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“Effacing the Body: Producing a Peaceful Death”

Abstract

This essay explores some of the ways in which modern death is both staged and enacted or made to make a particular kind of sense by and for very differently positioned spectators. Of particular interest to me is the way in which modern death is (as perhaps death has always been) a particular kind of performance, structured according to plot-devices that render it most one's own and most not. There is of course a certain generic quality to this story. It could be told by countless others who have followed friend or family member through the ravaging effects of established or experimental treatment protocols for terminal disease. But that is in some sense precisely the point: different actors, same play.

“The Making of a Peaceful Death”

“What a peaceful death” This is what the head nurse in the isolation unit remarked upon entering my father’s hospital room shortly after he died. The room was quiet, to be sure, but it had not been a peaceful departure. I know this for a fact. I was there. Still, throughout the early morning as medical personnel and family came and went, and what was left of the figure called “father” grew ever more rigid, the silence of the space was read as a sign of the kind of death that must have taken place within it. The machines had stopped administering fluids; the monitors that recorded and gave voice to a stream of ever more erratic vital signs had been turned off; the ever-more labored breathing of a body in distress had finally stopped. Life had departed and to the relief of those who came to witness the space of its last presence, it had done so quietly.

What I hope to do in this essay is consider how modern death is both staged and enacted or made to make a particular kind of sense by and for very differently positioned spectators. Of particular interest to me is the way in which modern death is (as perhaps death has always been) a particular kind of performance, structured according to plot-devices that render it most one’s own and most not. There is of course a certain generic quality to this story. It could be told by countless others who have followed friend or family member through the ravaging effects of established or experimental treatment protocols for terminal disease: the horizon shrinks to the always too cold examining room where the body is read and reread; to the schedule of pills, far too many in number to all be taken faithfully; to blood draws and test results; to what the body takes in and expels; to the ever-expanding list of after-hour and emergency numbers. Meaning is

both found and made in the sound of a breath, the color of mucus, the bright or dull sheen of the eyes, the islands of purple that come and go just beneath the skin's flaccid surface. And while death may be postponed— this is the goal after all in one sense, but clearly just the side effect in another— it has nevertheless made a claim that washes across what life is left, marking, shaping, signifying.

I.

The trajectory of my father's illness was a comparatively short, steep, and descending slope— a four month period from diagnosis to death—replete with the sort of quiet chaos and mesmerizing high drama that follows what initially seems like the sudden onset of a fatal disease, in Ed's case acute myeloid leukemia. One moment, he's in the car with his ex-wife arguing, on the way to the doctor's for a general check up: he's been anemic for some time and the condition needs monitoring. Several moments later he's signing in at the reception desk and collapses in cardiac arrest. It could have ended there on the floor of that office. But it doesn't. He's revived and rushed with sirens to an ICU where tests show he's seriously, indeed mortally, ill. Without treatment he will die within weeks but there is no standard treatment that someone his age can survive. There are many ironies here and in a moment of lucidity Ed grasps at least one of them: he collapsed, died, and was resuscitated only then to be told that he's terminally ill. He lies in a hospital bed instead of the morgue, it's true; but instead of being grateful, as the medical personnel that surround him seem to expect he should be—"you're a lucky man," they tell him— he's seething. There's danger in his silence, but no one takes the fury of a sick old man seriously. When he hurls a receptacle full of urine at the nurse and demands to be released, a guard is called. He's sedated and put in restraints. The first of many transfusions and transgressions

begins. We are buying time, but to what end?

The hematologist insists on a family meeting to discuss options. My older brother flies in and we meet our three younger siblings in the ICU at 7am. That is when the doctor will be making his rounds and has made himself available to talk with us but, predictably, he's late. We stand shoulder to shoulder in a very small space making very small talk. My father stares glassy-eyed at this and that and occasionally stabs the air with his finger, all in slow motion: he claims to see a grid-like pattern of very fine, vibrating lines and tries to explain how this fibrous web-like pattern forms around matter to hold it in place and together. He's drugged, but intrigued all the same and the stabbing gesture is apparently about disrupting the grid and then watching it resume its structure in ever-more elaborate patterns. When none of us can see these patterns, he grows confused and then sullen. My older brother, a physicist like our father, gives in and talks the science of matter and motion. One of my sisters rolls her eyes and shakes her head. My other sister tears up. My youngest brother leans over and whispers in my ear that our father is actually peering from this world to the next— the fibrous pattern is a gauze-like veil, he tells me, that separates the here from there. I nod and wonder if my father needs oxygen. I think my brother could probably use some too.

