



Death and Dying in the Contemporary United States: What are the Psychological Implications of Anticipated Death?

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Abstract

Over the last 200 years, where, when and how Americans die has changed dramatically. Throughout the 19th and early 20th centuries, most deaths occurred with little warning, typically due to short-term infectious diseases. In the contemporary United States, death typically happens to older adults following a long-term chronic illness. Most older adults die in institutions rather than at home, and many rely on life-extending medical technologies. For most older Americans, it is more useful and accurate to conceptualize the end of life as an anticipated and protracted process (i.e., dying) rather than a discrete and sudden event (i.e., death). In this article, I summarize historical and epidemiologic patterns of death and dying, and describe the implications of these patterns for two psychological processes: preparations for one's own end of life; and psychological adjustment to the death of a loved one.

Death is one of life's few certainties. All individuals will die, and all persons with loved ones will eventually become bereaved. Although death is a universal experience, the nature of death and dying has changed dramatically throughout recent history, and these changes have important implications for how individuals think, feel, and act. Prior to the 20th century, deaths typically occurred in infancy, childhood, or young adulthood, due primarily to short-term contagious illnesses, crises, or violence. Deaths were unexpected and sudden (Aries, 1981; Mitford, 1963). In contemporary society, death may strike at any point in the life course, yet the vast majority occurs to older adults. Nearly three-quarters of the 2.4 million deaths in the United States in 2010 were to persons ages 65 and older (Federal Interagency Forum on Aging-Related Statistics, 2011; Kochanek, Xu, Murphy, Minino, & Kung, 2011). Most late-life deaths occur following a prolonged period of chronic illness, discomfort, or cognitive impairment, and the dying patient often has received direct care from a loved one, or has spent some time in a health care institution (Carr, 2003). For most older adults in the contemporary United States, the dying process is protracted and anticipated, occurring after a long-term chronic illness – often an illness that is least partly related to controllable factors such as diet, exercise, or life style.

The contemporary context of later-life death has important implications for a range of psychological and interpersonal processes. Rather than “denying” death (Becker, 1981; Kellehear, 1984), individuals may acknowledge and explicitly prepare for practical, emotional, and spiritual aspects of their own death (Greenberg, Pyszczynski, & Solomon, 1986; Martin, 1999). Family members may use the time between their loved one's diagnosis and death to prepare practically and emotionally for the death, yet may also experience grief and distress during this period (Carr, House, Wortman, Nesse, & Kessler,

2001; Rando, 1986). In this article, I trace cultural and demographic patterns of death and dying from the 19th through the 21st centuries, and describe the implications of contemporary ways of dying for two psychological processes: preparations for one's own end of life; and psychological adjustment to the death of a loved one.

An Historical Overview of Death and Dying in the United States

The social, epidemiologic, and demographic contexts of death have shifted dramatically over the past two centuries. In the 19th century, death was often public and visible. Death tended to occur at a relatively young age, at home. The loss of a loved one was expressed by dramatic displays of grief among survivors, and elaborate efforts to memorialize the deceased (Aries, 1981). Throughout the late 19th and most of the 20th century, death became "invisible" (Aries, 1981) and "bureaucratized" (Blauner, 1966). Physicians and hospitals assumed control over dying, death and mourning became private, the handling of dead bodies and funeral rites were transferred from private homes to funeral parlors, and people were encouraged to deny the inevitability of death and stake their hopes on the promise of nascent medical technologies (Blauner, 1966). Treating dying patients in isolation was believed to help smooth the transition beyond death; reducing the social status of those who were about to die would minimize disruption of social and economic relationships.

In the late 20th and early 21st centuries, death has again become "visible" and the dying process is increasingly controlled by ill patients and their families. Widespread recognition that dying often is a socially isolated, physician-controlled experience has triggered a number of efforts to promote patient and family autonomy. The Patient Self-Determination Act, passed by Congress in 1990, requires all government-funded health providers to give patients the opportunity to formally articulate their end of life treatment preferences (via an advance directive) when admitted to a medical facility.

