TO BE ALIVE WHEN DYING. MORAL CATHARSIS AND HOPE IN PATIENTS WITH LIMITED LIFE PROGNOSIS

Anatole Broyard offers the following justification for his luminous book, full of brilliant metaphors, about the disease that will terminate his life: to make sure that he will be alive when he dies (Broyard 2013: 55). Facing the challenge of a limited life prognosis is a daunting prospect which requires a certain temperament or moral character. Some people build this character throughout their lives and this enables them to face death with serenity and meaning and to achieve a degree of continuity with their biographical background. For others, the prospect of death descends like stage curtains that drop implacably before the play is over, forcing the actors to improvise an ending. Is there any hope that this ending, albeit abrupt, can be full of meaning? Experience shows that it can. What is not clear is how this is possible, since under normal conditions a certain amount of time is needed not only to write a new script, but above all to be able to execute it.

In line with this, the first section emphasizes the importance of moral character when facing the ordeal of a dire prognosis. The second section highlights the impact that serious illness has on the patient's biography and the need for patients to assume a quest narrative that allows them to come to terms with the fatality of their destiny. The third section addresses the experiences of patients who apparently undergo a significant transformation in their moral character when there was seemingly no physical time for such a process. The fourth section highlights the need for patients to get through a grieving process, traversing the darkest nights of depression to emerge on the other side able to find a meaning to their quest. In the fifth section, this process is presented as having a certain cathartic effect. Finally, the sixth section connects the patient's journey with the heroic myth and the possibility of at least a moment of glory.

1. On the value of developing a good moral character

In the film *Ikiru (To Live)* by Akira Kurosawa (1952), Mr. Watanabe goes to see the doctor suffering from gastric pain and is diagnosed with terminal stomach cancer. Initially, the doctor adopts an altogether paternalistic attitude by not revealing the full extent of the disease to his patient, something which is not unusual in Japanese culture (Tanida, 1994: p. 50). However, Mr. Watanabe unwittingly becomes aware of the reality of his situation which gives him time to take action. Realising that he has not lived his life to the full, he makes the most of his final months to remedy the situation. Even so, there is something paradoxical about beginning to live one's life just as it is ending.

The Stoics teach us the importance of learning to accept death throughout our lifetime in such a way that time is well invested and not squandered. Being in a position to embrace death peacefully when the time comes will be vital to avoid, as Seneca so vividly describes, embracing the doctor's legs and begging for one's life to be saved, *wanting to live what has not been lived in the short space of time left.* To do so, one must have lived a full life and not merely existed. Stoic philosophy seeks to teach us to live (Seneca, 2001: II, 20). There is a certain air of stoicism in S. Nuland's reflections on his experience as a doctor, when he observes that the greatest dignity to be found in death is the dignity of the life that preceded it. This is, he explains, a form of hope we can all achieve and it resides in the meaning of what our lives have been (Nuland, 1993: p. 227).

In his book *Tuesdays with Morrie*, M. Albom reflects on the lessons he learned about the great questions of life during a series of conversations with Morrie Schwartz, his former professor who was in the final stages of the degenerative disease, ALS (Albom, 2012). The continued success of this book can be attributed in part to it being an exemplary testimony of the pursuit of the greater good in the face of unforgiving affliction, that is entirely in tune with the content of his teachings. Schwartz's last mission is

to provide lessons which may help others to better understand life and to make sense of things, and he does so with optimism and a touch of humour, making the most of every opportunity at his disposal at this final stage of his life. Schwartz, though, had already lived a full life, which undoubtedly helped him to face the process of his own death with strengthened resolve. He admits to having been ambitious, insensitive and preoccupied with his own material success (as does Albom himself before his meetings with Schwartz) but that he had already turned over a new leaf and changed his way of being before falling ill.

The way of being is determined by moral character, along with other psychological factors. Even the most renowned exponents of principlism, Beauchamp and Childress, recognise the importance of the moral agent having a good moral character, or in other words, possessing virtues. They consider this equally important to the moral agent relying on rules and principles (Beauchamp & Childress, 2013: p. 30-31). And, as it is known, Pellegrino and Thomasma have placed virtues at the core of their formulation of biomedical ethics (Pellegrino & Thomasma, 1993). Ultimately, as Aristotle demonstrates, virtues condition the possibility of a good decision (Aristotle, 1994: VI, 13). By implication, individuals with a poor moral character are capable of making *correct* decisions but their behaviour will not be characterized by them nor will their decisions be genuinely good. The process of undoing a pattern of behaviour is complex because it takes time. As Aristotle contends, habits are first exercised and then acquired, unlike faculties which are first acquired then actively exercised (Aristotle, 1994: II, 1, 1103a32-33). It is extremely difficult to accept and cope with a diagnosis as terrible as ALS without the foundation of a good moral character. Fortunately, M. Schwartz had a good moral character.