When the hematologist finally arrives, we are forced to retreat to the lounge. He's a big man and needs space to perform; he also needs us to be seated while he does so, a particularly positioned audience, looking up as he peers down, facing him and not each other. Unfortunately, I take an almost instant dislike to him. He wears an elaborately dyed, hand tooled pair of cowboy boots, tight black jeans with a seriously wide leather belt and an equally serious brass belt buckle

synched too tight below a middle aged gut. His hair is long and he wears it slicked back and tied at the neck in a pony tail, accentuating a receding hairline and a weak chin. The sleeves of his oxford cloth button down starched white shirt are perfectly rolled to the elbow. His Rolex hangs loose at the wrist.

He begins with the obvious: “your father is a very sick man.” I meet the eyes of my older brother and we exchange volumes. He doesn’t like this show either, but I can tell from the all-in-good-time way he sits back in his chair that he’s willing to hear the man out: the doctor has information that we need and, being the doctor, it’s his prerogative to orchestrate the character and pace of its delivery. “It used to be that families would take in someone as sick as your father is now and care for them. This is how children honored their parents in the old world. But people today don’t seem to feel such obligations; maybe they’re selfish, self-absorbed, overworked, unbalanced. Who really knows? What I can tell you, because I see it everyday, is that most people just can’t be bothered.”

The old world? This is not what I expected. And it strikes me that this man knows exactly nothing about what caring up-close for the sick and dying entails. It has been a short year since my grandmother died and I cared for her for six, in my home and for reasons of love rather than obligation with a patched together infrastructure of help whose reach was outrun every few months by her failing health. In hindsight it’s clear that stability was a carefully crafted illusion and the exponentially expanding financial costs to produce this illusion were staggering. However heartfelt, a sense of obligation alone could not have met the suffering or sustained the proliferating, messy needs of a body that simply refused to lay itself down. This is something

my siblings do not yet know and it will become a point of contention between us in the months ahead as need outstrips ability— they’ll grow frustrated with me and deaf to explanations they hear as self-serving, sanctimonious, and condescending. “I’m spent” will be my opening salvo; but it’s early in the negotiations over how and where my father will receive the care he requires and no one quite believes that I am as I say and, in truth, even more so.

It’s soon to get very complicated. However, sitting in the lounge of the ICU we’re not yet pointing accusatory fingers at each other. It’s the doctor who’s pointing his finger at us. As he drones on, I think about where this might end— and where it did end, with young men from the mortuary lifting my grandmother onto a stretcher that they will lift into a van waiting in the driveway upstairs, ferrying her to the funeral home. In truth, I didn’t see them put her on the metal gurney. I couldn’t watch. But I did watch the face of the long-term care aide as she watched the men transfer the body. And her flinch has stayed with me.

Unlike the doctor holding forth on familial obligations, the men who come to retrieve my grandmother are small. They’re dressed in black suits, with black shirts, and wildly colored polyester ties. I imagine they’re having difficulty lifting her from the bed, it sits low, and I am glad I know not to watch them handle a body I have for six years tried to protect from mishandling and indignity. When they emerge from the bedroom, I notice small beads of sweat on the forehead of the one who seems clearly to be in charge of the transport. I assume this because during our very abbreviated exchange— “*she’s in here*” (me), “*They’ll call you later*” (him) — he meets my eyes where the other man won’t. My grandmother lies under a tasteful burgundy coverlet, but a small patch of the pale blue blanket in which I swaddled her only hours

before peeks out at a corner, perhaps by her feet or maybe her head. I am struck by how nice the burgundy and the blue look together. It is early Easter morning. The sun has just risen. And I feel some relief that Thelma—that is her name—will be spirited away before the neighborhood is up and the kids are out in their Easter clothes or nightshirts hunting for eggs. I do not want her to be subjected to the curious stares of strangers. And, almost as strongly, I do not want mine to be known as the house where someone has died. Why this mattered that Easter morning escapes me.