The hospice movement, which began in the United States in the early 1970s to promote palliative care (or "comfort care") at the end of life, also has grown in popularity, with the number of sites increasing at about 3.5 percent a year during the first decade of the 21st century (National Hospice and Palliative Care Organization, 2010). Although three-quarters of adults still die in hospitals or nursing homes, the use of both in-home and in-hospital hospice services has increased. Pain management, open communication among family, patient, and care providers, and a peacefully accepted death are core goals of hospice (National Hospice and Palliative Care Organization, 2010). Bereavement and terminal illness support groups, both in-person and on-line have flourished, and courses on financial and medical preparations for the end of life are regularly offered by hospitals, community centers, assisted living facilities, and other organizations that work with elderly populations (Kiernan, 2006).

The epidemiology of death also has changed dramatically; "lifestyle-related" or "man-made" diseases have replaced infectious diseases as the leading causes of death (Olshansky & Ault, 1986; Omran, 1971). In the 19th and early 20th centuries deaths occurred primarily due to infectious diseases, such as diphtheria and pneumonia; death occurred relatively quickly after the initial onset of symptoms. Infectious diseases typically resulted from unsanitary living conditions, and were not stratified by social class, gender, or lifestyle, although the young and old were particularly susceptible (Preston & Haines, 1991).

In the latter half of the 20th and early 21st centuries, by contrast, most deaths are due to chronic illnesses that strike late in life, such as cancer, cardiovascular disease (CVD), and chronic obstructive pulmonary disorder (COPD) (Kochanek et al., 2011). Death

typically occurs at the end of a long, often debilitating, and painful illness where the dying patients' final days are spent in a hospital or nursing home, and life-sustaining technologies are used (Federal Interagency Forum on Aging-Related Statistics, 2011). Chronic diseases tend to strike older rather than younger adults, men more so than women, persons with fewer rather than richer economic resources, and those with unhealthy rather than healthy lifestyles. Omran (1971) characterized the current era as the age of "man-made diseases," because diseases such as cancer and CVD are linked partly to personal risk factors such as smoking, drinking, diet, and both personal and environmental stressors.

These epidemiologic shifts have been accompanied by transformations in cultural beliefs about risk and mortality. In the 19th and early 20th centuries, the widespread occurrence of infectious diseases and epidemics created a "shared sense of vulnerability." Epidemics had a rapid onset and a widespread impact, creating the "perception of a world not clearly under human control" (Brandt, 1997: 54). Efforts to curb the spread of contagious diseases, through medical intervention, sanitation, or quarantine usually failed. Death was widely believed to be beyond the individual's control. Although personal traits such as "constitution" or heredity were viewed as risk factors, personal choices and moral character seldom were indicted as a "cause" of disease (Rosenberg, 1989).

In contemporary western societies, by contrast, health risks are regarded as "acquired" via personal choices and behaviors (Crawford, 1987: 98). Individuals regularly receive and internalize messages from the media, health care providers, family members, and peers that their personal choices about diet, smoking, exercise, alcohol consumption, work conditions, and even emotional responses such as worrying, may contribute to their health and, ultimately, to their risk of death. These changes have created a context where individuals may hold themselves or their loved ones responsible for a death. For example, bereaved persons whose late spouses engaged in unhealthy behaviors such as smoking and drinking believe that the decedent partially contributed to their own death – an attribution that makes the bereavement process more difficult (Carr, 2009). Individuals also may blame their health care providers or loved ones for the death, an attribution that triggers anger, hostility and problematic adjustment to loss (Carr, 2003, 2009).

Taken together, historical and epidemiologic research reveals that contemporary death occurs in late life; is a protracted process often punctuated with discomfort for the patient and distress for loved ones; and is perceived to be at least partly under the control of the individual. Each of these patterns has important implications for psychological and interpersonal processes; individuals have both the time and the mindset required to think about, anticipate, and prepare for their own death; and bereaved family members are exposed to a range of stressful and protective factors during the dying process that affect their psychological well-being both prior to and following their loss.

Preparations for One's Own Death

Scholars have frequently asserted that individuals in contemporary western society "deny" or fear death, and these fears may lead to inactivity and alienation (Becker, 1981; Kellehear, 1984). Others counter, however, that the prospect of impending death motivates individuals to assume responsibility and seize opportunities that life offers (Frankl, 1963; Martin, 1999). Philosophical writings notwithstanding, most empirical studies show that adults often do take steps to prepare for the end of life, to the extent that their physical, emotional, cognitive, and financial capacities allow. Because the dying process usually occurs in later life and is marked by chronic illness, many older adults and their family

members are cognizant of the fact that death may occur in the not-so-distant future (Zimmermann & Rodin, 2004).