It may also be the case that the diagnosis of a serious disease awakens an active desire in patients to improve their moral character. This can be achieved with great effort and given sufficient time. In his book *The Illness Narratives,* A. Kleinman counts himself lucky to have met a certain Paddy Esposito, a highly respected bereavement counsellor in a small suburban hospital whose exemplary human and professional qualities helped him to overcome the "therapeutic nihilism" to which he had fallen victim as a result of a bad experience working with paralytic teenagers (Kleinman, 1988: pp. 138-145). According to confessions made by Esposito himself, he had been an "impatient, tremendously ambitious and selfish" individual before dedicating himself to helping others. It so happened that in the middle of his law degree, he was diagnosed with myocarditis – a disease which eventually took his life many years later – so he dropped out of university and travelled to Asia to train in Buddhism. He returned to the U.S.A. three years later apparently a new man; Esposito returned in far worse health but, he declared, "I was so much better" (Kleinman, 1988: p. 141).

Ultimately, it would seem that the stoic advice to learn to accept death throughout one's lifetime and to make the most of life is still valid. Those who follow this advice, like an experienced pilot, will suffer less in the face of adversity. Without doubt, being diagnosed with a disease that shows a poor prognosis is one of the most challenging of adversities.

2. The impact of illness. The need to rewrite one's life script

Unlike Mr. Schwartz, Mr. Esposito was inspired to reinvent himself and write a new life story on being diagnosed with a serious disease. In a study of coronary patients, it was revealed that following a heart attack, these individuals initially attempted to cling to their original, autonomously adopted life plan (Johnson, 1991: pp. 15-17). However, given the chronic nature of the disease, patients did not quite manage to do so and they suffered from frustration. In contrast, some patients who managed to come to terms with the harsh reality appeared "grateful for being given 'a second chance to live'" (Johnson, 1991: p. 29). In the face of a life-threatening disease, patients developed a new outlook on life. One individual claimed, perhaps somewhat rhetorically but quite significantly, that the heart attack had been "the best thing that could have happened to (him)". Upon further questioning, he responded "I'll be a better person for what has happened" (Johnson, 1991: p. 38).

For A. MacIntyre, human identity has narrative nature. He maintains that one's identity – or his lack of it – cannot be discovered in the psychological continuity or discontinuity of the self. The self inhabits a character whose unity is produced as a unit of a character. The question "What am I to do?" can only be answered if the prior question "what story or stories am I playing a part in?" can be answered (MacIntyre, 2007: pp. 216-217). My present is guided by an image of the future, in which goals are set and pursued, successfully or unsuccessfully but with the meaning accorded by a kind of narrative modelled on the collection of stories which form cultural traditions. According to MacIntyre, these traditions are fundamental to our education in virtues.

Illness is a huge blow which, according to Toombs, disrupts the fundamental unity between body and self which characterizes the lived body (Toombs, 1998: p. 215). Illness has a decisive impact on our lived experience of space and time.

Space is affected in the sense that our range of possible actions is restricted. Countless everyday actions which were previously taken for granted become a problem in themselves: holding a cup for a person with shaky hands, answering the phone or following a conversation for an individual with hearing difficulties, going upstairs for a chest angina sufferer, crossing the street for anybody living with a disability, and so on (Toombs, 1988: p. 211). In some cases, equipment can be used to improve the lived experience in terms of spatiality. These objects are incorporated in the patients' personal space and once they have become accustomed to them, they become in some way an extension of the body, as may be the case with a cane, a wheelchair, a prosthetic limb or a hearing aid.