Turning back to the moment at hand, it becomes clear why the doctor has opted to share with us his views on the decrepit state of the nuclear family and the fractured character of familial bonds: he wants to place Ed in clinical drug trials. To do so requires a level of daily oversight, record-keeping, and care that is best delivered by family members willing and able to interface with a number of discrete and complicated bureaucratic regimes. The treatment consists of two shots, a transgenetic serum, given 4 weeks apart and possibly a third shot if he responds well or not at all. My youngest brother asks for “the bottom line” and by this we all understand that he means “time.” How much time will this drug buy? The doctor is upbeat: if it works, and there’s no reason to expect it won’t, Ed’s life will be extended by 18 and maybe by as much as 36 months. If it doesn’t work or he chooses not to participate in the trials, he will live only another 12 to 16 weeks. Either way, the doctor tells us, he’ll be no worse off. The casual demeanor of the man as he delivers this lie is utterly breathtaking. It may not be his first lie of the morning, but it’s definitely his biggest and least forgivable.

The doctor wants to reconvene in ICU where he’ll instruct my father in the meaning of his illness

and present him with a set of choices—the decision is his after all, this man who believes he can see the seams of matter and who was watching the world around him come apart and together when last we left him. The doctor wants us to designate a point person with whom he will deal directly over the course of the treatment should my father opt to enroll in the drug trials. And then there's the question of where he will live. Because whether or not he opts for treatment, Ed can no longer live alone.

We're left to consider futures none of us want to face. What we don't know is that the oncologist has already contacted his colleagues at a major cancer research center and mobilized the all critical insurance networks; he's ordered the drug, scheduled the preliminary blood work that must be done before it's administered, and arranged for a PICC line to be inserted for its delivery. This will be his pattern while my father is under his care— initiating procedures that marshal a host of discrete but interlocking bureaucracies, each of which insists that it must be allowed to play out its own uninterrupted logic; each of which stakes a different, ostensibly unshakable, ostensibly coordinated claim on the body and its various processes under the auspices of serving and sustaining life. We will find ourselves moving down roads agreed to only after the fact and in directions we are told may be halted with great difficulty and untold consequences, but cannot be reversed.

The doctor is confident. When it comes time to talk with my father, he works an interesting seduction by appealing to Ed's love of gambling and general hubris with respect to science. They'll become collaborators in an experimental treatment at the medical frontier, together perhaps beating decidedly unfavorable odds and, in any event, gathering important information

along the way. They seal their pact with a handshake. My father might die in the process, they both acknowledge this possibility, but as sick as he is, and as gruesome as the process turns out to be, to the end it never really occurs to him that he will. Nor does it seem to occur to him that *he* is the diseased errant specimen upon they will together unleash a toxic brew of chemicals. Had he had a clear understanding of the inevitability of his disease— had he been competent enough to form such an understanding— would he have been willing to suffer through this debilitating attempt to postpone an end that statistically and practically was all but certain?¹ As Simon de Beauvoir writes of her mother, so too with Ed: until the very end, he seemed completely unaware of what he was living through.²

II

My younger brother— a man in his mid-thirties, successful by all measure, married and, in his own view, especially savvy when it comes to discerning the heart of any matter—my brother would disagree with my characterization here of our father’s capacity to understand what was happening to him and why. He sees instead someone who is merely acting vague and playing a difficult situation to his advantage. He has medical power of attorney and this he seems to regard as the power to appoint someone else to make decisions regarding our father’s care; or when the crisis seemed contained, to simply force Ed to finally own a life he has always made someone else’s problem. My brother deeply resents the responsibility he reluctantly assumed in

¹On the interpellation of the dying into medical mazes of hope, see Sherwin B. Nuland M.D., *How Die: Reflections of Life’s Final Chapter*, (New York: 1993) and Sandra M. Gilbert, *Death’s Door: Modern Dying and The Way We Grieve*, (New York: 2006), especially chapter 8 “Technologies of Dying.”

²Simon de Beauvoir, *A Very Easy Death*, (New York: 1965), 89.

the ICU and, as the weeks proceed, more deeply resents what he takes to be Ed's growing irrationality and dependence: "He has us exactly where he wants us, tending to his every whim."

