-life experiences: A scoping review of mental experiences occurring near death. *BMJ Supportive & Palliative Care, 13*(3), e624–e634. https://doi.org/10.1136/spcare-2022-003823

### 3. Psychedelics and Existential Distress at the End of Life

Reiche, S., Hermle, L., Gutwinski, S., Jungaberle, H., & Majić, T. (2018). Serotonergic hallucinogens in the treatment of anxiety and depression in patients suffering from a life-threatening disease: A systematic review. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 81*, 1–10. https://doi.org/10.1016/j.pnpbp.2017.09.012

Turner, A. (2024, March 18). Psychedelics can help the dying to deal with existential dread. *The Times*. https://www.thetimes.co.uk/article/pyschedelics-can-help-the-dying-to-deal-with-existential-dread-jrqc80fzt

### 4. Nursing Home Residents' Thoughts on Dying

Sundqvist, B., Karlsson, S., & Heikkilä, K. (2020). Nursing home residents' thoughts on dying and end-of-life care: A qualitative exploratory study. *BMC Nursing, 19*(1), Article 25. https://doi.org/10.1186/s12912-020-00514-x

### 5. The Lancet Commission on the Value of Death

Kellehear, A., Sallnow, L., & Smith, R. (2022). Report of the Lancet Commission on the Value of Death: Bringing death back into life. *The Lancet, 399*(10327), 837–884. https://doi.org/10.1016/S0140-6736(21)02314-X

### 6. Near-Death-Experiences (NDEs)

Greyson, B. (2003). *Near-death experiences in a psychiatric outpatient clinic population*. *Psychiatric Services, 54*(12), 1649–1651. https://doi.org/10.1176/appi.ps.54.12.1649

Dr. Bruce Greyson is one of the foremost researchers on NDEs. His work has helped define and validate the phenomenon scientifically, including the creation of the "Greyson Scale" used to assess NDEs.

van Lommel, P., Wees, R., Meyers, V., & Elfferich, I. (2001). *Near-death experience in survivors of cardiac arrest: A prospective study in the Netherlands*. *The Lancet, 358*(9298), 2039–2045. https://doi.org/10.1016/S0140-6736(01)07100-8

## IV. OBSERVED VIEWS ON END-OF-LIFE

*"I am the resurrection and the life. The one who believes in me will live, even though they die."*
—John 11:25 (NIV)

This section presents four distinct views of death that Mary and I encountered in our work in cancer care and hospice. It is prefaced by a short description of how cancer death compares to other causes of death.

### Dying of Cancer Versus Other Causes

Dying of cancer is often different from many other causes of death in that it typically allows for a longer, more gradual transition—a prolonged awareness of one's mortality. Unlike sudden deaths from accidents, strokes, or heart attacks, cancer often unfolds over weeks or months, offering a window of time that can be both a burden and a gift. This extended period can open space for reflection, reconciliation, spiritual exploration, and emotional processing. Patients and families may have time to say goodbye, to prepare, to tend to unresolved matters. Yet the drawn-out nature of cancer can also mean prolonged physical pain, emotional exhaustion, and the complex toll of treatments that extend life but sometimes at the cost of quality. The dying process may become deeply medicalized, which can either offer comfort or feel depersonalizing.

However, in a deeper human sense, dying of cancer is not fundamentally different from dying of other causes. The central existential questions—What did my life mean? Am I loved? What comes next?—emerge regardless of diagnosis. People still face fear, acceptance, resistance, and transformation, shaped more by their personal worldview than by the specific cause of death. Moreover, many other chronic conditions, such as advanced heart failure, ALS, or dementia, also bring a slow decline and emotional reckoning. What may make cancer more publicly visible is its prevalence and the dramatic arc it often takes, with moments of hope, remission, and recurrence. In the end, though, dying is a universal passage, and the essence of the journey is more about how we live through it than what initiates it.

### 1. The Integrative View: Death as Completion and Continuation

### Example: Eleanor (Fictious name)

Eleanor, 73, was a retired teacher and artist who had spent her life cultivating a spiritual practice rooted in love, reflection, and acceptance. When her cancer returned, she didn't fight it so much as she met it with grace. For her, dying was not about losing, but about completing a journey—returning to a cosmic whole. She meditated daily, journaled about her dreams, and used her final months to reflect, create, and say goodbye with clarity and peace.

**Beliefs and Values:**

- Life is part of a larger spiritual whole.
- Death is a natural transition, not an end.
- Presence and awareness bring peace.

**Behaviors:**

- Daily mindfulness and reflection.
- Honest, open communication with loved ones.
- Engagement in creative and legacy-oriented practices.

**Ways to Reduce Suffering for Integrative Types:**

1. Legacy Projects: Encourage them to make art, write letters, or record life stories.
2. Guided Visualizations: Use meditations focused on transition, light, and reunion.
3. Spiritual Companionship: Invite gentle exploration with chaplains or spiritual mentors.

**Suggested Book:**

Singh, K. D. (2000). *The grace in dying: How we are transformed spiritually as we die*. HarperOne.