The lived experience of time is also affected. Toombs, a person living with multiple sclerosis, affirms that a disproportionate amount of attention needs to be dedicated to the here and now, focusing on the activity being performed at any given moment. Mobility impairments convert mundane activities, such as getting out of bed, rising from a chair, getting in and out of the shower, tying a shoelace or undoing a button, into challenges which demand considerable exertion, intense concentration and a untoward amount of time (Toombs, 1995: p. 19). In the case of degenerative diseases, the future becomes a problem in itself, as patients can never be sure whether the tasks they can achieve one day will be possible for them in the future. "Things could be worse", so often a phrase meant to bring comfort, acquires bleaker connotations here (Toombs, 1995: p. 20).

As previously mentioned, individuals develop their own identity through narrative with an eye on future projects. So the diagnosis of a serious illness, especially one with a poor prognosis, shatters the patient's life, introducing chaos and undoing this narrative. H. Brody begins his book *Stories of Sickness*, with a quote from Tolstoy's *The Death of Ivan Ilich,* in which Ivan Ilich compares his own image in the mirror with his likeness in a photograph of himself and his wife, observing the considerable difference. Brody declares, "Ivan Ilich, as a result of the illness that will soon end in his death, has been turned into a different person" (Brody, 2003: p. 1). In fact, illness has the capacity to convert us into somebody else even though we continue to be the same person. The story of Ivan Ilich's illness highlights this dual nature of disease: on the one hand, the story of the same person; on the other, the appearance of an illness which marks a turning point in the trajectory of a life (Brody, 2003: p. 2).

For A.W Frank, stories do not merely describe identity, but they are the self's medium of being (Frank, 2013: p. 53). According to Frank, stories must repair the damage done to the individual by the illness. They are a means to drawing plans and discovering new destinations once again. Storytelling is like repair work on the wreck (Frank, 2013: p. 54). The patient's story however must not be reduced to the story of the illness. This is the doctor's version and it is presented in the form of medical records, which patients tend to echo. Patients need the support and the opportunity to narrate their own lived experience of the illness (Frank, 2013: p. 7).

Although each patient has a personal story to tell, Frank distinguishes between three basic types of illness narrative; every story is a combination of the three.

a) The first type is the restitution narrative (Frank, 2013: pp. 77 ss.) in which the temporarily damaged body becomes an object to be eventually repaired through a process dictated by a series of medical prescriptions. It follows the structure "yesterday I was well, today I am unwell, tomorrow I will be well again". The power of science is affirmed and *the doctor is the hero of this type of story*. This is clearly the preferred narrative, given that the normal trajectory of life remains intact and patients regain control of their life, the illness becoming a mere incident. For this reason, it is the story of choice for the advertising of pharmaceutical products. This type of story falls apart in the case of chronic or terminally ill patients.

b) When the evolution of the disease is unfavourable, stories become chaotic insofar as they lack narrative structure (chaos narrative) (Frank, 2013: pp. 97 ss.). These stories develop in a continual present without a memorable past and lacking a future worthy of consideration and their structure follows the format of "and then ... and then ...". Frank asserts that chaos cannot be denied and that sometimes life can be awful. This chaos must be accepted before new narratives can be constructed. There are no heroes in these stories, although I believe patients could reconcile themselves to being the anti-hero.

c) In contrast, *the patient is the hero* of the third type of narrative, the quest narrative (Frank, 2013: pp. 115 ss.). Here, patients manage to accept the interruption caused by the illness and they conceive it as the beginning of a journey with an as yet unknown destination. The illness inspires patients to rise to the occasion, a feat they achieve through a transformation of character which can then help others by way of example. Patients are not so much survivors here but they are *reborn*. Two metaphors illustrate this type of narrative particularly well: the phoenix and the snake that sheds its skin.

The narrators of this last type of stories also make frequent use of initiation stories which are in line with the hero myth. These heroes generally undertake a mission involving arduous ordeals and sore temptations along the way, and from which they will return transformed (Frank, 2013: p. 118).

According to J.Campbell, from an psychological point of view, the hero myth follows a pattern: separation from the world, initiation into a source of power, then the return to the ordinary world to live a life with more meaning (Campbell, 2009: p. 40). Campbell maintains that a hero ventures forth from the world of common day into a region of supernatural wonder: fabulous forces are there encountered and a decisive victory is won: the hero comes back from his mysterious adventure with the power to bestow boons on his fellow man (Campbell, 2009: p. 35). From an axiological perspective, Scheler considers that magnanimity is the fundamental virtue of the hero. For this reason, those who strive to achieve prosperity only for themselves or for their group cannot be considered heroes (Scheler, 2020: p. 86). The hero is a being who gives, not receives (Scheler, 2020: p. 89). Admittedly, the basic types are the soldier, the statesperson or similar figures, but as Scheler affirms, heroes are strong-willed and so it is not impossible for them to inhabit a fragile body (Scheler, 2020: p. 86-87).