Frustrations are shared across the sibling network. My father has insisted on returning home following the first of his three treatments and he is not happy that a condition of his return involves a live-in nurse. The presence of a stranger in his home is unnerving to him— he is weak, disoriented, and completely unable to care for himself, but each day it has to be explained anew who this stranger is and why they're living with him. Ed cannot hold on to this information. It does not help that he believes his brain is being eaten by insects that were surgically implanted during his hospital visit— when he closes his eyes he can see them, he says, slithering across brain matter, eating at leisure. The strangers in his house are part of it, sent by the hospital to harvest his organs once the insects have done their job. He rallies daily to threaten, accuse, and abuse. One, two and then three nurses quit; when a fourth arrives, a man, he calls the police.

My brother issues his own threats. There is the ever-present specter of the nursing home and this works as deterrence until my father promises to kill himself and come back to haunt his youngest and most loved. This stops my brother in his tracks— for him, remember, there is only a thin gossamer veil separating this world from the next, permitting then a certain promiscuity between the living and the dead. He opts to do nothing: "If he wants to live alone and take care of himself, so be it." He decides to believe that Ed is competent as if treating him as such actually makes him so and when he is reminded that our father is dying, he grows exasperated: "Why then doesn't he just die? What is he waiting for?"

My brother seems to assume that our father is refusing to make good use of the knowledge that his life is over. He has been given an opportunity to make right all the things that never were; he has been given time for self-examination, a reprieve of sorts, pulled back into life from a lifeless state to come to terms with himself and us, to make or at least add new meaning that would finally fill in the silences and complete the many sentences left hanging over a lifetime— “*Oh yes, son, what I meant by that was this....*” Such possibilities; and all of it he wastes. He lives to no end and yet still refuses to let go; to *will* himself gone; to stare with courage into the abyss and give himself over to it. My brother’s contempt at times is palpable. There is no “authentic Being-Toward-Death” here; just a messy lingering that is creating a tense time and all kinds of inconveniences.³

It is a romanticized view of self-hood that my brother wants to insist upon and an equally romanticized view of how death is met. But he’s encouraged in this production by Ed’s oncologist and the bereavement section at the local Barnes and Noble. The experimental treatment is not having any noticeable effect in facilitating the body’s ability to produce red blood cells and the situation is deteriorating. There is no oxygen, certainly not enough to sustain organic life. Ed is admitted to the ICU every eight to ten days now where he is put back in possession of himself— stabilized to the satisfaction of an ever growing number of specialists treating an ever growing number of failing organs— and released. He swallows only with great difficulty and refuses solid food and medicine. He has twice fallen and sports a black eye,

³The phrase is Heidegger’s, but made to make a particular kind of contemporary sense in Robert D.

Stolorow’s *Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections*, (New

cracked ribs, and a fractured wrist. His weight hovers at a hundred.

Still, Ed's oncologist congratulates him on his progress— two shots down— and counsels patience. He assures my siblings that it is not yet time to consider known but unnamed alternatives: “Ed is a fighter. You owe it to him to give this treatment time to work.” In a rare moment of lucidity, my father asks his doctor for the truth: “How much longer do you think I might live?” And, the doctor tells him three to five more years. He's pleased and now annoyed at all the many indignities we—his children— have subjected him to over the course of the last several months. Even as the transfer from the wheelchair to the car after this office visit proves a daunting challenge— he's tired and does not have the strength or focus required to will his limbs to move in a coordinated fashion— he details our betrayal. It has all become too much.

I am outraged by the doctor's latest lie and it is this lie that finally mobilizes me. I have stayed very much to the side of Ed's daily care, deferring to the decisions of my younger brother and sisters but I press them now. They agree to begin to consider the possibility of Hospice; they will take it up with the doctor. But they won't and the truth as it comes out later is that they have no intention of talking with the doctor about releasing him to less invasive medical regimes. They do not want him to die at home and, probably more to the point, do not want to take care of him while he dies at home. And what strikes me now is that this possibility never occurred to me. It never occurs to me that each time he's admitted to the hospital, they're relieved that the expanding crisis that engulfs Ed and that is Ed has been moved from one disorganized site to

York: 2007).

another. It never occurs to me that this shift allays their anxieties, reassures them, and offers some respite from the overwhelming responsibility of gathering up a dying man. And, most curiously, it never occurs to me that they hope it finally ends elsewhere, in a room and bed that others watch over, in a medical space and space of medicine that absorbs with indifference all they believe they cannot possibly endure.

