



# Natural Transitions

Volume 3 Issue 1

Conscious, holistic approaches to end of life



## Communication

Spiritual Aspects of Alzheimer's Care

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Shared Death Experiences: Glimpses of Eternity?

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Coma Communication

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UK: Liverpool's Care Pathway

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Connecting with the "So-called" Dead



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## Communication Creates Compassion Creates Community

by Karen van Vuuren

Earlier this year I was sitting in Patricia Kelley's living room in her modest Victorian-era home. A doyenne of end-of-life communication, Kelley is known primarily for her first book, *Final Gifts*, which she co-authored with fellow hospice nurse, Maggie Callanan, and published in 1992. Kelley, a cheerful, snowy-haired Brit, who is semi-retired, informed me that her book is still a best seller, nationally and internationally.

We reflected on the success of *Final Gifts*. In those days, Kelley's literary agent pitched the manuscript to numerous publishers, auctioning it to the highest bidder. The book's content—an exposé about what patients are telling us in their dying process—was novel then, and interest was high. If Kelley's book were to premiere in the bookstores now, we'd find it nestled alongside countless other publications on understanding death and dying. That's progress!

In this issue of NTM we focus on communication—how we communicate with the dying and how we communicate with each other around death. The word “communication” comes from the Latin verb *communicare*, to impart, share, or make common. The related noun is *communis*, literally “that which is common,” and from which we derive the word “community.”

Some wit once said that you can't have a community without communication. In other words, communication begets understanding and compassion, which begets community. NTM strives to build community through our writers, advertisers and readers. We hope you will savor this issue's illuminating articles on end-of-life communication from educators like Ann Jacob (coma and “unresponsive” states) and Megan Carnarius (dementia from a spiritual perspective), as well as from others who are changing the end-of-life care paradigm.

*Karen van Vuuren*



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mag@naturaltransitions.org  
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#### OUR VISION

- Acceptance of death, loss, and grief as a natural part of life

#### OUR MISSION

- To share holistic approaches to end of life
- To provide a forum for end-of-life caregivers and educators

EXECUTIVE EDITOR Karen van Vuuren

COPY EDITOR / PROOFREADER

Margaret Pevec

DESIGN Sean Doyle [www.doylegraphics.com](http://www.doylegraphics.com)

LAYOUT Ann Erwin

ILLUSTRATOR Christina Lewis

ADVERTISING DIRECTOR Marcie Cole  
magads@naturaltransitions.org

## An Innovative Approach to Hospice Sustainability



In 2011, the first baby boomers became eligible for Medicare when they turned 65; each year moving forward, the demand for care and resources will continue to grow. At the same time, training and recruitment of healthcare professionals is not matching attrition rates and burnout. For example, in 2012 the average age of nurses in the US was 50. By 2020, half of all nurses will have retired. They too are part of what's been called the "silver tsunami" and may need care themselves. These major changes mean that healthcare sustainability efforts have become critical as never before. FairCare is an innovative model created to support organizational sustainability based on the triple bottom line approach to business; this is where the planet, people and profit are all considered to be foundational, interconnected elements of the bottom line.

Green Hospice is part of the FairCare model and part of the movement to reclaim death and dying as a normal and sacred part of the life cycle rather than as a medical failure. The work of Green Hospice and FairCare is based on the philosophy that the people are the product and that healthcare organizations—like healthcare professionals—should be accountable to the ethic: "Do no harm." Hospice and palliative care, like other sectors of the healthcare industry, have become excessively driven by fiscal compliance and productivity, while ignoring the needs of both clients and healthcare professionals.

Green Hospice has partnered with the Green Burial Council and the National Home Funeral Alliance (all FairCare affiliates) to offer a certification program in emotional intelligence as a systemic way of addressing the movement away from putting humans at the center of hospice concerns. These trainings are available to individuals and healthcare leadership teams.

Emotional intelligence is the ability to effectively combine thoughts and feelings for the purpose of making better decisions and to develop and sustain more mutually respectful relationships with ourselves and others. Emotional intelligence refers to a set of skills that can be taught and learned and become more natural with practice. Skills that are basic to emotional intelligence include self-awareness, empathy, optimism, intrinsic motivation, and self-management. Researchers at the Harvard School of Business recently announced that emotional intelligence is the number one predictor of business success.

In addition to being environmentally and fiscally green, there is also a need for "saging," that is, passing along the wisdom and experience of hospice and palliative care experts, many of whom have decades of experience working with the dying. The Solace Teachings is an in-depth training program that was developed as a result of the documentary *Solace: Wisdom of the Dying*.

Sustainability addresses long-term viability from an environmental, economic, and social viewpoint. It is vital that stewardship and responsible oversight of resources and resiliency become priorities in navigating the changes in healthcare. Through courage, flexibility, and change, we have the opportunity for healing by aligning organizations and the healthcare professions to their roots: people. This is the time and hospice is the place where the problem has never been so close to the solution.

For more information please visit [www.camilleadair.com](http://www.camilleadair.com).

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*Natural Transitions* has always focused on building community. With that goal in mind, our Community Forum page is to encourage communication among our subscribers and within this movement for more conscious, holistic, and greener approaches to end of life. We welcome comments on the articles and sharing news and inspiration from your part of the world! Email your letters to [mag@naturaltransitions.org](mailto:mag@naturaltransitions.org).



# *The Fruition of Mindfulness*

by Kathy Emery

The practice of basic attendance is as old as the human experience itself—one individual caring for another in a time of need, caring with body, mind, and spirit, wholly present. The “whole presence” in caregiving is at the heart of the vision and discipline of basic attendance as practiced in the Windhorse approach to care. This approach to caring for the dying, aging, or people experiencing extreme states, is inspired by the contemplative traditions as taught at Naropa University in Boulder, Colorado. Eastern and Western traditions and practices that synchronize one’s body, mind, and environment provide the ground and path for cultivating this presence. In particular, mindfulness—awareness meditation has been key in the development of this ability to be present with warmth and awareness.

The Socratic adage, “Know thyself,” is inherent in basic attendance as a method of caregiving. There are many forms of meditation. Some are focused on relaxation and calming oneself. Others, like mindfulness, are focused on being present with whatever arises in the moment on an inner or outer level of experience. This practice of nowness strengthens our ability to return to our immediate experience with a sense of openness, curiosity, and expanded awareness. Another Socratic adage is “Befriend thyself.” What can occur as we get to know ourselves better is that we see both our wisdom and confusion more clearly. Making friends with oneself is the basis for basic attending as well as for befriending the world.

One might ask how this applies to working with elders and the dying. As caregivers in such situations, we may experience our own deep, core issues, such as our own fear of losing control of our minds, bodies, lives. We can have visceral experiences of tasting our own death and coming face to face with the reality of dying. The poignant and potentially painful vigils held with one who is dying can dissolve the barriers

between us and can cause us to either recoil or open to the inevitable.

If we have spent time with ourselves plumbing the depths and textures of our fears regarding aging and dying, we are more likely not to react out of that fear when offering care to a loved one or client. If we can acknowledge our own feelings and fears like an old friend, breathing out the tension and struggle, we can then respond to or simply be with the person we are caring for in a more skillful and compassionate way. The practice of mindfulness can help cultivate clarity during those moments when we can either react, suppress, or respond to our world. Through this befriending, we can experience a feeling of warmth toward ourselves and the other person. This process of coming back to our experience in the moment can foster qualities of openness, clarity, and warmth towards ourselves, towards others we serve, and towards the world.

## *Our experiences with others can serve as beacons on our own path of awakening to these qualities.*

As we deepen the process within ourselves and find openness, clarity, and warmth—fundamental qualities to the human experience and named in Buddhist teachings as an “awakened noble heart”—our awareness can help us to be more available to another’s suffering, confusion, or need. We then can move toward such experiences rather than shying away from them to protect ourselves.

Our experiences with others can serve as beacons on our own path of awakening to these qualities. At Windhorse, we often talk about the mutual path of “care giving and care receiving” as part of basic attendance work, as coined by one of our staff members. We become teachers for one another on our shared journey. In Eastern teachings, generosity is defined as a giving and receiving practice.

Other vivid expressions of this approach and attitude toward caregiving are expressed in teaching slogans such as “No escape, no problem.” In other words, taking whatever we might preconceive as an unworkable situation, rife with claustrophobia, and bringing an attitude of workability to it, based on our intention to come back to the moment. Everything we encounter becomes part of this intention to be present.

This approach is embedded in the name and symbol of “Windhorse,” a term widely referenced in Eastern cultures to represent a fundamental energy inherent in the human experience that can be evoked, cultivated, and roused to heal ourselves and others. This energy is likened to the term chi in Eastern traditions. Through the practice of synchronizing body and mind in a contemplative discipline—i.e., mindfulness meditation, yoga, tai chi—the possibility of being present in groundless and uncertain moments is more likely to occur.

Basic attendance has been practiced in contemplative settings and was named and developed further under the late Ed Podvoll, MD, whose book, *Recovering Sanity: A Compassionate Approach to Understanding and Treating Psychosis*, includes a chapter entitled: “Learning Basic Attendance.” This chapter includes a description of the 10 skills of basic attendance. These are not necessarily linear or intended as a recipe, but rather as guideposts: 1) being present, 2) letting in, 3) bringing home, 4) letting be, 5) bringing along, 6) recognizing, 7) finding energy, 8) leaning in, 9) discovering friendship, and 10) learning. These expanding skills can arise from being present in attending our loved ones and clients.

**Being present** is the on-going touchstone as one practices basic attendance. When I am with an elder or a dying person, I can notice the contrast between my speed of mind and the slowed down and potentially spacious

process of the person I am attending. Making conscious note of this contrast brings me back to the moment. Entering the environment of a dying person invites an attunement to the ever-present nowness of the situation. For example, while I was attending my dying mother, I returned to the rhythm of her breathing, the temperature in the room, her level of pain as a way of cultivating an opening rather than a closing down.

**Letting in** speaks to the natural process of touching another's state of mind. For example, after feeling the contrast of my speedy mind, I can open to another's quality of mind—whether it is slow, spacious, anxious, fearful, or depressed. Or I can retreat further into my mental speed and my need to distance. Letting in is the practice of opening to another person's felt experience. As a person is dying, her state of being can be highly agitated. I was present at a family member's dying as she went through this process. Two days prior to her passing, she was accepting and open-hearted about her impending death and even named the day she would pass. As the days unfolded, she moved into an agitated phase. A group of us surrounded her during her last hours, holding her and the space for her karmic unfolding. It was as if we were a mandala of open hearts breathing with her, letting in and letting go.

**Bringing home** refers to the practice of including mundane activities in the discipline of basic attendance, synchronizing body, mind, and environment in any activity such as doing the dishes, attending to a client's personal care needs, preparing meals,



*Kathy Emery and Tibetan client*

or taking out the trash. There is no limit to the opportunities for practice. Again, the environment is a reflection of the mind and the mind is a reflection of the environment. I have witnessed family members attending to a deceased patient's environment with precise care and attention, such as folding the ancestral blanket around the body as they prepared their beloved for a prayer vigil. These acts were imbued with meaning.