Dying persons may choose to assert and even preserve their identities and preferences in a variety of ways; I will focus on two. First, adults may use formal advance care planning strategies to exert control over the medical treatments they receive, in the event that one becomes mentally incapacitated and unable to state their preferences at the moment the decision is required. Second, individuals may use both private and public strategies to ensure that their “self” persists after death, whether in memory, through formal rituals and legacies, or through bequests to loved ones and charitable organizations.

Advance care planning

Mounting research explores how dying persons and their families make decisions about the type, site, and duration of care they want to receive at the end of life. Both philosophical writings and empirical studies of the “good death” emphasize the central role of patient autonomy (Byock, 1997; Carr, 2003). For example, one study evaluated the views of health care providers, dying patients, and their family members about the essential components of a good death; “involvement in decision making” emerged as one of the six most frequently mentioned components. Other essential features included pain and symptom management, preparation for death, a feeling of completion or closure, the knowledge that one has contributed to others, and an affirmation of one’s uniqueness (Steinhauser et al., 2000).

Bioethicists concur that physicians should share, and in some cases delegate, medical decision-making control to dying patients and their families (President’s Council on Bioethics, 2005). In practice, however, many dying persons are unable to convey their preferences for medical treatments because they are incapacitated when the decision is required (Field & Cassel, 1997). As such, difficult decisions about stopping or continuing treatment often fall to family members who may be distressed or and may disagree among themselves about appropriate care (Kramer, Boelk, & Auer, 2006). When families and health care providers cannot agree on a course of action, the default decision is to continue treatments which may be financially and emotionally draining for family members, and physically distressing to the patient (Field & Cassel, 1997).

In an effort to prevent problematic, futile, or contested end-of-life care, practitioners encourage adults to express and document their treatment preferences when they are still in good health (American Medical Association, Council on Scientific Affairs, 1996). Adults may convey their treatment preferences *formally* through a living will or a durable power of attorney for health care (DPAHC) appointment, or *informally* via discussions with significant others. A living will states the treatments that an individual would want (or not want) at the end of life; such treatments might include ventilators, feeding tubes, or cardiopulmonary resuscitation (CPR). A DPAHC is a legal document designating an individual who will make a decision on behalf of the patient, in the event that he or she is incapacitated; the vast majority select a spouse, child, or other relative as their proxy (Carr & Khodyakov, 2007). The use of these legal tools is encouraged and facilitated by the 1990 Patient Self-Determination Act (PSDA).

Despite professional endorsements and widely publicized reports of the advantages of advance care planning, studies consistently show that only one-third to one-half of all adults in the United States have completed advance directives (U.S. Department of Health and Human Services, 2008). Some scholars argue that this pattern reflects a “death-denying” ethos in contemporary western society (Kellehear, 1984). However,

others have pointed out structural obstacles to end-of-life planning and discussions, including limited access to health care and legal professionals who could assist in advance care planning (Carr, 2011a).

Cognitive barriers to advance care planning may be just as acute as structural barriers. Patients may not know their preferences, or may lack the language or literacy skills to effectively convey their preferences – whether through informal communications or legal documents. In his book, *Death Foretold*, Nicholas Christakis (1999) documents that physicians are not adept at projecting their patients' future symptoms or life spans; as such, patients do not necessarily know when or how they should engage in advance care planning. Other researchers have documented that patients may lack knowledge about treatment options, and thus cannot make an informed decision about whether they want a particular technology used. Further, some terminally ill adults believe (incorrectly) that advance care planning is unnecessary because one's family members intuitively understand and thus can convey the patient's preferences at the end of life (Coppola, Ditto, Joseph, Danks, & Smucker, 2001; Field & Cassel, 1997; Porensky & Carpenter, 2008).

Social science research has identified several practices or strategies that may enhance both the prevalence and effectiveness of advance care planning. First, Carr and colleagues (Carr & Khodyakov, 2007; Carr & Moorman, 2009) have documented that persons who had witnessed the painful or prolonged death of a significant other (e.g., spouse, parent) were nearly twice as likely as their non-bereaved counterparts to engage in advance care planning; these strategies were viewed as a way to sidestep the fate that befell their loved one. These findings suggest that knowledge and beliefs about death may not necessarily be formed in the abstract, but are cognitions based on direct observation and socialization.