This is a fundamental misunderstanding: we are working together but moving, it turns out, in two altogether different directions or, indeed, in two altogether different worlds. It will be this way almost to the very end— me, on the one hand, thinking it's just a matter of time before we extricate Ed from the particular claims, logics, and techniques of care each practice of which has had its own brutal momentum and inflicted its own brutal mark; my siblings, on the other hand, fearing most the unmediated, private death this extrication would bring. They hover by Ed's bedside making small talk and even touching him from time to time, 'but they have already placed themselves on the far side of his history.'⁴

Ed is taken to the emergency room a mere three days after he's reassured by his oncologist that he can expect to live as much as five more years. As it turns out, the oncologist is on vacation and so too the various other specialists that have worked so diligently to keep their respective organs functional.⁵ The attending physician who admits him to the ICU reviews his records and

⁴Beauvoir, *A Very Easy Death*, 68.

⁵Were they "actually" on vacation? This seemed odd to me at the time, but plausible and in most respects a relief. However, Nuland provides another way to understand the curiously abrupt departure of these specialists from the stage of Ed's illness and that is that they simply lost of interest: "There is a specific form of abandonment that is

follows the drug protocol detailed in the chart to a point, stabilizing a racing heart and sedating for pain. But he explains to my younger brother that a decision on how to proceed must be made and that he must make it. There is no mistaking or postponing what this doctor is insisting must now be considered: “Were this my father,” he begins.

A family meeting is called. My older brother flies in and we arrive to meet our three younger siblings in the ICU at 7am. They are running late. We stand by our father’s bed watching the various monitors to which he is attached fluctuate wildly. He groans and my brother reaches for his hand, tears quickly forming and now running down his face. He leans forward and speaks softly, his cheek brushing the side of Ed’s forehead. The tenderness in the gesture, the ease and intimacy of this move to comfort, my brother leaning in to meet our father’s need and greet his own loss— all of this catches me off-guard and I am for a moment captive to a grief whose face I first saw standing by my mother’s bed in ICU some thirty-five years earlier and again by Thelma’s only the year before. Choking my throat closed, its sudden arrival here now has no place. This is not my moment. My brother’s voice is soothing even as it cracks and in its tone and cadence I hear a history opening between father and estranged son that belongs only to them.

particularly common among patients near death from cancer, and it requires comment. I refer here to the abandonment by doctors. Doctors rarely *want* to give up. As long as there is any possibility of solving the Riddle [of disease and cure], they will keep at it...When it becomes obvious, though, that there is no longer a Riddle on which to focus, many doctors lose the drive that sustained their enthusiasm. As the long siege drags on and one after another treatment has begun to fail, those enthusiasms tend to fall by the wayside. Emotionally, doctors then tend to disappear; physically too, they sometimes all but disappear....To stay and oversee the triumph of unrestrainable nature is to acquiesce to his own impotence.” *How We Die*, 258-259.

I go in search of Starbucks.

When I return, my siblings are assembled in the hospital lobby, having more or less mapped out a course of action: Ed will be stabilized, transfused, and kept comfortable with antibiotics, fluids, and an assortment of other drugs that will help his heart maintain its rhythm. This gives him one last, but credible chance to rally, my younger brother explains: he needs to decide if he wants to go on and if he doesn't then at least we can say we gave him the chance. I wonder if he's yet seen our father this morning and what untapped reservoirs of strength he imagines are left to foster an eleventh hour rally. Leukemic cells are now in his spine and during the night, a vein into which fluids from his IV were fed collapsed, leaving his arm and hand, the good arm and hand as opposed to the one so recently fractured, horribly distended and excruciating to the touch. Could he possibly believe that there is a cognizant, willing, and accountable agent hiding out in some interior corner of that body as yet uncolonized by pain, taking as his own Hamlet's question? I want my younger brother to stop with the clichés and the fantasies they foster. No more playing of odds; no more valorization of the heroic ethos; no more deference to promises of resurrection; no more confusing medical care with love.