**Letting be** has to do with a sense of equanimity in one's care, not being so attached to an outcome that we are focused on results, but rather remaining open to the unknown of the situation—which can be chaotic, groundless, and changeable—and also suspending judgment about one's effectiveness. It is challenging to practice this middle path and, again, is cultivated through contemplative disciplines and the letting go of one's agenda.

**Bringing along** speaks to the possibility of bringing one's world into

the caregiving and not restricting one's actions to be task-driven alone. When possible, you can include your interests as well as elements of your life—family stories, favorite books, hobbies, and so forth. One particular client of mine enjoyed having my daughter play her cello when possible, especially during the last few hours of her life.

**Recognizing** refers to the possibility of wisdom and sanity being present in the most painful and confused states of mind and body. One 85-year-old elder with whom I worked—who wasn't particularly known for her kindness to her own family and who had significant dementia—would often give us advice about our own lives when asked, and shared a wisdom that reflected her deep concern, caring, and understanding. The ability to recognize moments to allow for a client to share their wisdom can lead to rare moments of kindness toward oneself.

**Finding energy** has to do with the possibility of connecting with sounds,

smells, tastes, visual perceptions, and touch as a means of expanding the client's world. Even when a person is in significant decline, the sense perceptions can be soothing and relaxing. One staff member working with a woman with severe depression started taking walks through the neighborhood and tasting the fresh fruit from the trees along the way. The senses of smell and taste helped her awaken from the narrowed world of her client's depression.

**Leaning in** refers to the compassionate skill of sensing when to lean into rousing a person and when to let the person be, based on your perception that the person needs or chooses to withdraw. Again, this occurs within the practice of being present and attuning to another person's rhythm in the moment.

**Discovering friendship** can arise within the context of caregiving intimacy and is marked by practicing honest

communication and authenticity in the client/caregiver relationship. The fruits of this friendship can create an environment of relaxation. Often our clients and their families feel that we are extended family. Authenticity in relationships fosters a deep trust and bond as we experience a threshold like death as we live life.

*[T]he journey shared informs our path as we face our own uncertainties about life and death.*

**Learning** is about the mutual path of practicing quality caregiving. We learn as much or more from our clients when we consciously pay attention to the moments of transmission. In practicing openness to our present experience, the journey shared informs our path as we face our own uncertainties about life and death.

We have had clients share themselves with us through writings, videos,

artwork, and recordings, all passing on the wisdom of their lives. These are precious legacies that we share in our community.

These are the skills of the practice of basic attendance, which arise out of the mindful and aware sense of presence.

They are not considered techniques. The result of meeting one's inner and outer experiences with a sense of openness, clarity, and warmth can manifest this way. Although the practice of basic attendance is profound, it is also practical and easily accessible to everyone. 🌱

*Kathy Emery, MA, LPC, is a psychotherapist who has worked for thirty years with the Windhorse model. She is also a former adjunct faculty member at Naropa University, in Boulder, CO.*

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# Awakening to Spiritual Aspects of

by Megan Carnarius

## *When they don't seem present, they're very busy.*

My background is in nursing and special education. I earned my nursing degree so I would be eligible to study a special form of massage and hydrotherapy in Europe. Now I manage and design care facilities for people with Alzheimer's and memory loss. Although my mother did not have Alzheimer's disease, my journey with her illness fundamentally affirmed the way I view the people in my care.

My mother, Rusty—spiritual counselor, Tarot master, and psychic—suffered a severe stroke when she was 63 due to a blood clot that formed while she was recovering from foot surgery. I took care of Mom long distance for nine years after her stroke.

At one point during those nine years, a caregiver left her unattended in a Hoyer lift that had been raised to its highest level. Mother toppled out and landed on her head. So, on top of health challenges from the stroke, she now had to cope with a head injury. She became somnolent for eight months. She went through a terrible period of nausea and vomiting. During this time of physical and emotional withdrawal, I encouraged her to get up, to engage in something, but her response was always, “I just need to sleep.”

Up until her illness, Rusty had been a public speaker on topics of self-motivation and spirituality. (We were Quakers and I grew up in conservative Lancaster County, Pennsylvania.) One day, after she had gained some ground in her recovery, she announced, “I have to give a lecture!” Her thinking seemed tangential, so I was nervous and suggested she do a breakout session instead of a keynote address.

Helping Rusty get ready for this event was like working with a high priestess. There was so much tension about how she would do. The theme of Rusty's

talk was “preparation for a peaceful transition.” She spoke of how her post-accident debility afforded her space to work on “forgivenesses.” She said it was “an absolutely productive, amazing time,” during which she gained insight into the repercussions of her actions on others. She was able to view past situations with heightened consciousness. She told me, “I think that's what goes on when you die. When you cross over, you get a life review of your impact on others, their impact on you, and how all that feels. It was very fruitful.”

## *I had always asked myself, “If they aren't ‘here,’ where are they? What are they working on?”*

I trusted my mother's accuracy because I knew how in tune she was with herself. I thought of the residents in the Alzheimer's facility where I work. I had always asked myself, “If they aren't here, where are they? What are they working on?” I reflected on how their experiences in this incarnation could benefit them in their next transition. People with end-stage dementia do what I call “cloistering,” appearing to enter into deep meditation. When people are sleeping 16 out of 20 hours a day, perhaps it's because they are preparing themselves to cross over.

Rusty taught me the difference between a guardian angel and a guidance angel, which has helped me to understand how the angelic realm supports our personal growth. Guardian angels have the easier job. “They hover and assist in gently guiding, inclusive of momentum, the trajectory, responding to wants and desires in a direct fashion. They are often praised and thanked for their help and assistance. Guidance angels, however, must present obstacles, stop trajectory and momentum, and cause the stunned participant to find a new direction or path. Guidance angels are often deeply misunderstood and underappreciated in the moment. It takes longer to understand what the change in direction facilitated.”

## *Challenge as opportunity*

At one time I was involved in a study group based on the work of George I. Gurdjieff, who led a spiritual community in France. I had heard a story about an old man who lived in that community who was “the personification of difficult.” According to the story, this man was irritable, messy, unwilling to clean up or help at all, and no one got along with him. After many frustrating months, the old man departed for Paris. Gurdjieff followed him and tried to convince him to return. But the man refused. Then Gurdjieff offered the man a generous monthly stipend to return. The man agreed, and when he returned, community members were in disbelief.

They complained that Gurdjieff was paying this man while they were being charged. Gurdjieff listened, then laughed and explained, “This man is like the yeast for bread; without him here, you would never really learn about anger, irritability, patience, and compassion. That's why you pay me and why I hire him.”

## *Further lessons in letting go and compassion*

For me, Alzheimer's is not about decline; it's about transition and transformation. It's shedding and letting go, and moving into the next reality. For some reason, end of life for people with dementia includes this “wafting off” experience. As their caregivers, we sometimes have discussions about whether residents will remember their time with us after they have left their bodies. I say, “Well, they might look back and think they were living in a weird fraternity house for a while!” In truth, my sense is that our inner work with them is what they will take with them when they die. What counts are our intentions, our goodness, and our wish to interact with them. This is what will somehow find itself into their life review when they transition.

As caregivers, we are in charge of the bodies of those with late-stage



# Alzheimer's Care

Alzheimer's. We provide water for them when they wake as we would for a monk in deep meditation. As their disease progresses, these people enter a quiet and peaceful depth and largely live in this depth during the latter phases. Attempting to rouse someone from that state feels like a rude interruption.

People with mid- to late-stage Alzheimer's often talk about relatives who have died. They'll say, "I've seen my mother. I just had a wonderful conversation with her." Who am I to say they're wrong? When delusions and hallucinations occur with dementia, we have to make sure that the person is not physically ill or that their medicine isn't causing problems. With these ruled out, there is often a spiritual aspect to these visions and feelings because the threshold for those with Alzheimer's has thinned. People can often cross back and forth from the here to the hereafter because of the deep and loving connections they have to others.

I think of myself as a compassionate person, and I felt like I knew a lot about this work. But losing my mom in her physical form—not having this best friend to talk to—made me much more raw when I interacted with other families. That led me to consider the following: That which makes us more compassionate usually involves the experience of something profoundly painful. Losing my mom afforded me a greater understanding of loss. Getting diabetes woke me up in another way.

I'd always rated myself as healthy. Then I had the flu during which a virus settled into my pancreas and started killing off my insulin-producing cells. I ended up with Type I diabetes. Although I'm a nurse, I didn't even know one could get that kind of diabetes from a virus. Suddenly, I had to watch my blood chemistry. I realized that I had not been paying much attention to myself. Diabetes and the need to give myself insulin injections regularly forced me to shift gears. I wish I hadn't had to learn to do it this way, but it was part

of the dynamic I needed. I could say, "I just got the virus and everything was accidental," but there's a part of me that doesn't believe that. Why was I vulnerable to that virus when someone else wasn't? I got it, so what am I supposed to be doing with it? I realized that I'm like a giant satellite dish that's broadcasting: "Megan's available! How can I make your life better?" Since my diabetes diagnosis I have learned to turn that same attention to myself.

## *Life recapitulation and review*

When someone with Alzheimer's gets to the stage when they lose fine motor skills, they're letting go at a fundamental level so they can cross the threshold. In essence, they're leaving as they came in, without their physical and mental facilities. There's an intense spiritual purity about that. The experience of Alzheimer's and memory loss is stark and raw. If a person can't talk to you about her stories, does that mean she's not there? She doesn't have value? One way to respond is this: "You're a whole spirit having a handicapping experience." Those were my mother's words about my younger, disabled sister.

## *When they get to end stage, it's as if they enter into deep meditation.*

In this lifetime an individual may have grown up, worked a job, raised a family, and "done what was expected." Then he goes through this handicapping

phenomenon that forces him to review his life. What are some of the things he can access through his dementia that he couldn't have otherwise?" Here are two examples.

A married couple came from a generation in which people never divorced. Theirs was a difficult relationship because the wife had severe depression and the husband was always trying to fill in the gaps. He wanted to make her feel better, but he often felt angry with this role. The husband was in his eighties when his wife's clinical depression intensified, and she was also declining physically. Around the same time, the husband started to exhibit dementia. When I met him, I had a strong sense of his inner stance, one of "I must stay! I must be here!" He was so committed to the dynamics of the relationship that he couldn't physically remove himself from the situation. He wasn't able to say, "This hasn't worked! I need to go on to something else." Then, as soon as his wife entered a nursing home and he was in a memory facility, he started getting



Wynn Bruce



clearer. He was able to talk with lucidity about many things. Dementia gave this man an opportunity to review his role in life and the ability to grieve.

Dementia can also allow parents to let go of long-held matriarchal or patriarchal behavior patterns. Children who have never felt empowered, who have always depended on their parents might find their parents slowly relinquishing control. By the time the parent is dying, he or she knows the child is safe and able to function as a responsible adult. Alzheimer's facilitates this shift in view. If death had come suddenly to the parent, the shock may have further disempowered the child/adult; a more gradual transition allows the child/adult an opportunity to pick up the reins.

It's up to us to remain awake to the spiritual experience of the person with a dementing illness. Our task is to hold people with dementia in our consciousness, especially when they are

unavailable to us in the conventional sense. For the caregiver, it's a spiritual opportunity to learn compassion and introspection..