Second, researchers have noted that advance directives focused on specific treatment preferences may be less effective in conveying patient preferences than broader tools that focus on general value orientations at the end of life. For example, patient advocate groups have criticized advance directives for focusing on specific treatment preferences (e.g., use of a ventilator), rather than broad personal values, such as self-determination or acceptance at the end-of-life (Collins, Parks, & Winter, 2006). Consequently, both medical and patient advocate communities have developed alternative forms of advance care planning, where health care providers obtain a patient's "values history." The value history captures one's general beliefs regarding health care, and these general orientations are then used to identify the patient's preferred approach to a variety of specific end-of-life situations (Doukas & McCullough, 1991). These documents, called "combined directives," emphasize that treatment preferences may depend less on one's attitudes toward a particular medication or intervention, and are instead shaped by one's personal definitions of a "good life" or a "life worth living" (President's Council on Bioethics, 2005).

Construction of a post-self

Dying patients and their family members today also may use the time period between diagnosis and death to ensure that the memory of the decedent will persist after loss. The notion that the dying process may be used as a time to assert one's identity was first set forth in *Death and Identity*, where Robert Fulton (1965) argued that "preserving rather than losing...personal identity" is a critical aspect of the dying process. Victor Marshall (1980) subsequently proposed that heightened awareness of one's impending death triggers increased self-reflection, reminiscence, and the conscious construction of a coherent personal history.

More recently, terror management theory proposed that in order to defend against death anxiety and protect one's self-esteem and sense of meaning, people must believe that some valued aspect of themselves will continue, either literally or symbolically, after their deaths (Greenberg et al., 1986). Literal immortality may take the form of an afterlife, whereas symbolic immortality encompasses extensions of the self. Such extensions may include offspring, bequeaths, or professional and creative achievements that persist after one's biological death (Martin, 1999). Similarly, Shneiderman (1995) proposed that dying persons actively construct a "post-self" or a lasting image of the self that will persist after their death.

In practice, dying persons are increasingly working with their family members to plan memorials and legacies (Leland, 2006). For example, dying individuals often are advised to write their own biography, as a way to highlight the accomplishments, social roles and relationships that were most important to them. Planning (or advising family members to bypass) a memorial service is a way to convey one's religious and spiritual views to others (Kastenbaum, 2004). Dying persons also may convey who they were "as a person" through the selection of the text to be read, music played, and photos or other sources of art to be displayed at the funeral service.

The selection of a particular charity to whom memorial donations should be sent also allows the dying person to communicate his or her values, political and social views, and personal preferences to both loved ones and the larger community. The bequests of assets, via a will or trust, is a strategy to ensure that one protects his or her loved ones financially even after one exits the role of parent, spouse, or provider (Brody, 2009). In sum, the planning period prior to death enables the dying to engage in an active "presentation of self" even after they have passed on (Goffman, 1959).

Bereavement Following an Anticipated Loss

The death of a loved one is among the most stressful of all life events, yet the psychological impact varies widely based on the nature of the death, the relationship, and the bereaved person's resources and risk factors (Carr, Nesse, & Wortman, 2006). One of the most contested questions in bereavement research is whether psychological adjustment to loss is "easier" for those who lose a loved one suddenly, or after a prolonged period of illness and suffering (Carnelley, Wortman, & Kessler, 1999; Carr et al., 2001; Lee & Carr, 2007; O'Bryant, 1990–1991; Rando, 1986). Answers to this question are complex, however; both sudden and anticipated deaths pose distinctive psychological challenges for the bereaved.

The proposition that sudden deaths are more distressing than anticipated deaths was first suggested in Lindemann's (1944) classic study, "Symptomatology and Management of Acute Grief." Wives of soldiers serving in World War II experienced grief-like symptoms (or *anticipatory grief*) before their spouses actually died, but they emotionally disengaged in anticipation of their spouses' deaths, and were not highly grief-stricken upon the actual death. By contrast, the relatives of young adults killed suddenly in a nightclub fire suffered severe and persistent grief symptoms upon learning of the deaths (Lindemann, 1944). Drawing upon these studies, grief scholars and practitioners have concluded that individuals who anticipate a loved one's death will use the forewarning period to prepare psychologically and practically for the bereavement transition, thus yielding fewer symptoms of grief and distress (Rando, 1986).