Ed is moved from the ICU to a room set up for quarantine. He is in and out of consciousness, but his heart is steady and his pain, more or less managed despite the reluctance of a nursing staff to actually dispense the prescribed opiates "as needed." Initially, it seems to be a simple mistake or misunderstanding. We ask and nobody comes; we ask and the shift is changing; we ask and the head nurse is unavailable, off the floor, in a meeting, with an administrator or tending to another patient. All of this, of course, is plausible. But it happens with such consistency through

the day that I come to understand this call and response not only as it appears to be— a simple, routine oversight; an anxiety inducing inconvenience; evidence of an inept, perhaps overworked, probably understaffed shift. I come to understand this call and response as the opening movement of a well-choreographed dance of narcotic allocation: it is a way for the staff to ensure they are not over-medicating, fostering dependency, hastening or administrating death. It is also a way to ensure that they are medicating for a patient's pain and not the family's suffering.

Still, we watch for the promised syringe, junkies after a fashion, and when it arrives, we know not to appear too eager and angry. There are more questions that must be credibly answered to establish the epistemic basis for our claims or else the nurse will find some reason to be called away, forcing us to start anew. And so it begins, the first question every time: How do you know your father's in pain? How did he communicate his pain? And on the basis of that communication, how severe would you say his pain is? Or, in the absence of any direct or mimed communication, how is this body declaring its need? Can you describe the movement or moans that led you to conclude that this is a body in distress? What are you reading as distress and what leads you to believe that pain is its source? The doctor has reassured us that he has left orders in the chart for medicating at the sign of even slight discomfort. Pointing this out to the nursing staff gets us precisely nowhere.

My siblings leave the hospital in the early evening. It has been a long day and Ed has been quiet through most of it. He does not appear to them to be in imminent danger of expiring any time soon and they opt to take the night off and reconvene in the morning. I read his stillness differently. It seems to me that he is much closer to the end of his life than the others regard him

and I do not want him to die anymore alone than he has already been made by the many noble lies that have been told for his benefit, but also in truth with his collusion. Still, the time for such stories— that he is gravely ill and perhaps, after all, not terminally so— is over. It may be the case that he never regains consciousness or is enough in possession of himself even if he does surface to know whether someone stayed or who that someone was. And, there are worlds of struggle between Ed and I, histories of violence and stone-cold cruelty. But there is something else that seems to me to matter, not more than these histories or instead of them but certainly as much. And what matters is that this is the end of a life, not simply in a physiological or biological sense although that is happening too. It is the end of a singular life, the life of *someone*, whose condition of possibility and of human singularity has always been dependent upon the presence of others, beheld at the beginning, clearly, as it must also no less critically be so at the end. Ed may have lived against that dependency, in an adversarial relationship with it; he was certainly confused by it and, at times, helpless and hateful with respect to it. But, the fact of it prevails. This means for me that we cannot write the conclusion in advance or anticipation of the end we nevertheless know will come: we cannot take leave of him before he, finally, leaves us. And that ending, both shared and beheld, is a bare but basic acknowledgment of his humanity and our own under circumstances that have obscured both. If resurrection sat at the core of my siblings' fantasies, honoring the human at its end together *with them* sat at the center of mine. Each was a fantasy of redemption and neither, as such, was even remotely possible.

As the night progresses— midnight, 1 a.m. and then 2 a.m. — my father's breathing becomes labored and his moaning, sharp, consistent, and immune to drugs. The nursing staff nevertheless determines that he is doing fine, better in fact than they expected and offer me a bed in the next

room. At 2:30 his color changes and he feels hot to the touch; I have been talking to him, gently stroking his hair, both for hours, trying to sooth where the morphine might not. But suddenly it seems, everything about the feel, look, and smell of him changes.

I seek out a nurse because I have agreed to do this if I sense a change in Ed's condition. She takes his temperature and finds it now to be hovering at 104. "Antibiotics or aspirin?" she asks, "it's your call"; and of course we both know that it's not. My brother has directed them to keep the antibiotics running when indicated so that our father's death, when it comes, is a real death, a "natural" one he could be said to have chosen rather than a death precipitated by a lack of care or the withholding of drugs. I say "aspirin" and the nurse simply nods as she hands me a wet washcloth to rest against his forehead. Within two hours following this modest dose of tylenol, my father dies, but not without struggling against respiratory failure and not without opening his eyes with great effort at the end, seeking me out and holding my gaze. Tears stream down the sides of his face. He breathes, clenches his jaw, grimaces in pain, and then is still. The room is suddenly quiet, but I am too stunned by this last moment of having been called in close by him to fully take in that it is all now finally over, that we have reached an end. I put my hand on his chest and there can be no mistaking what has just happened. I lean in to kiss his forehead and give over to that grief that has been lingering, patiently, to the side since the previous morning with my brother in ICU. Eventually, I will leave to find a nurse; who will in turn call a doctor; who will in turn determine that death has indeed occurred but at precisely the hour she encounters it, a good 45 minutes after the fact.