Our society often disqualifies or disregards people with dementia. There is dementia-ism as well as ageism, and I've spent my career distancing myself from both. Who are we to say that those with dementia and Alzheimer's are not experiencing something holy?

For me, working with the process of dementia or Alzheimer's is a lesson in impermanence. We all know that things change and that life moves us into unimaginable experiences. Some of these are good. Others, at first glance, appear as bad. It is easy to trust the flow of the universe when events bring joy, happiness, or ease to our lives. It is much harder to embrace the painful things that challenge us deeply and make us grow. Alzheimer's has been called the "plague" of modern times, and we often view it

with fear. But I believe that our bodies are physical homes for our eternal and unchanging spiritual beings. We are much more than the matter of our brains. 🌐

## References

The Fourth Way refers to a concept used by G.I. Gurdjieff to describe an approach to self-development learned over his years of travel in the East.

*Gnosis* magazine (1985–1991), San Francisco: Lumen Foundation, Edition #20, Summer 1991.

For some wonderful wisdom from my mother, see Rusty's *Friendly Tarot for Self-development* by Rusty Smith Carnarius, published by Infinity Press.





Wynn Bruce

## *Meditation for dealing with a difficult person with dementia*

*This meditation was developed by Marshall White, a former chaplain intern at the memory care facility I manage. He now works at Sharp Memorial Hospital, San Diego, CA. For ease of use, feminine pronouns have been inserted. Please substitute masculine pronouns if the individual you are working with is male.*

Create a quiet space for yourself. Think about the person. In your mind's eye, look at her face. Imagine that person as well as you can: her posture, how she performs certain activities. Look at how her life is now and what she is doing right now in it.

Imagine the point in time when things started to become really difficult and challenging for her. (Maybe you didn't know her then.) Think of when

she became really vulnerable to this onslaught, to this disease process. Go back and envision the person as completely whole. Go back to what life was like when that wholeness was felt by her in a more clear and concrete way. What were her hobbies? What did she like doing? Envision her in her wholeness. Then thank her for the things she's teaching you. Thank her for being. Imagine her thanking you back.

You can also weave in the particular behaviors of the person you are struggling with and think of how the person is using those behaviors to feel safe, to express herself, or to show initiative. Do this in a relaxed, non-judgmental way. Is she perhaps trying to defend herself in a situation in which she feels fear? How can you reassure and calm her?



*Megan Carnarius, RN NHA MT, has specialized in memory care for 24 years. She is currently working on a book about the spiritual gifts of Alzheimer's that's scheduled for publication in the fall of 2013. Megan is executive director at Balfour Cherrywood Village, a secure memory care assisted living residence in Louisville, CO. You can contact her at [mcarnarius@balfourcare.com](mailto:mcarnarius@balfourcare.com).*



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# Shared Death Experiences: Glimpses of Eternity?

by Raymond A. Moody, Jr.

Quite commonly, bystanders at the death of someone else emphatically report co-living the dying experience of that other person. I first heard such a shared death experience from one of my professors of medicine, who was also a practicing physician, in December 1972.

This doctor had the unfortunate duty of trying to resuscitate her own mother, who died despite the resuscitation effort. She told me that when she felt her mother die, she found herself floating out of her body and viewing the scene from above. She saw her own physical body and the now-deceased body of her mother down below. She said, "As I was trying to get my bearings," (her exact words) she became aware of her mother, "now in spirit form" (again, her exact words) alongside her.

She said her goodbyes to her mother, who receded into an intensely brilliant, white light. The physician saw figures emerging from the light as though to greet the spirit of her dying mother. The physician recognized some of the figures as deceased relatives and friends of her mother's. However, she did not recognize the others and assumed that they were loved ones of her mother who had died before she herself had been born.

My professor saw the spirit of her mother reunited with the figures, whereupon they appeared to be drawn back into the light. Then the light

was gone. The way the light vanished reminded her of the way in which the lens of a camera closes in a spiral. She found herself back in her own physical body, standing beside the deceased body of her mother.

When I wrote my book *Life after Life* in 1974, my professor's account was all I knew of shared death experiences. However, as I lectured on near-death experiences throughout the late 1970s and into the 1980s, I heard more stories. These were almost exclusively reported by medical personnel—doctors or nurses who attended the dying. In the late 1980s and into the 1990s, though, I began to hear more and more such accounts from relatives or friends who had been present at a death.

I can only conjecture that a concurrent change in medical practice is at least a partial explanation for this shift. In the 1970s, it was standard hospital procedure for doctors and nurses to preside over death. They would gently escort dying patients' families away from the scene. The rationale, as I recall, was that witnessing a death would be overwhelming for the families, and trained medical professionals were better

prepared to handle the experiences. That model began to change in the 1980s, and nowadays doctors and nurses encourage family members to be there with dying patients until the end. This change in the



medical profession helps explain why I hear shared death experiences from the families of people who died.

However, I am still at a loss to explain another puzzle. I began to talk about shared death experiences in the late 1980s and mentioned them in print as well. I would discuss the subject when television crews came to interview me about near-death experiences. But when the interviews appeared on television, my remarks on shared death experiences had been cut from

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*Perhaps we are unable to imagine our own death. Imagining ourselves at the death of someone else is a somewhat easier proposition.*



Similarly, near-death experiences intrigue us because they happen to another person. That other person gets out of the body, speeds through a passageway, enters a brilliant light, communicates with deceased loved ones, sees life pass in a sweeping, panoramic review, and then returns to the body. The rest of us can participate safely and vicariously in the adventure without being directly involved. Listening to narratives of near-death experiences, we can maintain a safe distance from the troubling idea of death. Psychologically, near-death experiences can be inspiring and engender hope.


Shared death experiences, however, raise different issues.

Perhaps we are unable to imagine our own death. Imagining ourselves at the death of someone else is a somewhat easier proposition. Hence, we can imagine ourselves having a shared death experience, and that makes the prospect of death somehow more real. I suspect this is why shared death experiences remain in the shadows, while near-death experiences have become widely known all over the world.

the presentation. This was puzzling and somewhat frustrating, and only recently has a possible explanation dawned on me.

Sigmund Freud and Ludwig Wittgenstein, among other great thinkers, pointed out that we have an inbuilt resistance or inability to imagine our own death. For many, death is an unwanted, frightening, or even terrifying prospect.

We don't want to think about the possibility of our own death, and for most of us, death is something that happens to someone else.

Shared death experiences are now showing signs of emerging into the public consciousness in the United States and Europe. This development has the potential to revolutionize rational inquiry into life after death. The first step toward that goal is to delineate the main characteristics of shared death experiences. Then the implications for investigating the question of an afterlife will become obvious. 

*Raymond A. Moody, Jr, MD, PhD, is well-known internationally as a leading authority on near-death experiences. His seminal work on the topic, Life after Life, has sold more than thirteen million copies. For more information on his work, visit [www.lifeafterlife.com](http://www.lifeafterlife.com).*

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# Never too Soon

## Ellen Goodman's Conversation Project

by Kim Mooney

According to Ellen Goodman, Pulitzer-Prize winning journalist, we often look at and talk about end-of-life care and dying in a confused way. It's clear that we're a death-denying society. And, as we find ourselves needing end-of-life care, it's important to recognize the complexity of our medical system and to understand how our declining health can affect the choices we make.

Ellen Goodman started the Conversation Project in 2010 after caring for her dying mother. She realized that families often do not know what kind of care a dying person wants. This past May, she launched the first local chapter of the Project in Boulder, CO, to a standing-room-only audience, including end-of-life educators, caregivers, and interested citizens. Goodman explained how the project provides opportunities for people to stay in charge of their lives. She discussed research on preferences and realities in end-of-life situations. For example, 60% of people say that making sure their family is not burdened by tough decisions is "extremely important," but 56% say they have not communicated their end-of-life wishes.

The conversation begins with taking a deep breath and deciding to share our personal feelings about dying with our loved ones—our fears, our hopes, our choices. "We know that everyone has a story of a good death or a hard death, and we know that the difference between those two stories is often whether they have had the conversation," elucidates Goodman.

During her Boulder presentation, Goodman's assistant led the participants in exercises to help them share their stories and values. One of these was: "What can you imagine not wanting to live without?" Participants reported surprise at the impact of Goodman's simple questions and the personal consequences of their responses. One audience member had an epiphany:


***It's too early to have  
the conversation  
until it's too late.***



Ellen Goodman

Although the conversation was about death, her own life values were guiding her choices.

Two aspects of the Conversation Project make it particularly powerful: its focus on "the conversation" (not on completing advance directives or other medical or legal documents), and its intention—to allow ordinary people to talk to their families and friends without the involvement of medical professionals. These make it one of the most accessible and potentially, one of the most successful advance care planning movements in the US.

Visit [theconversationproject.org](http://theconversationproject.org) to learn more or to download a copy of the Conversation Starter Kit. 

Kim Mooney is the director of Community Education for TRU Community Care (formerly HospiceCare of Boulder and Broomfield Counties). Contact her at [kimmoooney@trucaare.org](mailto:kimmoooney@trucaare.org).

# Reading the Signs: Coma Communication

Methods of communicating described in this article provide a map to uncharted territory for many people. Coma communication is based on non-verbal ways to connect with someone who is in a coma preceding death or while in any other state of consciousness, such as dementia, that inhibits direct or “normal” verbal exchanges. This way of thinking and communicating can lead to extraordinary and unexpected moments of meaning, relationship, and awareness to extend the opportunity to cherish and connect with people we love.

My life partner, Stan Tomandl, and I head an organization called Coma Communication and Process Oriented Facilitation. We specialize in working with people in states of altered consciousness due to illness, dementia, traumatic brain injury, coma, grief, and other times of fragility and strength. The belief that a person’s essence is present in all states of consciousness is a guiding principle of our work. Arnold Mindell, author of *Coma: The Dreambody Near Death*, says that people in a near-death state are “wakeful human beings going through one more meaningful step in their process.” He also says that many people in comas “venture to the heights and depths to find some degree of ecstasy, prophetic insight, and self knowledge.” Mindell believes that, at death, “people are prepared more than ever to live fully.”

As humans, we continually change our consciousness through meditation, prayer, yoga, dance, walking, running, and even by loving and fighting. During the process of dying, we have another opportunity to enter new worlds of experience through our altered state of consciousness. This transformation may be profound. The quiet person might share, the grump might love, the extrovert might become introverted, the kind person might grow in kindness. An attentive person may lose interest in his or her outer life and put greater focus on what’s happening internally. There are often opportunities for the heart to

open wider than ever before. Although death may be difficult or painful, it can also be an ecstatic experience filled with radiance and love when important events occur. Our role as carers is to find ways to support opportunities for transformation in those who are living into their dying.

*Each time you speak, notice if anything changes in the person who is dying.*

For example, a dying individual might appear to be running like hell, arms and legs flailing, dodging the bullets of war in his delirium, but also revealing his energy, strength, and courage. Another individual might say or do things that a loved one had never thought possible. One example of this happened to Stan. His father had been in an advanced state of Alzheimer’s and had seemingly forgotten his son. One day he reached out and stroked Stan’s hair; he hadn’t lovingly touched his son since Stan was twelve.