Frank emphasizes that patients who narrate their own story of quest or mission obtain something that must be passed on to others, that is, their testimony. This is why the story cannot be invented. It must be real because *it must in some way serve as a guide to others or as an example for their lives* (Frank, 2013:pp. 17-18). In this context, I. Kidd maintains that a pathography (the account of the lived experience of an illness) has the capacity to transmit multiple truths and lessons; it can be morally edifying (Kidd, 2017: pp. 325-326). The documentary *Eso que tú me das (That thing you give me)* (J.Évole and R.Lara, directors, 2020) is about the singer Pau Donés, lead singer of the well-known Spanish group Jarabe de Palo. He had been suffering from cancer for five years and the filming took place a fortnight before his passing. The singer remarks that he had contacted the journalist because he "wanted to talk" and to "give one last interview before dying". He also talks of wishing to be an "authentic witness" in stark contrast to the widespread frivolity of the artistic world "to show who artists really are". His enlightening testimony teaches us to appreciate the truly important things in life.

The patient's story is underpinned by the *transformative experience* which was triggered by his illness. Pau Donés speaks of how he has learnt to enjoy the sunset, to cry or to say I love you. Frank (2013) refers

to "individual change" (p. 123)[1], "new identity" (p. 123), "to be more than she has been" (p. 128)[2], "change of character" (p. 128), "to become the recreated moral version of that self" (p. 130). For Frank, the impact of this kind of story depends to a great extent on how far it demonstrates the change in character of the protagonist. Frank asserts that readers choose stories of sickness for all kinds of reasons, "but the moral purpose of reading them is to witness a change of character through suffering" (p. 128).

In short, being diagnosed with a disease with a poor prognosis tends to deeply affect the patient's identity. As this identity is of a narrative nature, it has to be restored narratively. But only the quest narrative brings patients the hope that their suffering will be of some use to someone else.

Now, unlike works of fiction, in which one merely writes a text, narrative identity is constructed through action. And, as mentioned in section 1, action is strongly influenced by the moral character of the individual, leading to optimal behaviour in the case of M. Schwartz and T. Esposito, or introducing chaos and utter confusion in the life of Mr. Watanabe. As Aristotle shows, there is no practical wisdom without moral virtue (and vice versa) (Aristotle, 1994, VI, 11).

3. Moral change and time

Despite his disorientation and discouragement, Mr. Watanabe did not lose hope and fortunately he did things right. His colleagues were astonished by the change and wondered, "I don't understand, how come Mr. Watanabe has changed his character so suddenly?" The question is not futile, because changing takes time. However, the experience of the terminally ill supports Mr. Watanabe, in the sense that sudden change (although not of character) is possible. The question is how this is possible.

In antiquity, even the access to theoretical truth demanded prior preparation of the individual, a care of theself *(épiméleia heautou),* as highlighted by Foucault. He observes that philosophy is not merely a way of thinking which ponders over what is true or false, but also by that which makes the true and the false exist and can exist. That is to say, through the conditions and the limits of the individual's access to the truth. For this to happen, the ancients considered that it was necessary to call upon "the quest, practice and experiences through complex self-transformations that will bring the individual in the position of having access to the truth". This is what Foucault called "spirituality" and it includes practices such as purifications, ascetic exercises, renunciations, conversions of looking and modifications of existence (Foucault, 1987: pp. 37-38). In contrast, many centuries later, Modernity will claim that knowledge is the only means of having access to the truth without the need for self-modification (Foucault, 1987: p. 40).

As regards practical knowledge, the same tendency can be identified in modernity: the tendency to think that a modification in moral character is not necessary to be able to judge and do the right thing. This misunderstanding is particularly evident in those who make ethics exclusively a matter of values and who think that to effect a moral change boils down to devising a new table of values with which to write a new biography. This is tantamount to thinking that simply saying "cheer up" would be sufficient to lift an unhappy person from their state of despondency. In contrast, as previously mentioned, Aristotle shows that correct behavior is functional to the way of being (ἕξις) of the moral agent. For this reason, he defines prudence or practical wisdom (φρόνησις) as a "true and practical state involving reason, concerned with what is good and bad for a human being"(Aristotle, 1994: 1140b4-5][3].