However, recent empirical studies suggest that anticipated deaths, especially following a long-term chronic illness, may also carry serious (albeit different) psychological strains for

bereaved family members. Earlier case studies concluding that anticipated losses weren't particularly distressing are distinguished by two limitations. First, "sudden death" was confounded with age of the decedent and cause of death. Sudden deaths typically befall younger people, as they are more likely to die of accidents and violent causes, and are less likely to die of long-term chronic illnesses. Further, deaths to young people are considered "off-time" or before one has lived a long and full life. Stress theories propose that events that occur "off-time" create adjustment strains because one has neither the preparation nor the institutional or social supports to help them adjust to the stressor (e.g., Thoits, 1983). Moreover, deaths that are deemed "unjust," especially deaths at the hands of others (i.e., homicide, murder) are particularly distressing (Carr, 2009). Thus, it is not clear whether suddenness of a loss is highly distressing, or whether suddenness is a proxy for other factors associated with a particularly bad or distressing loss. For older adults, even relatively "sudden" deaths may be anticipated and timely, and the bereaved typically have a large pool of widowed peers who may offer support and advice (Neugarthen & Hagestad, 1976).

Early studies of sudden versus anticipated deaths also failed to statistically control for the strains (or protective factors) that may accompany an anticipated death. The time period prior to an expected death may be accompanied by chronic stressors such as difficult caregiving duties (Aneshensel, Pearlin, Mullan, Zarit, & Whitlach, 1995; Wells & Kendig, 1997), isolation from family members and friends (Kramer, 1996–97), and the neglect of one's own physical and emotional health (Sweeting & Gilhooly, 1990). Stress related to the "extended death watch" period (Gerber, 1974) may be particularly difficult for older adults because of their age and accompanying health problems (Averill & Wisocki, 1981; George & Gwyther, 1986).

However, the weeks, months, or even years leading up to deaths from protracted terminal illness also may provide individuals the opportunity to prepare psychologically and practically for their impending loss (Kalish, 1981; Rando, 1986). Grief theories including the "dual process model" (Stroebe & Schut, 1999) propose that practical adaptations to loss, including successfully taking on new household and financial tasks, are just as important to one's adjustment as are emotional adaptations to loss. As such, persons who have the time to prepare for, discuss, and learn how to perform the household or financial tasks done by their partner may be particularly well-equipped to survive life as a widowed person (Rando, 1986). Similarly couples who use the time between diagnosis and death to resolve emotional "unfinished business" may find their relationships strengthened in the final days (Blauner, 1966). Bereaved persons who were by their ailing spouse's side at the moment of death have been found to cope better with the loss than those who did not reach such closure (Bennett & Vidal-Hall, 2000).

While the physical demands of caregiving may be distressing, multiple studies also reveal positive aspects; caregiving may increase closeness with the dying person, and may provide a lasting sense of purpose to the caregiver (O'Bryant, Straw, & Meddaugh, 1990; Wright, 1991). This sense of purpose may linger long after the death, and provide a source of psychological solace and meaning for the bereaved. For those who found caregiving highly distressing, the patient's death may bring a sense of relief and freedom (Schulz, Boerner, & Hebert, 2008).

The place and cause of death, both factors associated with the duration of one's illness, also shape the bereavement process. As noted earlier, most older persons suffering from chronic illness die in hospitals and long-term care facilities. Although dying persons consistently report that they would prefer to die at home, their loved ones often fare better psychologically when the decedent's final days were spent in a formal care setting. The

institutionalization process has been characterized as “quasi-widowhood,” because spouses have reduced daily contact and communication, may emotionally disengage from one another, and are spared the daily stresses of direct caregiving (DeSpelder & Strickland, 1992; Ross, Rosenthal, & Dawson, 1993).

A mounting body of work reveals that at-home deaths may be associated with less distress for the bereaved, however, if the decedent experienced a “good death” (Carr, 2003) and had been receiving hospice or palliative care services (Christakis & Iwashyna, 2003). For example, Teno et al. (2004) found that family members of recent decedents who received at-home hospice services were more likely than the families of those who died at hospitals or nursing homes to say that their loved one received high quality care and was treated with respect and dignity at the end of life, and that they and the patient received adequate emotional support. By contrast, older adults who believe that their loved one was in pain or received problematic medical care at the end of life report greater anxiety and anger than persons whose loved one had a “good death” (Carr, 2003).