There are four main themes people tend to explore near end of life: reviewing their life story, fighting heroic battles, processing relationships and deep loves, and opening their spiritual hearts. In experiencing these inner and outer processes, people may see what and who is around them as well as having inner visual experiences and memories; they may have feelings or bodily sensations; they may hear, both inside and outside of themselves; they may move in response to inner and outer events; and they may relate, with both inner figures and outer people and world events.

To the carer, the dying person may seem to be melting away, far different than the known and loved person of before, who is now altered in consciousness and ability. It can be hard to tell what, beyond dying, is going on.

As coma communicators, we try to find a way to be with a person that furthers her inner and outer dying process. Our passion is to relieve the isolation felt by the dying person and her loved ones.

People are often more afraid of being trapped in “weird” states of consciousness than they are of death itself. When an individual no longer talks, those caring for her can easily become shy or nervous, and even want to leave the room to escape the feeling of not knowing what to do. What a dying person is asking, essentially, is: “Please be with me as I am, how I am, for as long as this takes.” There are many wonderful ways to be with the dying.

We might take time to gather around the bed, holding her hands and expressing our love. Or, we might say, “It’s been quite a ride over these years!” We might hum or sing a family song, or a favorite tune from her era.

A man once told his buddy and drinking partner, “I’ll keep our secrets, my friend.” He then sang a simple tune and was joined by members of the family. Stan and I noticed this created a feeling moment of union in the midst of the family’s grief, so we encouraged them to keep singing, an idea they enthusiastically welcomed. Sitting with awareness allows one to respond to changes in the room and encourage and model healing moments like that one.

When someone is delirious, we can say things like: “I’m not your mother, I’m your daughter,” in the hope that the dying person will return to himself. If that fails, a next step might be to become that mother, expressing positive mothering



by Ann Jacob

qualities, such as tenderness and sensitivity. In this way, the mistaken identity can be used as a vehicle and a metaphor for what might be the next step the person needs for his journey.

Stan and I were at home when we received an emergency call from a family we did not know. The caller informed us, "Our dad is in the hospital with a stroke. He's only 54 and in intensive care. We want to do everything we can to help him. The whole family is flying to be with him." The caller had heard that we were willing to work via Skype video, that we could read signals coming from a person even when they were in a coma, and that we could enhance communication

beyond what is often considered possible. Desperation and death open a door between strangers, and we were welcomed as long-lost friends by this family.

When we got on Skype we could see the people in the hospital room talking in groups of two or three; we could see and feel the fear and chaos they were feeling and the yearning to find new ways to connect to their loved one in a coma. We invited them to gather around the bed. They were relieved to have some guidance and to be nearer their father, brother, and uncle. A hush descended naturally, and we encouraged everyone to pay attention to the patient's breath and to breathe with him. In doing this, they spontaneously reached out for each other and laid their hands on him. The atmosphere softened. Later that night, the man died, bathed in his family's love.

## Breathing

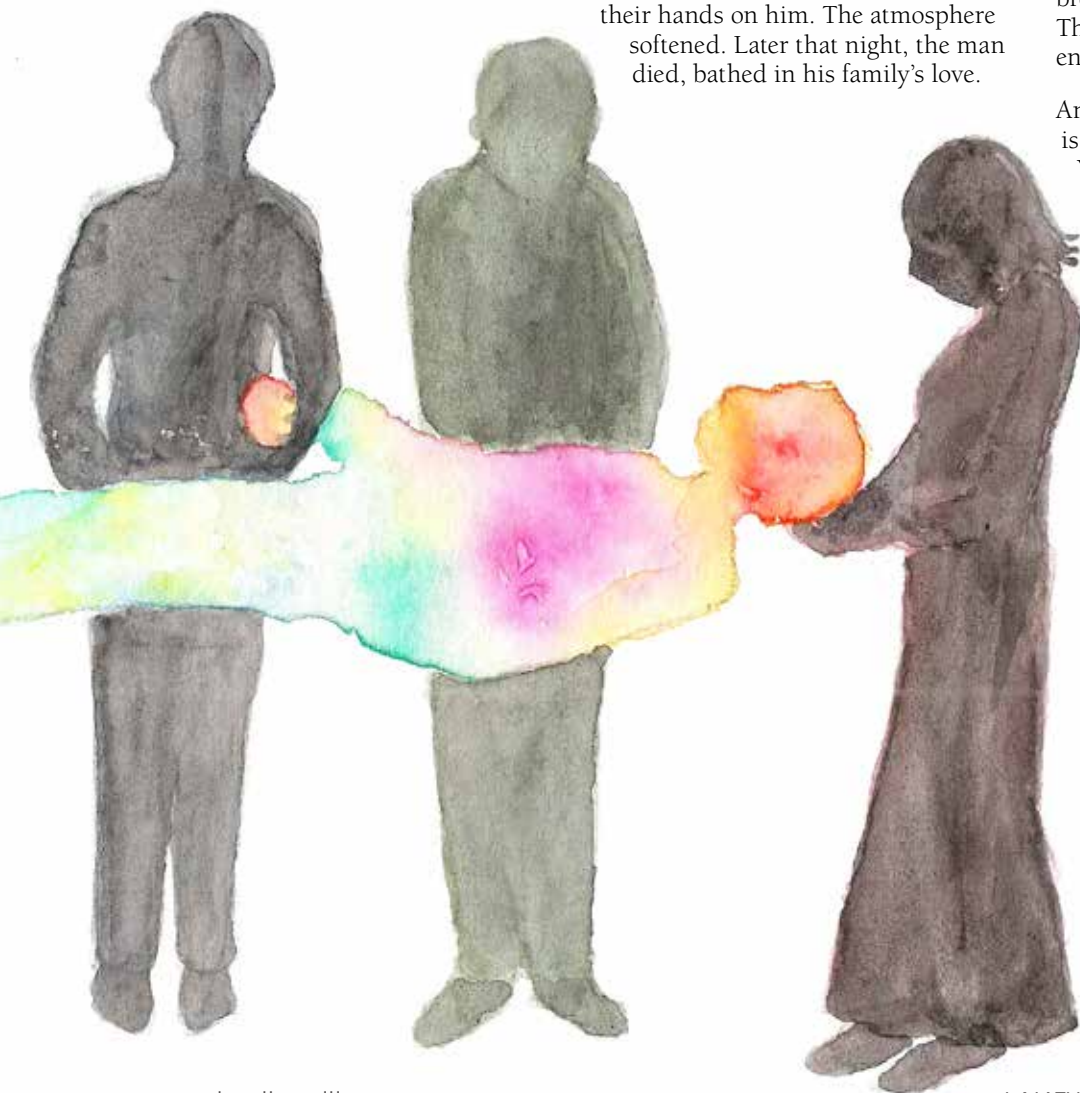
Breath is a vehicle for establishing deep connection and feelings of rapport. It is a bridge that allows us to join a person who is in an altered state. Breath is something beyond country, culture, language, and belief; we all have breath in common.

If a loved one is in a coma, try to breathe with her for a few breaths. Breathe into the same place in your body that she is breathing into—upper chest, belly, diaphragm. If the breathing is too fast, slow, or shallow for you to keep up, keep trying, even for only a brief time. It is a way to enter into another's experience. Give yourself permission to do with your breath what you observe in the other. This may be new for you, but it is easy enough to learn.

Another way to connect using the breath is to speak when the patient is exhaling.

You might only be able to say a few words at a time, slowing down your speech to a pace the person is more able to follow. For example, speaking only on his out-breath, you might say: "I am here ... with you ... we are in this together ... forgive me ... I forgive you ... thank you ... I love you." Your inner attitude and healing words can include: "Believe in your experiences; they are meant for you." This opens up worlds of possibility and provides a sense of relief for all.

Each time you speak, notice if anything changes in the person who is dying. Does she take a deeper breath? Do his eyelids flicker? Does a feeling of peace enter the atmosphere? Does the sun burst into the room? For example, if you ask, "How are you?" and a plate crashes in the hallway, you might say something like, "Things are crashing!" Then watch to see if there is any response, any tiny or large change in the person. If there is, you have made a non-linear, meaningful, perhaps magical connection.





*Use every signal as a potential portal  
for communication and conversation  
with the soul of the other.*



*Stan Tomandl and Ann Jacob*

Remain open to taking the “conversation” further and use every signal as a potential portal for communication and conversation with the soul of the other. For instance, if the person’s arm moves, even a little, you could say “Yes, that left arm is wise. Follow its movement. It will show you the way.” Provide plenty of positive encouragement, watching carefully to check if you are speaking the right language. If you notice that the patient’s arm moves more, his eyelids flutter, his mouth shifts slightly, he swallows, or water comes from his eyes, encourage him. You could say something like, “Ah, moving!” or “Feel what you are feeling as you move,” or “Water coming from your eyes.” These are examples of neutral terms, what we call “blank access words” to encourage open-ended exploration and awareness. If there are no changes, sit and wait for the next moment of possibility. There will always be another chance. Be aware, also, of when you need to take a break.

### *Pacing the Breath*

Pacing the breath is another way of working with breathing. Inform your client or loved one that you want to touch her, then place your hand on the back of her hand, wrist, shoulder, or ankle. At the next inhale, squeeze gently to meet the expansion of her inhalation. As she exhales, relax your hand while maintaining contact. As she inhales, squeeze again; as she exhales, relax. You can try this calming and centering practice on yourself first to get the hang of it and will probably find it draws you inwards. When practiced on someone else, it can deepen and amplify sacred connection.

### *Vocalizing*

Pacing the breath can also be done with sounds or sighs, even with patients on ventilators. If someone is moaning, you can moan with him, a little bit louder and longer. This helps him to perceive that you are willing and able to speak

his language. This is similar to what we do with young children learning language: We make sounds and pace our reactions in accordance with what they are expressing.

Sometimes incoherent sounds, offered back with compassion, are the feedback a person needs to make the thoughts inside her head come out in an understandable way. This was the case with one woman who had been speaking gibberish. After hearing her sounds lovingly reflected, she found a way to clearly say, “I’m ready now. May I go?” We were then able to respond directly,

“You can stay or you can go, whatever is right for you.” She took one more breath and left.

Following a stroke, a loving father we worked with could make only loud, raucous noises. His adult children were anxious that he was reacting to pain. We encouraged them to say their goodbyes and noticed that whenever someone said, “I love you,” their father let out a mountain-sized roar from deep within, his best attempt at echoing back, “I love you.” Pointing out our observation changed the atmosphere in the room from anxiety and fear to excitement, wonder, and closeness. The family stories of appreciation for their father’s life began pouring out.

After we had been breathing with a dying woman for a few breaths, she began to quiver and grimace. Her daughter’s first thought was, “Oh, she is in pain!” I responded by saying “I don’t know your mother. Is that how she looks when she is in pain?” in an attempt to slow the rush to “do something, anything.” With the daughter’s permission, I told her mother



what I was about to do, then placed one of my hands under the mother's elbow and the other under the wrist of the arm that had quivered. One technique in coma communication is to make contact with bony structures to allow the person to still move freely, even if she no longer has the strength to move on her own.