As far as good and bad are concerned, the way of being is entirely determined by habits. This is why virtue is at the heart of Aristotle's ethics, because it is the condition of the possibility of the good decision. However, as previously noted, unlike faculties, which are first held and then exercised, habits

[1]In this case, quoting Oliver Sacks: "My adventure was drawing to an end. But I knew that something important had happened that could leave its mark on me and meaningfully transform me from now on. A whole life, an entire universe had been compressed into these weeks: a destiny of experience that is neither given to the majority of men nor desired by them. But a destiny which, with its passing, would renew and guide me". (Sacks, Oliver. *A Leg to Stand On.* Cit. in [16], pp. 123-124).
[2]Citing here the book "*No Less a Woman*" by Deborah Kahane, in which the character Terri says: "I would never have chosen to be taught in this way, but I like my transformation. I suppose I had to go to the limit to get there" (cit. in [16], p. 128).
[3]"Λείπεται ἄρα εἶναι *ἕξιν ἀληθῆ μετὰ λόγου πρακτικὴ περὶ τά ἀνθρῴπῳ ἀγαθὰ καὶ κακά"*. Italics added.

are first exercised and then held, so developing a virtue is a process that requires a considerable amount of time, especially when the starting point is a bad habit.

This may sound somewhat aristocratic, and indeed Aristotelian ethics is just that, but it has always been said that death is democratic in nature, because it comes to everyone. I believe that this leveling nature can be extended to the last moments of life, because mortal illness makes it easier for everyone, not only the virtuous, to write a good end to their biographies.

M. de Hennezel worked as a psychologist in France's first palliative care unit. Her experiences with terminally ill patients are gathered in the book *Intimate Death.* Through this work, she sets out to explore the following miracle: "When death is near, when grief and suffering are the order of the day, it is still possible to find life. There can still be happiness, feelings and spiritual change of such an intensity that has never been experienced before" (Hennezel, 1996: p. 15). She maintains that dying is not an absurd period of time devoid of all sense but the time preceding death can be a time of personal development" (Hennezel, 1996: p. 16). In her view, humans have never said their last word, but rather "are in a constant process of self-construction, perfecting and developing, ever capable of self-transformation, even throughout the crises and trials life presents" (Hennezel, 1996: p. 36). F. Mitterand, former President of the French Republic, summarises in the prologue what the greatest lesson is for him of this book: "death has the power to enable a human being to become what he was destined to be; in the most complete sense of the term, death can be a *fulfillment*" (Mitterand, in Hennezel, 1996: p. 12).

Some of the heart patients whose testimonies are gathered by Johnson in the aforementioned study seem to attribute the motivation for change to the closeness to death: "As the informants contemplated the possibility of death they were often prompted to review their lives" (Johnson, 1991: p. 28). Finding themselves in the situation of having a second shot at life (having survived a heart attack) they realised that they had not been living life to its fullest (Johnson, 1991: p. 29). In some cases, the will to live life to the full was strengthened by the experience of a close brush with death (Johnson, 1991: p. 83).

In light of these testimonies, one might conclude that the sensations generated by the so-called close brush with death could have triggered instant access to the (practical) truth, something which requires time under normal circumstances. In her essay entitled *"Love's Knowledge",* M. Nussbaum considers the Proustian idea that sentiment creates truth through the cataleptic impression. In Proust's *In Search of lost Time,* the main character discovers he is in love with Albertine – this essay covers knowledge of love in particular – when he receives the following news: "Miss Albertine has gone" (Nussbaum, 2005). This news has such an impact on the protagonist that all the clouds that were preventing him from being aware of the love he felt for the girl dissipated. For Proust, suffering becomes the most subtle and powerful instrument for knowing the truth, which is illustrated when he writes: "But this knowledge, which the shrewdest perceptions of the mind would not have given me, had now been brought to me, hard, glittering, strange, like a crystallised salt, by the abrupt reaction of pain" (Proust, III, 426, *apud* Nussbaum, 2005: p. 477). Consequently, the cataleptic impression becomes, in this context, knowledge *through suffering*.