**Why this book matters:**

Kathleen Dowling Singh's *The Grace in Dying* offers a deeply moving look at how individuals near death often undergo profound spiritual transformations. Drawing from her work in hospice care, Singh maps out a psychological and spiritual process that mirrors traditional mystical paths. For individuals like Eleanor, who approach dying as a sacred passage, this book affirms and deepens their experience. It's especially helpful for caregivers hoping to support that process with sensitivity.

**2. The Stoic View: Death as Duty and Dignity**

**Example: Robert (Fictious name)**

Robert, 68, was a retired Army officer and engineer who valued self-discipline, order, and privacy. When diagnosed with advanced prostate cancer, he focused on maintaining control—organizing his affairs, limiting his emotional vulnerability, and preserving a sense of dignity. Though not openly expressive, he responded well to structured breathing exercises and respectful touch therapy, which provided relief without emotional demand.

**Beliefs and Values:**

- Death is part of life and should be met with composure.
- Emotional expression is often unnecessary.
- Dignity lies in self-reliance and clarity.

**Behaviors:**

- Planning for legal and logistical matters.
- Limiting dependence on others.
- Preferring structured support over emotional sharing.

**Ways to Reduce Suffering for Stoic Types:**

1. Respect Autonomy: Empower them with choices that preserve control.
2. Structured Mindfulness: Offer practical, neutral exercises like breath awareness.
3. Task-Oriented Support: Help with final arrangements to meet their sense of duty.

**Suggested Book:**

Gawande, A. (2014). *Being mortal: Medicine and what matters in the end*. Metropolitan Books.

**Why this book matters:**

In *Being Mortal*, surgeon Atul Gawande blends personal narrative with case studies to challenge the overmedicalization of death. He emphasizes that autonomy, dignity, and meaning are central to how people want to die—not just how long they live. For stoic individuals like Robert, the book affirms the value of self-determination and provides guidance for approaching death with integrity rather than denial.

### 3. The Relational View: Death as a Call for Connection and Healing

**Example: Carla (Fictious name)**

Carla, 55, was a former teacher who had long felt invisible—her emotional life buried under years of caretaking and unresolved trauma. Her breast cancer diagnosis brought a deep urgency to reconnect: to apologize, to forgive, to be seen and loved. Through journaling, life coaching, and meditation, she explored old wounds and opened herself to healing. Dying became, for her, a time of reclamation and profound human connection.

**Beliefs and Values:**

- Relationships are central to a meaningful life.
- Death invites unfinished emotional work to the surface.
- Vulnerability can be transformative.

**Behaviors:**

- Seeking emotional reconciliation.
- Engaging in expressive practices like writing or speaking.
- Desiring authentic connection over superficial support.

**Ways to Reduce Suffering for Relational Types:**

1. Facilitate Conversations: Create opportunities for open dialogue with loved ones.
2. Life Review: Help them explore key life moments and relationships.
3. Loving-Kindness Practice: Introduce meditations focused on compassion and forgiveness.

**Suggested Book:**

Callanan, M., & Kelley, P. (1997). *Final gifts: Understanding the special awareness, needs, and communications of the dying*. Bantam Books.

**Why this book matters:**

Based on years of hospice experience, *Final Gifts* offers extraordinary insights into how the dying communicate their emotional and spiritual needs. Through touching stories, the authors reveal that dying people often seek deep connection and reconciliation. For relational individuals like Carla, the book provides both language and validation for the emotional work they feel compelled to do at life's end.

### 4. The Resistant View: Death as Defeat, Injustice, or Terror

**Example: Dennis ((Fictious name)**

Dennis, 61, was a successful sales executive who lived for performance and control. His pancreatic cancer diagnosis ignited panic and fury. He saw death as unjust, a robbery of potential. He rejected most emotional support and resisted discussions about his mortality. But beneath the surface was deep fear. Over time, he found some solace in simple grounding exercises and in having one-on-one sessions where he didn't have to perform.

**Beliefs and Values:**

- Death is unfair, to be fought or denied.
- Identity is tied to power, success, and control.
- Vulnerability equals weakness.

**Behaviors:**

- Fixating on treatments, even when unhelpful.
- Avoiding emotional expression or spiritual reflection.
- Oscillating between rage and isolation.

**Ways to Reduce Suffering for Resistant Types:**

1. Normalize Fear: Acknowledge their fear as common and valid, without pressure to change.

2. Micro-Mindfulness: Use short, nonverbal grounding tools (e.g., breath awareness, sensory focus).

3. Safe Expression: Provide a private outlet for anger, frustration, or existential dread.

**Suggested Book:**

Chödrön, P. (1997). *When things fall apart: Heart advice for difficult times*. Shambhala Publications.

**Why this book matters:**

Pema Chödrön's *When Things Fall Apart* offers a gentle yet direct invitation to face life's messiness without trying to fix it. Drawing from Buddhist principles, she encourages readers to stay present with discomfort and impermanence. For those like Dennis, who resist and fear loss of control, the book can offer a counterintuitive path to peace, not by overcoming fear, but by making space for it without shame.