Thus supported, the dying mother began lifting her frail arms over her head. Her face was bursting with ecstasy, lighting up the whole room. Her eyes gazed attentively upward. The daughter, relieved and grateful to see her mother doing so well during her last moments on earth, envisioned her mother being greeted by the love of her spiritual guide.

There are so many ways we can be with the dying, joining with them, cherishing and connecting with them. Each moment is precious, and it is a privilege to be with all that is present: wonder, pain, love, joy—hearts beating together, even as one heart is stopping. 🌱

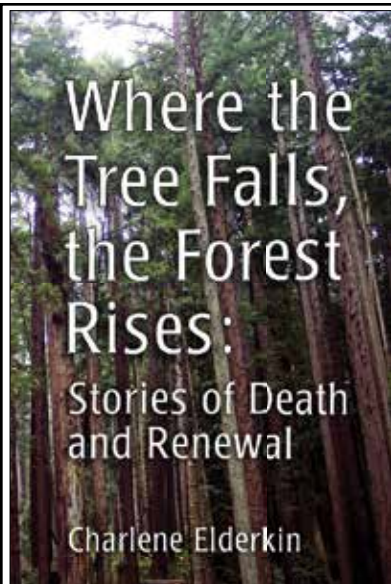
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*Ann Jacob is a coma communication counselor, consultant, and trainer based in Victoria, British Columbia, Canada. She works with her partner, Stan Tomandl. Ann and Stan serve on the faculties of the Sacred Art of Living Center and the Anamcara Project in Bend, Oregon, as well as participating as members on the Board of ComaCARE in Cape Town, South Africa. They train caregivers around the world in coma communication. Ann and Stan can be reached via their website: [www.comacommunication.com](http://www.comacommunication.com).*

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Charlene Elderkin is a hospice volunteer, a home funeral educator, a member of the National Home Funeral Alliance, and co-founder of the Threshold Care Circle. Find her online at [www.charleneelderkin.net](http://www.charleneelderkin.net); follow *charkin* on twitter.

## The Rocky Road of Liverpool's Care Pathway: A Program for the Dying

by Kate Granger

When staff at the Royal Liverpool Hospital and the Marie Curie Hospice first unveiled the Liverpool Care Pathway (LCP), they understood it to be a program to help medical professionals determine the best care for those with terminal illnesses, a framework for the provision of compassionate, dignified end-of-life care.

But beginning in 2009 and more recently, the LCP has come under fire. The “death panel” talk that marred attempts to promote hospice and advance directives for healthcare in the US, became the language of some within the UK press as well. Concerns mounted about the LCP approach, which can include the withdrawal of drugs, food, and fluids along with the administration of pain relief to those at the very end of life.

Newspaper stories raised questions about the competence and ability of physicians to determine whether a patient was actually dying. Poorly educated doctors were said to be making life and death decisions about patients. There were tales of doctors placing patients on the LCP protocol without discussion with either the terminally ill person or with family members. Hospital staff were accused of placing patients on the LCP to meet government-mandated targets (which included financial rewards).

In 2012, more than 85% of National Health Service hospitals had adopted the LCP. Despite the controversy, a survey by the *British Medical Journal* of more than 500 doctors found that 90% believe the LCP provide the best care for the terminally ill. Many organizations representing the interests of the sick and dying also defend the LCP, which is currently undergoing an independent review.

Dr. Kate Granger, a 31-year-old UK doctor with a rare form of cancer is one of the LCP's most vocal champions. Granger is a geriatric care specialist, author, and regular blogger on end-of-life issues. Below are edited excerpts from her blog.



I was horrified when I read an article in the *Daily Mail*, a UK newspaper, suggesting that the Liverpool Care Pathway was a way to kill people whom doctors deemed worthless. As a physician specializing in geriatric medicine, and as a terminally-ill cancer patient myself, I have strong views on these issues, both personally and professionally.

The LCP is accused of being a “backdoor form of euthanasia.” We, as doctors, are said to be using it for sinister motives to deliberately hasten our patients’ deaths. In reality, the LCP is simply a document we use when we feel a patient has entered the final stages of life, the last hours or days. The LCP prompts us to begin open discussions with relatives and, if possible, with patients, to stop unnecessary medication, to discontinue futile medical interventions, and to shift the focus of care to symptom control, comfort, and dignity.

We doctors are also accused of heavily sedating patients at end of life. This is untrue. We use small doses of medicines,

such as morphine or Midazolam, to help relieve the distressing symptoms of dying, such as pain, breathlessness, or agitation. Studies of the use of medication prescribed to patients on the LCP found very conservative doses were used and patients were certainly not “heavily sedated.” My intention when prescribing at the end of life is solely to relieve suffering, not to hasten death.

In my experience, most patients on the LCP are too poorly to eat or drink. In my hospital, when a patient is alert enough to swallow, we continue to offer food and fluids orally. Patients are not “starved to death,” as suggested in the press. If there are concerns about a patient suffering from thirst or if the family has strong views on the withdrawal of artificial hydration, sometimes we continue fluids subcutaneously. The problem with the continuation of intravenous fluids in these patients is that we must insert tubes into their veins in order to administer them, a procedure often very difficult and painful. Sometimes, it can be almost impossible to do this for patients who have been in hospital for weeks.

I know, when I reach the final days of my life, I do not want to suffer multiple attempts to insert tubes in me. I would much prefer good mouth-care to keep my lips and tongue moist.



The LCP is not a one-way road to death. One in ten patients initially cared for on the Pathway come off it because of clinical improvement. We as doctors cannot accurately predict the future in all cases, and much of what we do in palliative care is based on experience rather than hard science. Patients surprise us all the time. The key to the provision of good care is conducting regular review and keeping an open mind while we communicate the uncertainties about the progression of a patient’s illness.

When my time comes, I hope my care will follow the holistic, standardized LCP approach. I fully believe that the

LCP improves care at the very end of life and results in more “good deaths.” In my experience, patients on the LCP do not undergo futile treatments, they are more comfortable, and their relatives are well-informed and emotionally supported. This makes the grieving process that little bit easier.



To elaborate on the “death lists,” which family practitioners have been accused of keeping: These are more properly known as “end-of-life registers” or, in my area, the Gold Standards Framework (GSF). With patients who are frail or who have multiple health problems, or with people like me with life-limiting conditions, GPs ask themselves the “golden” question: “Would I be surprised if this patient died in the next year?” If the answer is no, they enter the patient on the register. The answer may spark a cascade of discussions about service provision and care. For example, patients may be asked about advance care planning. This includes important decisions such as choosing the preferred place of care for death. The vast majority of people say they would like to die at home. In reality, most people in the UK die in hospital.

My name appears on the GSF and I am extremely comfortable with this. Although I am currently well, working and living a full, productive life, a time will come in the foreseeable future when I am less well. I want to have planned properly for this time so that I can experience my end-of-life wishes. I believe that because I am flagged as a patient who will need palliative care services, I will be able to die in my own way. End-of-life registers are not about “singling out” patients to allow them to die. Rather they allow people at end of life to die on their own terms.



Resuscitation is a highly emotive topic in discussions about end-of-life care. As a doctor, I have witnessed numerous resuscitation attempts, and early on in my illness, I made it clear that I did not

want cardiopulmonary resuscitation if I experienced cardiac arrest. Only a tiny percentage of patients survive it, and it is a brutal, undignified way to die. An even tinier proportion of these patients leave the hospital alive. Even when it is successful in restarting someone’s heartbeat, it doesn’t take away their cancer or the underlying chronic disease. The panic and chaos surrounding a resuscitation attempt is horrendous. Regularly, ribs are broken during chest compressions, and because it can be difficult to access veins to give drugs such as adrenaline, patients are often stabbed multiple times with needles.

As a profession, we as doctors do not communicate well enough about resuscitation. It is a treatment, and we physicians are not obliged to provide treatments we feel are futile. However, it is important to convey this sensitively, so that our rationale is not misunderstood. In my experience most older people are quite happy to talk about it and do not want resuscitation.



Recently I have been contemplating why the furor about the LCP started. In the UK, we have been using the Pathway for years—so why now? I recollect that a few years ago, some eminent doctors criticized the approach in the national press, but after a couple of articles and brief disquiet, the debate simmered down. The issue certainly was not debated in every mainstream current affairs media outlet and politicized with numerous relatives stepping out into the arena to tell their own horror stories. As practicing clinicians, we continued to use what is considered the framework for best practice when delivering end-of-life care.

So what has happened in the last few years? The LCP itself has not really changed. Perhaps the document has been developed a little more, but the fundamental principles of care remain the same. Maybe it is society’s expectations that have changed. There remains a huge taboo about any open discussion

on death and dying despite the work of UK organizations such as Dying Matters and Good Life Good Death Good Grief. The taboo makes it hard for us to accept that not all illness can be cured. This can lead to much friction between health professionals and devastated relatives when a patient reaches the end of the line and there are questions about continuing active treatment.

Perhaps it is because the UK press loves to indulge in a little of what I glibly call “doctor bashing.” Perhaps some members of the media feel that sinister, ulterior motives underlie our work as end-of-life care physicians. In sowing these seeds of doubt that we as a profession should not be trusted, preying on society’s deep-seated fears about death, journalists create news stories that sell papers. More and more frequently, the perceptions prevail that monetary factors, pressures to make beds available, and lack of resources within the National Health Service—not the patient’s best interests—are the motivators to decisions by doctors. This view saddens me. I go to work primarily to look after people.

Perhaps pressure on the NHS in recent years has created such a time-deprived environment in some hospitals that communications have suffered. Perhaps families are not feeling as cared for and as informed as they should be, leading to misunderstandings about using an LCP approach. It takes time to communicate about the complexities and uncertainties surrounding care of the dying.

One thing is clear: The media’s irresponsible handling of the LCP story has placed us as clinicians in a difficult and worrying position. As a doctor, I hope that my relationships with my patients and their families are based on a solid foundation of trust, a trust that my role is to act solely in their best interests and to care for them. As a patient myself, I trust my own family practitioner and oncologist implicitly. But when the press and occasionally the politicians start to undermine this trust, we find ourselves in a place of darkness.






How can we change this? I believe that the real problem has nothing to do with the LCP itself. The solution is really very simple, although it might be difficult to achieve. When someone is diagnosed with a condition that will limit their lifespan—such as heart failure, dementia, or metastatic cancer—early, open, and honest discussion about the prognosis and care options is a necessity. This allows the patient to make choices and to have some degree of control over what will happen in his or her life. Investment in palliative care services early on when there is life-limiting illness allows highly-skilled professionals to become involved and will undoubtedly help promote discussions with patients and families.

One of the best illustrations of this approach is cancer care. A patient diagnosed with metastatic cancer is treated by an oncologist. Eventually, the

oncologist's treatments become futile and a palliative care team takes over, even for a relatively short part of the patient's care journey. In my clinic, the palliative care practitioner is there when the patient is first diagnosed, to work in partnership with the patient all the way. This scenario reminds me of something Dame Cicely Saunders, founder of the modern hospice movement, said: "You matter because you are you, and you matter until the last moment of your life. We will do all we can, not only to help you die peacefully, but also to live until you die."