The psychological consequences of loss also vary based on the cause of death. Many chronic illnesses that account for the majority of late life deaths today, such as cancer or COPD, may create an experience of “quasi-widowhood” before the actual death occurs. Cancer, for example, may engender a process that Kastenbaum (2010) refers to as a “dialectic between hope and acceptance-resignation.” A patient’s prospects for survival may wax and wane as different treatments are attempted and either continued or rejected. Throughout this process, family members may become susceptible to “habituated grief.” The intensity of one’s grief erodes over time, as one adjusts or “habituates” to the daily repetition of caregiver stress. Loved ones who have witnessed a patient’s long and difficult struggle may have little emotional energy left to grieve when the end finally comes.

Chronic illnesses that have been accompanied by Alzheimer’s disease or dementia also may trigger “habituated grief” among loved ones. Yet these deaths also create other psychological challenges for the bereaved, who may become anxious about the prospect of suffering from dementia one’s self, some day. As Kastenbaum (2010: 77) observes, “people who see a family member vanish into the oblivion of his or her own dissolving memory often fear that they might be seeing their own future selves”.

Conclusion

Over the past century, death has transitioned from a sudden and unexpected event that befalls the young and is perceived to be beyond human control, to a protracted transition occurring to older adults following a chronic illness. These changes have created a new context of dying. For older dying persons and their families today, the interval between the onset of terminal illness and one’s ultimate demise provides opportunities to articulate and communicate preferences for end of life care, to construct a “post-self” that persists even after one has died, to bequeath one’s assets to family members, to achieve closure with one’s family members, and to prepare one’s surviving spouse for the emotional and practical challenges they will ultimately face as a widow(er). Each of these psychological and social strategies may help to ensure a better quality death for the dying and their family members (Byock, 1997; Carr, 2003, 2009).

However, an emerging body of research suggests that the extent to which older adults and their families prepare effectively for the end of life varies widely, based on a range of sociodemographic characteristics, especially race/ethnicity and social class. For instance, Blacks and Latinos have fewer assets than Whites and thus are far less likely to have wills,

or to bequeath assets to their loved ones (e.g., Keister & Moller, 2000). This is one way in which they face obstacles to constructing a “post-self” or to maintain a legacy. Further, Blacks, Latinos and persons with fewer economic resources are far less likely than Whites and persons with richer economic resources to engage in advance care planning (e.g., Carr, 2011a,b; Kwak & Haley, 2005). As a result, each of these subgroups is far less likely to receive hospice or comfort care at the end of life, and incurs substantially higher costs for end of life care, and a poorer overall quality of death (Greiner, Perera, & Ahluwalia, 2003; Hanchate, Kronman, Young-Xu, Ash, & Emanuel, 2009; McCarthy, Burns, Ngo-Metzger, Davis, & Phillips, 2003; Nicholas, Langa, Iwashyna, & Weir, 2011).

As norms and expectations for a “good death” solidify, a fruitful line of social science inquiry may be identifying the obstacles to a good death, and documenting the consequences for bereaved family members and health care providers when a death occurs under conditions that fail to meet their ideal. Such inquiries may guide practitioners and policy makers toward interventions that may help to ensure a “good death” for all.

For example, recent research suggests that Blacks, Latinos, and persons with fewer economic assets have very low rates of advance care planning due partly to the fact that they have few economic assets to protect and thus are unlikely to engage in estate planning. Estate planning, in turn, often triggers health-related advance care planning; the legal or financial professionals who assist older adults in writing their wills often encourage them to engage in other forms of preparation for death (Carr, 2011b). As a result, those with fewer economic resources are less likely to articulate and convey their treatment preferences to health care providers, and may be less likely to have their preferences met.

One way to ensure that older adults have equal access to advance care planning tools is to revitalize the original Patient Protection and Affordable Care Act (PPACA) proposal to include one voluntary advance care planning session as an option included in the annual wellness visit for Medicare beneficiaries. This benefit would give older patients – regardless of financial status – the opportunity to discuss their treatment preferences with a health care provider. However, political uproar regarding (unsubstantiated) fear of “death panels” contributed to President Barack Obama’s deletion of the proposed benefit from PPACA in January 2011 (Pear, 2011). This simple and relatively low-cost aspect of the proposed health care reform may be one step toward ensuring a better quality death for all dying adults and their families.

Short Biography

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