III

In what sense could this be called a “peaceful death?” The room is silent, it’s true, and the darkness of night has just begun to give way so the world around us is growing flush with the quiet promise and possibility that is first light. I sit with the body, still because lifeless, and wait for my brothers, trying once, again, to see what it is that the nurses saw in order to make sense of what I know will become the authorized end to this story. But what I see still bears an excess of meaning that does not fit neatly within the narrative frame of “peaceful.”

Under the blanket positioned now so tastefully just beneath Ed’s chin is a bruised and broken body wagered in a high stakes gamble he was in no position to understand and in no condition to survive. His agitation, confusion, and frustration revealed at every turn the expectation that he would get well or could at least get better *but for*.... And here he seemed to lose the thread, unable to think himself around or through a murky swamp of dense intangibles. *Better, but for what?* Admission, transfusion, injection, release—all to seed regeneration and yet nothing takes root; admission, transfusion, injection, release and still life ebbs. Luminous fibers everywhere holding matter in place; insects moving freely under the skull, eating away brain. Something was going wrong, this he knew, but what precisely this something was he could neither identify nor explain to his own satisfaction and this scared him— the persistent impasse, no matter his efforts, the disintegration of a well-ordered world and his sense of place in it. He struggled to perform a competence he no longer possessed; he struggled against the sure knowledge we held of his impending death although, in either case, the “he” who exerted itself against the increasingly intolerable conditions of daily life was daily being transformed by them. Sons and daughters came and went talking too fast and too loud in a language he was losing; strangers and

friends moved through his home with a speed and purpose that was simply bewildering. He feared all and trusted no one. Already isolated by the knowledge he refused and was refused, he demanded to be left alone to find where he had last been before the calamitous onslaught of all this misplaced attention. But sitting ever-so-still on the couch, he could barely discern where he now was: Whose house was this? Whose life? In such a place, there was no peace.

Still waiting for my brothers, I study the sparse but tidy composition that is Ed's hospital room: early morning light now streaming through the window, the bed half in the shadows, half bathed with sun, a disease-haunted body lying now hidden under clean linen, his face, pale, but free of strain. I think that if I had not been here through the night, I would imagine this to have been the scene of a very different kind of death than the one I witnessed at my father's side. And it's with this that I begin to see: if I stay precisely within the parameters of this room and moment; if I bracket the particulars that shape the meaning of him being here, extract his body from its history, sequester the abuses and vice grip of suffering that have shaped the last 12 weeks and months before; if I decontextualize and dehistoricize, I begin to understand how I too might join others in producing this as a "peaceful death." It wasn't something that emerged with a quiet grace, but if we bring the lens in very tight, it could be: he was of the age, he reached the end. And in what sense or for whom does any of the rest matter?

If this end was peaceful, from the hospital's perspective, I suppose, it was also then well-managed. And from well-managed all things follow but especially the "positive closure" that much of the contemporary literature on dying suggests is the necessary next step for bereaved families. This would please my younger brother, a moment finally on script. But the story has

nothing to do with Ed, though in truth not much does now, not even the body growing ever more rigid on the bed. Still, if all that is left of him lives in the stories we might tell, does it matter that these stories might begin with a lie no one has the heart, courage, or good manners to refuse?; one told, originally, in the service of redemption rather than remembrance although with each telling, the distinction matters less until it ceases to matter at all. Once home, the horizon begins to expand and I listen to my older brother call relatives on the east coast to let them know our father has died. I wonder at his ability to stay on point: he speaks with ease and offers them the same trivial story offered us from which no greater sense can or need be made. “It was a mercifully short illness” he tells them, “and all told, a peaceful end.”