When patients reach the point that the LCP is appropriate, they and their families will hopefully be well informed and more accepting of their situation. The patient's wishes will be well known, the holy grail of the "good death," within reach. The partnership with the palliative care team can work seamlessly into those final hours and days.

One of the reasons I have been so open about my own dying, both in public and in private with those I love, is that I believe openness is inextricably linked to achieving that "good death" and perhaps, more importantly, the "good grief" for those left behind. 

*Dr. Kate Granger is the author of The Other Side and The Bright Side. For more information, visit her website at [www.theothersidestory.co.uk](http://www.theothersidestory.co.uk). Her blog is [drkategranger.wordpress.com](http://drkategranger.wordpress.com).*

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# Being Present for Death: *A Homesteader Reflects*

by Cassandra Yonder

When its goat kidding season at our homestead, I manage to be present for most of the births (especially if it's a doe's first freshening). During my regular night checks when a pregnant goat starts to paw the ground, I know that labor has progressed, and I can usually be found settling down on a nearby bale of hay, wearing a snowsuit and drinking a cup of tea.

Most often my direct assistance is not required, but I believe that my presence is important. If it's really cold or multiple kids are being born in quick succession, I'll use a dry towel to help clean off the afterbirth. Sometimes I need to reposition or pull kids, and sometimes I need to wake my partner to help with an injection or some emergency stall reconstruction. But usually I don't do anything at all. I'm simply present, and everything occurs without words by the light of a flashlight or the moon.

People often tell me they'd like to see a baby goat being born. They ask me to call them when a doe is in labor so they can watch. Often it seems as if they're looking for an experience that fits their attention span, a drama that fits their preconceived notion of what birth is. What they don't understand is that being present for birth is not something you can schedule. Mostly it's just about staying with the ordinary, everyday rhythms of life, making sure all the animals are well fed, hydrated, and sheltered, monitoring the social dynamics of the herd, and noting if a buck is overly intrusive or a

*I think it is true that in not loving, one can protect oneself from the pain of grief.*

doe might need added privacy with her kids to prevent rejection. It can take days to ensure that all the kids are nursing properly, and even longer if I've decided to bottle-feed. Goat kidding season is a period of time, not a single moment.

Goat kids are the cutest and most persistent of creatures, and they do test my patience. But I love watching them learn to jump, buck, and play king of the castle. I don't disbud them with a hot iron (a practice of removing the horn buds so the horns do not grow). Nor do I put elastic bands around the males' testicles; I don't want them to feel unnecessary pain. I don't want them to suffer. I de-worm the herd and trim their hooves. I admire the doe's big, full udders. I watch the kids learn to graze.

When the goat kids are about eight weeks old, and when I feel they are ready, I wean them. For me this is the worst day of the year on the farm. I feel like a master of slaves as I carry each terrified kid to another barn as they desperately scream for their mothers. The combined worry, resignation, relief, and sadness that I imagine the mother goats are feeling only deepens my own heartache. They cry and call out to each other to a lessening degree over several days, during which time my own anguish dissolves into absolute bliss over the taste of the fresh milk.

I place bleached glass jars, stainless steel buckets, thermometers, cheesecloth, and spoons on accessible shelves in the kitchen, and soon, cheese and yogurt appear on our table. I find myself trading for fresh-baked goods and organic vegetables with rural neighbors. Ironically, I am unable to afford these items at the farmer's market or grocery store. Best of all is the wondrous gratitude I feel each time I kneel beside one of my goats in the barn and rhythmically squeeze streams of milk into the pail given to me by my deceased neighbor. Each doe has her own song, which I often sing at milking time. In some ways, this chore defines the life of our family, and we rarely take vacations. Milking the goats is "home."

When the first spring grass starts to go to seed, we move the kids to the summer grazing pasture with the horses. We fall





# on Animal Slaughter

into a regular rhythm of feeding, milking, and watering the goats, whose coats become glossy and smooth. Sometimes in the summertime, we have campfires in the field with them. By the time the frosts are regular and the surrounding red maples on the highland slopes begin their brilliant display, rutting season is upon us. The buck's perfume is in the air and he cackles and chortles, sticks out his tongue, and pees on his own beard. He uses every possible Pan-like strategy to display his fertility to the does, who become receptive to him in waves. Their milk has dried up by now, and they flag their tails when they are ovulating. Most will be pregnant again by October. Not long after that, we begin preparations for a Canadian winter, wrapping the footings of the old farmhouse in hay and plastic in the same way we do the animal shelters.

Vegetables and fruits have been harvested already, and now that the pasture is no longer productive, it is time to think about the livestock. I study the goat kids who weigh about 100 pounds at this point, and I know they will each yield about 50 pounds of meat. The best female kids are reintroduced to the main herd where they jostle for social rank and usually bond most strongly again with their mothers. Over the years, it is interesting to observe the relationships between the does since they are all aunts, sisters, nieces, and grandmothers to one another—all related in the matriarchal line, though the buck is replaced every few years to prevent inbreeding. I've known some does for as many as 15 years. They've provided us many kids and countless liters of milk, but now I must judge their productivity and decide if any will be slaughtered with this year's kids.

Those same friends who wanted to come over at kidding time now eye me distastefully and say, "I could never do that." I find myself in a strange, lonely

chasm between animal lovers who refuse to kill their own food, and farmers who refuse to name their meat. By that I mean that they protect themselves emotionally from the difficult feelings of killing an animal with which they have developed an attachment. I think it is true that in not loving, one can protect oneself from

*I find myself in a strange, lonely chasm between "animal lovers" who refuse to kill their own food and "farmers" who refuse to name their meat.*

the pain of grief. For sure, post-industrial farming methods provide the same service. People don't have to consider the life of the chicken that laid their eggs or the origin of that cellophane-wrapped steak. Since I myself choose to eat meat, I believe in participating in the processes that allow me to do so.

At just 38, I'm not part of any back-to-the-land movement. I was raised in an urban environment and experienced

an upper middle-class education and opportunities. I didn't know what a homesteader was until I became one. My desire to become engaged with the production of my own food is the result of a personal investigative process toward self-sufficiency that makes me feel as if my integrity is intact. The alienation

I used to feel from the food I ate made life seem empty and meaningless. I thought it was possible to live

without harming others because layers of consumer culture veiled the harm I inflicted. In other words, I was paying a professional to do my "dirty work" for me. Living on a farm has taught me that every living thing takes from others in order to survive. That is far from a shameful thing; it is a joyful affirmation of life.

This rationale for life on our farm doesn't lessen my sadness during the





days leading up to slaughter. I attempt to communicate with the goats about what is going to happen, and while I don't think they understand me, I do think they trust me more because of my attentive explanations. It is a trust that is betrayed when I catch a goat and lead it to a small pen alongside the main one. We give it some grain, and when it is distracted, my partner lowers a gun onto the back of its head behind its horns. He aims carefully toward the lower jaw and pulls the trigger. At that point, the goat usually falls to the ground, stunned, and I do something for which I have no logical explanation. It is just something I do and have done my entire life with hundreds of animals at my dad's veterinary clinic while I was growing up. I did it with wild birds and the animals I had raised

that didn't make it, with my handsome "Gramps" on his deathbed, with clients at nursing homes and hospitals, with my neighbor who died unexpectedly at home one day, with countless animals we have reared, and at this moment in the autumn, when we slaughter a goat kid who I probably so tenderly helped to nurse just nine months earlier. This thing I do can best be described as "nothing." Yet it is the very thing upon which I presently build my private practice in death midwifery. It is a simple offering of conscious presence, a willingness to show up for the hard as well as the easy parts of life.

Many homesteaders believe that showing respect for an animal one is slaughtering involves some kind of reverent protocol.

As a culture, we seem to expect ourselves to feel solemn when killing a large animal, indifferent when killing a small one, primal when killing a deer, vengeful when killing an insect, and joyful when killing a carrot. No wonder so many of us are confused and intimidated at the bedside of our loved ones who are dead or dying! We lack meaningful ritual because we are alienated from death and dying. We equip ourselves with information but lack visceral involvement with death. By familiarizing myself with death in this physical and tangible way, I've learned that authentic presence is all I really have to offer, and that authentic presence is more than enough.

When one of my beloved goats has fallen from the bullet, I am nowhere else. Sometimes I cry. Usually I pet the goat and tell it how good it is, or just do whatever seems comforting while my partner slits its throat and the blood drains out. There really is no special skill required besides making myself available to do what seems right at the time. I stay present to the ordinary, everyday rhythms of life, making sure all the animals are well-fed, hydrated, and sheltered, and I monitor the social dynamic of the herd. I intend not to cause unnecessary suffering and continue to grapple with what that might mean. I observe the uniqueness of dying and have come to respect that, sometimes, physical pain is part of that natural process, even though I try to prevent it. I've developed a sense of trust that each individual finds the death that is right for him or her. I recognize that, like birth, death is not a singular moment in time. I do for the goats just what home funeral guides and death midwives do for human families at the time of death and afterward, and what birth midwives do for families at the time of birth. It's part of an ancient tradition.

The mood changes after death has occurred. The disposition of the body feels like a new chapter in a book. On the homestead this new chapter is defined by gratitude, and that is how I feel when we hang the goat's lifeless body in a nearby tree and begin to gut it. Gratitude soon gives way to fascination, even after all these years. My job is to flesh the hide to store for later tanning with the animal's



brains. By then, my partner has sorted all the internal organs and is quartering the carcass. Meanwhile, our children are getting cranky from boredom. One day, I hope we'll have a nice barn kitchen with state-of-the-art meat cutting saws and grinders. But now it is a labor of love, undertaken in the old farm kitchen with knives and small cutting boards. My partner usually outlasts the rest of us and is up until the wee hours of the morning, cutting the muscle into ever-smaller chunks, then storing it in bags and loading it into the freezer.

Surprisingly, I am not a good cook. I joke that I do my cooking in the field by caring for the animals. My partner can claim the satisfaction of filling our family's bellies with nutritious, curried goat meat, which he likes to serve with organic onion, garlic, and potato for which we've traded yogurt with a nearby farm and the fiddleheads we collect from the North River basin. The goat meat is topped with the crumbled queso blanco I make by curdling hot goat milk with vinegar. Before sitting down together for a leisurely meal, we wash our hands with our soap, made from the tallow from our pigs and goats. Although our lives are busy, we are present to the food, in the same way we are present to birth and death. This is our way of life.

Developing a relationship to my food has allowed me to understand why a willingness to participate in death care—to be present for death—gives meaning to life and helps cope with grief. When we engage on only a cognitive level, we cease to feel. At death, paying someone else to provide care is different than doing it oneself. The challenge is as much about developing specialized skills as it is about being present—simply showing up, in person, ready to do nothing at all. 🌱

*Cassandra Yonder is a death midwife who offers death-care education, home funeral guidance, and bereavement support from her remote homestead in Cape Breton, Nova Scotia. She is a board member of the National Home Funeral Alliance, as well as the burgeoning Canadian Organization for Death Midwifery. Her website is [www.deathmidwifery.ca](http://www.deathmidwifery.ca).*



*Cassandra Yonder working on a goatskin*

***This thing I do can best be described as “nothing.” It is the very “thing” upon which I presently build my private practice in death midwifery.***



## Saint Francis at the Bedside: Kate's Story

by Loraine Johnson

Kate's casket sat in the room adjoining her bedroom at Swallows' Nest, her rural Nova Scotia home. It served as an altar for her up until she died at age 41 from ovarian cancer. Handcrafted by her close friend, Jan, it was pine with inlaid applewood hearts and cherrywood hummingbirds for latches. A local blacksmith added the iron handles after Kate died.