## V. CLOSING REFLECTION

*"The dust returns to the earth as it was, and the spirit returns to God who gave it."*

—Ecclesiastes 12:7

The way we die reflects, often quite vividly, the way we have lived. Our core beliefs, hopes, fears, and behavioral patterns don't disappear as we approach the end; they surface more sharply. The quiet or unspoken truths of a person's life often become more visible in those final weeks or days. Dying is not only a medical or biological event, but also an existential and relational experience. As caregivers, whether we are family members, clinicians, or companions offering spiritual or emotional support, our role is not to impose meaning, but to recognize and respond to the meaning already present in each person's way of dying.

*"In my view, our time with patients invited a deep inward reflection, often returning me to my earlier studies in consciousness. I began to sense that what may endure beyond physical death is consciousness itself—what some call the soul, others the spirit. In the quiet, sacred space beside the dying, I often felt we were touching something eternal—the part of us that was never born, and therefore never truly dies."*

What Mary and I have learned through our years working with cancer patients at the Cleveland Clinic, and earlier as a hospice volunteer, is that no two deaths are the same. Just as people live with different temperaments, philosophies, and coping mechanisms, they die with them too. In some cases, death is met with calm acceptance and even reverence. In others, it arrives as an unwanted and terrifying stranger. Sometimes it is seen as a challenge to endure, or a final opportunity to heal broken relationships. Occasionally, it is something to be denied altogether. Each response is deeply personal, shaped by a lifetime of spiritual formation, personality traits, cultural messages, and human experiences.

In Mary's words, *"Life is an extraordinary gift. For most of us, it's only when we stand at the edge of it—through the experience of end-of-life—that we truly begin to understand its value. Working with those nearing their final breath taught me how deeply precious each moment is."*

By observing and listening closely, we've come to recognize at least four recurring patterns in how people approach the end of life. The **Integrative** view embraces death as a meaningful transition, often imbued with spiritual significance. The **Stoic** approach regards death as a fact of life to be faced with dignity, control, and composure. The **Relational** perspective sees dying as a time to connect, to forgive, and to love more deeply. And the **Resistant** view meets death with anger, denial, or fear—sometimes with a fierce refusal to relinquish control. These four views are not rigid categories; they overlap, evolve, and intermingle. Still, they offer a helpful framework for caregivers seeking to understand the internal landscape of someone nearing life's end.

Each of these perspectives calls for a different kind of presence from those around the dying person. Some need space for spiritual exploration; others need clarity and structure. Some are yearning for connection, while others are struggling simply to cope with the terror of what's to come. The task for us, as caregivers and companions, is to respond not with a one-size-fits-all approach but with attuned, individualized care. To listen without fixing. To be steady in the face of uncertainty. To honor the person as they are, not as we think they should be.

Modern research confirms what ancient wisdom has long suggested: that the way we approach death can shape not only the quality of our final days but the legacy we leave behind. Studies on near-death experiences, the psychological processes of dying, and even neurological activity in the final moments all suggest that consciousness and meaning remain vital until the very end. Spiritual and emotional care, whether through touch, silence, poetry, conversation, or simple presence, can offer comfort even when medical interventions no longer can.

Ultimately, the way we accompany someone at the end of life is an act of reverence. It is an opportunity to bear witness to their story in full. To let their truths unfold. To reduce suffering, not only physical pain, but the suffering that comes from feeling unseen or misunderstood. Whether someone is integrative, stoic, relational, or resistant, they deserve the dignity of being met where they are.

If we can do that—if we can offer compassionate presence shaped by curiosity rather than judgment—then we are not only helping them to die well; we are helping ourselves to live better. For death, in all its complexity, teaches us how precious life is, how deep human connection can be, and how important it is to face the unknown not with certainty, but with love.

In conclusion, what are the five most important qualities of a “good death” or “a well-supported end of life?

### 1. Dignity

A peaceful death respects the person’s identity, values, and autonomy. They are treated not as a patient or case, but as a full human being—honored in their choices, preferences, and the story of their life. Dignity means being seen, not just medically managed

### 2. Comfort (Physical and Emotional)

Minimizing pain, breathlessness, and physical distress is essential. Equally important is emotional comfort—relief from fear, anxiety, or unresolved grief. This includes access to palliative care and the presence of trusted caregivers who offer calm and compassion.

### 3. Connection

A meaningful end of life often involves deepening connections—with loved ones, with self, or with the sacred. This can include reconciliation, expressing love, sharing memories, or simply being together in silence. Loneliness, by contrast, is one of the most painful ways to die.

### 4. Meaning

Even as the body declines, the spirit seeks coherence. A peaceful passing allows the person to reflect on their life, affirm what mattered, and leave a sense of legacy or spiritual completeness—whether through storytelling, rituals, or quiet awareness.

### 5. Choice

Agency matters. The opportunity to make choices—about treatment, environment, who is present, and how pain is managed—can make the difference between peace and distress. A well-supported death honors these choices to the very end.

> “Death is not the opposite of life, but a part of it.”
>
> — Haruki Murakami, *Blind Willow, Sleeping Woman* (2006)