Kate's world began to shrink in early 1997 as spring lightened the world outside. Window shades were drawn when the light became too intense for her. In the last year of her life, she dealt with her personal directives, her will, and her wishes for her death care. She planned parts of her memorial service and designed an elaborate 5ft. headstone, inlaid with glass irises. Upon it were inscribed her deeply held beliefs: God doesn't fit into one religion; I may be gone, but I will be in your heart forever.

I remember getting ready to go to my first shift as her overnight caregiver after teaching a yoga class and being suddenly gripped with fear. It was fear of the unknown that surrounds death. All I could see as I cast my thoughts in that direction was black. What if she died while I was there? I calmed myself

by remembering that death is a natural process and nothing to fear.

During my time caring for Kate, I was simply present with her on her journey. It felt so normal, although some amazing spiritual visitations began to occur as death drew close. Kate had a big cement statue of Saint Francis at the foot of her bed, and she saw it move back and forth. One day the disciples of Saint Francis came to visit. She asked me, "Raynee, do you see them?" The threshold veil kept them shaded from my view, but I have no doubt Kate saw them.

These experiences brought Kate great comfort as did resources such as the *Tibetan Book of Living and Dying* by Sogyal Rinpoche, the Lord's Prayer, poems by Rumi, as well as various anthroposophical texts.

Shortly after her diagnosis, Kate had attended Joan Halifax's course "Being with Dying," to prepare for her transition. Roshi Halifax had passed on the Rumi poem, "Garden Beyond Paradise," which Kate especially treasured:

Behold the body, born of dust – how perfect it has become!

Why should you fear its end?

When were you ever made less by dying?

One chilly night, a couple days before she died, I was staying over to care for her. I was in bed next to her, wearing thick bed socks and a layer of extra clothes. I was under layers of blankets, but I still felt cold. Kate, on the other hand, was very hot.

We both fell asleep, until she woke me asking, "Can I hold your hand?" in a voice that did not sound like hers. As we lay there in the stillness, she reached out for me with her right hand. I wondered if I was dreaming. I felt heat slowly flowing into my left hand, up my arm,

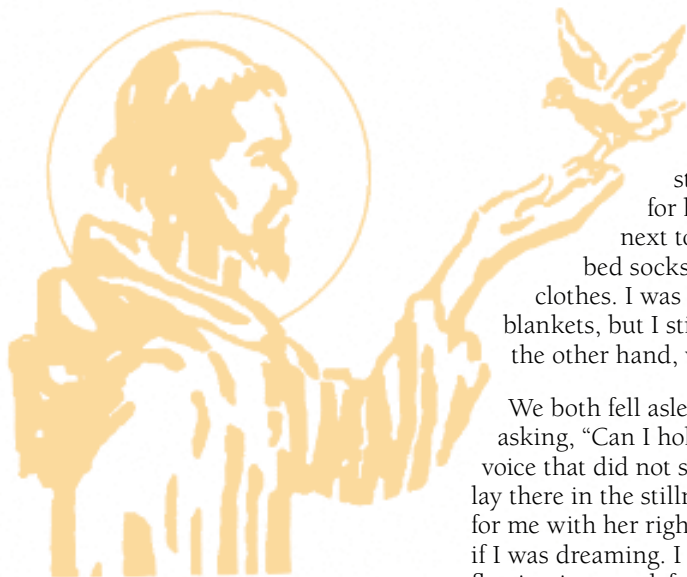
and penetrating my whole body. Careful not to move much, I peeled off the socks and tossed off some of the blankets. Then I felt her body go cold and her spirit slip away. I thought, "She's died. What do I do now?" But I was so comfortable. There didn't seem to be a need to move and I soon fell asleep. I was shocked when she awoke the next morning and said, "Isn't that amazing?"

The next night, lying in bed, Kate was again very hot and I was chilly. We both said some prayers and drifted into sleep. In the middle of the night, I woke from a dream. Kate's body and mine were very close, and I remember thinking in the dream how weird it was that her body was so emaciated. I wondered how this change could have happened to her. Then she spoke again in that strange, far-away voice:

"My heart  
My home  
My father  
I am going now  
Goodbye."

I said "goodbye" and felt her presence slip away. Again, the experience was so comforting, I fell back to sleep. The next morning we both woke up with the same thought that she expressed: "That was amazing." I asked her what she was referring to and she told me she had gone to heaven and come back. I asked her what that had felt like, and her only comment was, "Like in the books." I immediately thought of the book, *Goodbye from Heaven*, which someone had recently given her. I didn't press her for any further information. To this day, I don't know why.

Early the morning of Saturday, May 27, 1997, I felt strongly that her time was near. With each passing moment, her voice faded more and more. Her close circle of friends arrived to sit vigil during the day. I returned to her bedside early that evening, after lighting a beeswax candle at her shrine to Mother Mary and Jesus, Saint Francis, and other spiritual teachers.



I had just seated myself beside her when she took her last breath. Those gathered around spoke prayers, smudged sage, and closed Kate's eyes. A close friend and I kept vigil until sunrise.

Then five women friends prepared the body. I had assembled a basket of items for that moment. We anointed Kate's hair with infused sage water, as Cherokee teacher Dhyani Ywahoo had advised in a letter to me. We then shampooed her hair and spritzed her body with rose water (which, as an aromatherapist, I consider the fragrance of the heart). We cut one of Kate's favorite dresses at the back to make it easier to put on, and when she was ready, we carried her to her casket. It had been padded with pillows and strewn with rose petals. We washed her bed down with rosemary water to lift away any spirits.

During the 30-hour vigil with Kate's body, friends and family played music, recited poetry, and danced. A small oversight—we had forgotten to notify the family doctor who would pronounce her dead and sign the death certificate. Kate had requested a closed casket, but we had to open it for the physician when he arrived.


At the end of the vigil, we encountered another challenge when we tried to get the casket out of the house and to the memorial service at the church. It wouldn't fit through the door. We had

to remove the door and the frame and ease the casket out slowly. Home funeral advocates, take note: It's better to figure out the route before hand!

Kate's body traveled to the cemetery in a borrowed station wagon with the back open because the casket wouldn't fit otherwise. At the cemetery gate, her family and community of friends formed two rows a few feet apart so everyone could touch the casket and pass it along to her gravesite. One friend later said, "Touching that casket helped to demystify death for me."

After the graveside service, a few women friends took up shovels to fill in the grave. A garden now grows there, and a stained glass cement bench allows us to sit and marvel at her magnificent headstone.

After the service, I sat on the grass outside Kate's house, gazing into the blue skies. Out of nowhere, an eagle appeared directly overhead. Then another seemed to morph out of the first. And finally, a third circled above. The three magnificent birds came together, then parted and glided on. A week later, I inherited an orphan crow. In Native American tradition, crows represent the magic and mystery of death. I felt this crow had taken on the spirit of Kate and I named it Aireala. She was a balm for my grief, doing silly things that made me laugh and reminding me that life goes on.

The hands-on experience with Kate's death care opened me to both these messages, and lifted the darkness and fear of transition. 



*Rayne (Lorraine) Johnson is an educator on life and death matters, a transition coach, and advocate for integrative contemplative practices in end-of-life care. You can contact her at [www.infiniteearth.com](http://www.infiniteearth.com) or [www.tearcups.com](http://www.tearcups.com). She resides in Edmonton, Alberta, Canada.*

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## Connecting with the “So-called” Dead

by Cheryl Sanders-Sardello

*“You have tasted of death now,” said the Old Man. “Is it good?”*

*“It is good,” said Mossy. “It is better than life.”*

*“No,” said the Old Man, “It is only more life.”*

– *The Golden Key*  
by George MacDonald

In our class “Caritas: Caring for Those Who Have Died” at our School of Spiritual Psychology, questions are often raised about the “so-called” dead, a term from Rudolf Steiner. He knew that our reference to the “dead”—those who have crossed a threshold between one kind of life and another—mis-speaks the actual condition one moves into at the moment of leaving the physical body. More than half of the more than 6000 lectures Steiner gave, directly or indirectly address the metamorphoses of the human soul/spirit at the point we typically call death.

Many people have a sense of the continued existence of soul versus simply blinking out of existence. And yet we do not live as if we will always be living entities. Instead, in some way or another, we subscribe to the fantasy that we are just here for a short time and should therefore get all we can for ourselves before we are gone. It is this almost unconscious belief that creates the ground for such utter grief when a loved one dies. We are not sure what has become of them—if they are okay, if they need us or even remember us. The questions become even more intense when one loses a child or when someone dies unexpectedly before us.

Grief is peculiar. It involves the physical body so completely that we are often overwhelmed and cannot process what has occurred. It can completely take over. For a long time, life can seem to have no meaning. When we can become aware of feeling as well as how we are swept bodily away by it, then we can follow grief into a vast teaching. If we become emotionally trapped, however, we are simply trapped.

The essence of staying connected to the so-called dead, however, lies in this very distinction between feeling and emotion. Simply put, the “feeling” is a conscious soul-awareness of the one who has died, and the “emotion” is our bodily identification with loss. As the word itself suggests, feeling involves both us and something “felt”—the presence of the soul/spirit of the one who has died. Our feeling is also that which surrounds us, informs us, guides us from the seen and unseen realms.

Emotion, on the other hand, is a state in which we are cut off from the wholeness of earthly and spiritual participation and are contracted solely into feeling itself, rather than experiencing our soul-unity with the one who has died. Hence, emotion often traps us. Our perception is not able to penetrate the subtle realms where the so-called dead seek our participation.

***Their efforts to stay connected with us can be perceived only by the heart’s capacity to enter into contemplative and prayerful silence.***

These subtle realms are of a complete and utterly alien nature to us in the physical world. Everything in the world inhabited by the so-called dead is a reversal of what we know to be real here. But we must not think of their world as lacking. If we can think and imagine it spiritually, we can be with those who have died on their own terms.

When we look for signs of the presence of the so-called dead, we are looking for something recognizable to us from our point of view. And yet, these beloveds who have entered other regions of life are actually sending us hints of their presence all the time. Their efforts to stay connected with us can be perceived only by the heart’s capacity to enter into contemplative and prayerful silence, and by radical listening and observing without expectation or judgment.

Within our souls, the so-called dead are constantly pressing, leaning toward us, bearing us along. They are ever-present with us. They never leave us. Rather it is we who move away from them. When we think of them, it is because they are thinking of us. When we long for them to be near, to touch or hold us, it is because they are longing for us first. Every time we think of a beloved who seems to be gone, we are receiving his or her heart’s connection to our heart.

All human beings are born with a capacity to “live in the heart.” In our current culture, we do not naturally live this way, but rather in the rational, logical thought processes that we are taught are the most efficient and effective ways to succeed in a competitive world. Heart forces arise occasionally, perhaps in times of challenge or hardship or loss. But the assumption is that we are to get over or through our difficulties as soon as possible, so we can keep going. This limits our ability to stay connected to those on the other side of the threshold. It is not that we should remain in a traumatized state all the time in

order to foster spiritual connection, but rather we should remain awakened to the heart’s feeling in connection with that which is greater than our narrow self-interest. From this place, the presence of those we think of as lost becomes more of a reality that we can feel.

When we remain more closely connected to silence and live the prayerful life of the heart, the presence of those who have died arises in our feeling life. We can then begin to communicate, in deepest reverence, with those who penetrate our very bodily awareness with their love and assurance. The presence of the other is beyond proof or explanation. It lies in the quiet, contemplative heart that is receptive to feeling and free from overwhelming emotion. The moment of going to sleep, the moment of awakening, before the chatty brain takes over for the day’s events—these are the bodily





“Rebirth” – Watercolor by Kate Mortimer

given moments of a contemplative nature. These are opportunities to develop an inner knowing of the presence of the so-called dead. The notion of invoking, calling up, awaiting a spiritual presence to attend our demands is the ego’s presumption. We must listen. In the silence of the heart, we can create a space for this by stilling our egocentric grasping. Then we can perceive that the ever-present, ever-faithful so-called dead are with us.


It can be a simple and ordinary matter to notice the presence of the so-called dead. A smell might bring an entire season of

***Within our souls, the “so-called” dead are constantly pressing, leaning toward us, bearing us along...***

joy and togetherness to the heart. A small, insignificant object might awaken us to a series of events from the past. These are the easy signposts the so-called dead offer

our aching hearts. More often there are more subtle coincidences that we brush off or, worse, do not even notice. For example, a few weeks ago, a dear friend crossed the threshold prematurely. The unexpectedness caused enormous grief and some confusion that reverberated throughout the School of Spiritual Psychology.

At the time of our friend’s transition, there was a class in attendance. We were all outside to prepare a biodynamic formula to apply to the land. As we all stood in a circle, diligently stirring the preparation, someone noticed an unusual presence across the field. A silver fox, not normal for this neighborhood, was crossing the land. It had stopped to observe our small group and stood calmly staring for some minutes before slipping into the woods. The heart recognized the drawing near of our dear friend, who wanted so much to be with us, but decided it was not a good time. And yet, there she was, without a doubt. Not to have recognized her would have been cruel. Not to have rejoiced in her appearance would have been a great loss.

The realm of the so-called dead is filled with giving. It graces the world of the living with the faith that our realms are not separated by an abyss. Each world exists for the spiritual furtherance of the other. Through reverent, heartfelt presence with those who have died, we inherently help them find their way. Those who have died are deeply interested in our lives and to what extent we permeate them with spiritual presence. The so-called dead want to know how open we are to fostering connection with the spiritual world. 

*Cheryl L. Sanders-Sardello, PhD, is co-founder and co-director of the School of Spiritual Psychology in Benson, NC. For further information please contact [www.spiritualschool.org](http://www.spiritualschool.org).*

## Book Review

### The Amateur's Guide to Death and Dying: Enhancing the End of Life

by Richard Wagner, MDiv, PhD, ACS

Reviewed by Lee Webster

What does it mean to die a good death? Sure, we all have a fair idea of the self-explanatory concept, but have we really thought out the nuts and bolts of it? Have we taken the time or made the effort in a clear, compassionate, and all-encompassing way to envision our own end or the end of a loved one?

*The Amateur's Guide to Death and Dying: Enhancing the End of Life* is not a book for a good night's read, cozying up to the fire. In fact, it's not exactly a book at all in the conventional sense.

Wagner begins by introducing the reader to ten characters who make up an imaginary death and dying support group. Each has his or her own baggage, concerns, fears, and life experiences.

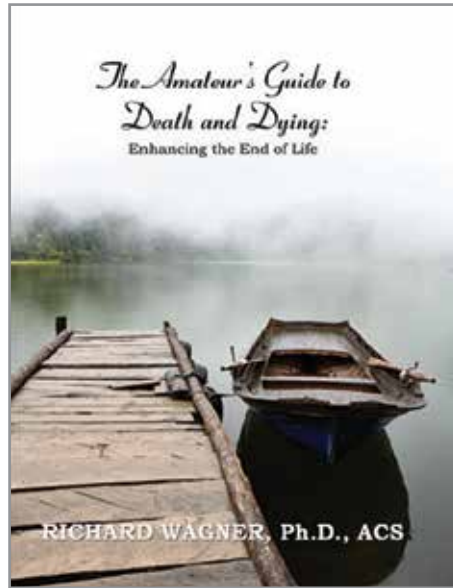
In ten weeks—ten chapters—each expresses valuable and, at times, uncomfortable thoughts and feelings to the group, while exploring the issues of death and dying.

Wagner then invites the reader to participate in the virtual group, to write in an included workbook, and do check-ins, exercises, and homework that have been designed to stimulate the reader's personal thoughts and observations while sharing in the struggles and epiphanies expressed by characters in the book.

For many of us, the prospect of facing our own mortality and that of those we love within a real group setting would be excruciating. *The Amateur's Guide* makes a fictitious group event into a supported solitary pursuit, allowing the reader to wade through difficult emotional waters at his or her own pace, and to linger with thoughts and insights while simultaneously "observing" the reactions of other participants in the group—all on paper. It's a unique approach to self-exploration within community.

"All of this," Wagner writes, "is designed to help make the end of life less of an intimidating process and more of a rich, poignant transition."

Written in an engaging, deeply human style, the characters come to life through both burdens and revelations. They remind us of the vastly different roles our families play in forming our outlook and capacity for internalizing and coping with our own deaths. They remind us that our historical and cultural context has formed our attitudes towards death and that a renegotiation is required if we are not comfortable with the prevailing messages.




They remind us that as much as we say we live in a death-defying culture, we spend an awful lot of time flirting with death. And that love becomes the intrinsic focus of the death experience—whether love is or was present becomes paramount in defining our relationship to death, both personally and universally.

There is no limit to the reminders provided in this book that will potentially bring readers into sharper consciousness regarding mortality and, more importantly, help integrate a deeper understanding of death into our waking lives through faithful participation in this valuable process.

The many practical (telling someone where to find the keys) and spiritual (are you in a right relationship with yourself, friends, family, God?) topics are presented to help center the reader on what is important in the moment to mindfully prepare for death. The exercises Wagner offers are worth the time and effort. After all, what other resource is likely to provide an opportunity to write your own obituary?

### About the Author

Richard Wagner's experience as a clinical psychotherapist and former Catholic priest compelled him to create Paradigm Programs, Inc., through which he provides outreach to the terminally and chronically ill and the elderly. He also designs training seminars for professionals in death-related fields and for those in contact with the dying. Wagner is also the only known Catholic priest with a degree in human sexuality and who writes a syndicated sex advice column. 



*Lee Webster writes from her home in the White Mountains of New Hampshire. She is a frequent public speaker on the benefits of home funerals and green burial, a freelance writer, conservationist, gardener, quilt maker, and hospice volunteer. Contact Lee at [turningleafhomefunerals@gmail.com](mailto:turningleafhomefunerals@gmail.com).*



*As Above, So Below*

Kate Mortimer (1955–1997) was a Canadian Waldorf teacher who painted out of a deep passion for her spiritual life, family, friends and community.

## The Weaver

My life is but a weaving  
Between my Lord and me;  
I cannot see the colors  
He worketh steadily.

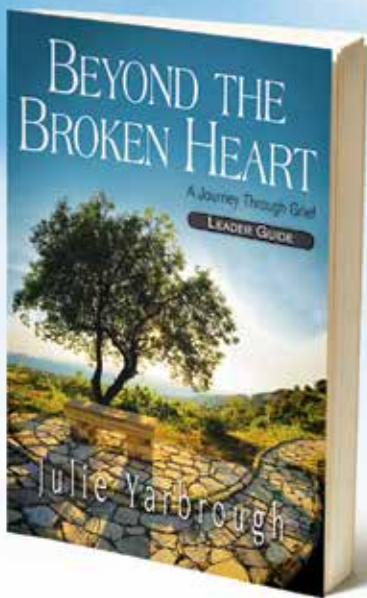
Sometimes He weaveth sorrow,  
And I in foolish pride  
Forget he sees the upper  
And I the underside.

Not 'til the loom is silent  
And the shuttles cease to fly  
Shall God unroll the canvas  
And explain the reason why.

The dark threads are as needed  
In the Weaver's skillful hands  
As the threads of gold and silver  
In the pattern He has planned.

*NTM is grateful to Megan Carnarius for the words to The Weaver, a traditional Scottish or Irish prayer of unknown origin. Carnarius has set them to music and has sung "The Weaver" often during times of overwhelming difficulty.*





## CULTIVATE NEW LIFE FROM A SEASON OF GRIEF

A Grief Support Program for Your Church

### Beyond the Broken Heart

A Journey Through Grief

by Julie Yarbrough

How does the heart understand grief when it is broken by the death of a loved one? To survive and live forward, those who grieve must find answers. This 8-week support and ministry program is crafted for those who are grieving the loss of a loved one. Julie Yarbrough chronicles her own experience combined with a love of Scripture and years of leading grief support groups to create an authentic and deeply personal exploration of the grief journey.

*"I highly recommend this remarkable grief ministry program to you."*

—James W. Moore

Pastor in Residence

Highland Park United Methodist Church

Dallas, Texas

### PROGRAM COMPONENTS

#### Participant Book

Includes stories from the author's own journey through grief, help for navigating grief, Scriptures, and questions for personal reflection with space for journaling.  
9781426744372.

#### Leader Guide

Includes outlines for 8 group sessions, plus 2 supplemental sessions on the holidays and personal finances.  
9781426744365.

#### DVD

8 video segments featuring the author and a licensed professional counselor.  
9781426744396.

#### Boxed Kit

Includes a Participant Book, a Leader Guide, a Daily Devotional, a DVD, and a preview book.  
843504027896.

### RELATED RESOURCES

#### Daily Devotional Book—*Beyond the Broken Heart:*

*Daily Devotions for Your Grief Journey*

One year of devotions with daily meditations that include a Scripture, a thought to consider, a prayer, and words of assurance. Includes space for journaling.  
9781426744389.

#### Preview Book—*A Journey Through Grief*

An affordable pocket-sized gift book that pastors can give to the grief-stricken, offering comfort as well as spiritual and practical guidance for the journey through grief.  
9781426745102.

#### The Original Book—*Inside the Broken Heart:*

*Grief Understanding for Widows and Widowers*


This standalone book offers spiritual and practical guidance for the grieving process.  
9781426744440.

### About the author:



**Julie Yarbrough.** Inspired by her personal experience after the death of her husband, Dr. Leighton Farrell, senior minister at Highland Park United Methodist Church for many years, Yarbrough established a support group for widows and widowers and began writing for persons who are grieving. She is president of Yarbrough Investments and lives in Dallas, Texas.

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