In the same way, it is conceivable that an announcement such as "you have six months to live" could also be brutally revealing as regards the discovery of which goods in life are really worth loving. This type of knowledge will be just as vital as the knowledge which made Saint Paul fall from his horse on the way to Damascus.

As stated by Nussbaum, "cataleptic" derives from the Greek term *katalèptikè,* an adjective from the verb *katalambanein,* which means "comprehend", "grasp", "retain". As its meaning is more likely to be active than passive, it would refer to that which "firmly grasps (reality)" in such a way that the noun katalepsis could be translated as "certitude". Ultimately, Nussbaum affirms, katalepsis expresses "the essential point that this person now has an absolutely indubitable and unshakable grasp of some part of reality" (Nussbaum, 2005: p. 478). For Zenon, according to Nussbaum's interpretation, our entire knowledge of the wider world "is built upon the foundation of certain special perceptual impressions: those which, by

their own internal character, their own experienced quality, certify their own veracity" (Nussbaum, 2005: p. 478).

It is worth considering whether or not a kind of cataleptic impression is experienced by those heart patients whose illness and brush with death have provided them with an opportunity to give their lives new direction, as mentioned by some informants. Johnson (1991: p. 28) writes:

> A heart attack is a potentially life threatening event, and individuals who experience a heart attack are faced with the possibility that they may not survive. Many of the individuals in this study had not contemplated the possibility of their death prior to the time of their attack. The ability to survive a life threatening event was considered a profound experience, and this event affected the way in which the informants envisioned their futures.

One informant notes that on the fourth day after his heart attack he was given a newspaper and when he reached the obituary pages and did not see his name, he thought "This is the day I'd have been buried" and he felt "very, very grateful"(Johnson, 1991: p. 29). Another informant also refers to this feeling, declaring that she was "grateful" for the heart attack as it forced her to make necessary changes in her life (Johnson, 1991: p. 37).

Johnson reports that those patients who understood their "brush with death" as a second chance felt a powerful desire to live life more to the full, and so they had an optimistic outlook (Johnson, 1991: p. 29). On the contrary, those who became despondent and pessimistic, dwelling on the fact that their life would be shorter, did not experience the same miracle. The most difficult changes to adopt were those that involved changes in attitude (Johnson, 1991: p. 78). The influence of moral character is evident here. In contrast, the optimists were determined not to let their lives be dictated by their heart attacks and they expressed their desire to live life to its fullest. Johnson indicates that in some cases, this desire was rekindled by the close brush with death experience (Johnson, 1991: p. 83).

Nussbaum is critical of the Proustian idea of a cataleptic knowledge of love. Instead, she proposes the experience of Ruth, the main character in Ann Beattie's novel *Learning to Fall*, who struggles to accept her own self-deception about the love she feels for a man. However, her knowledge evolves over time without experiencing any crushing blows and despite a complete lack of certitude (Nussbaum, 2002: pp. 493 ff.). Johnson's study effectively concludes that in fact, once patients have come to terms with the reality of their new world, they need time until they can start to take steps in a new direction. The "New Man", to use Pauline terminology, is only born with the help of freedom; the old man must accept his own death. "The informants believed that they were faced with two options: They could continue to ruminate about what happened to them or they could look to the future and attempt to make adjustments" (Johnson, 1991: p. 36). Some patients took these steps very quickly while others needed longer, but in any case, it is a process which *requires time*.

4. The need to get through a grieving process. Acceptance of the unavoidable

At first, patients cling to the hope that the diagnosis or the prognosis might be false or or that the miracle of healing will occur. It is this false hope which impedes the transformation process. As Proust writes: "And so my suffering was far crueller than that week over the New Year, because now within my soul resided not the pure and simple acceptance of pain but the constant hope that it would cease" (Proust, 2004: vol. 1, p. 372). In contrast, elsewhere he writes: "... illnesses are among those many things which bring new hopes to replace the old ones ..." (Proust, 2004: vol. 1, p. 303).

As it is known, Kübler-Ross has described five stages typically undergone during the grieving process: denial, anger, bargaining, depression and acceptance (2002: pp. 59 ff.).

At first, once patients have been made aware of the reality of their situation, they generally fall into a kind of stupor and are unable to digest the news they have been given due to its essence and magnitude. According to Kübler-Ross, denial functions as a cushion which allows patients to recuperate from the unexpected and dumbfounding nature of the news (2002: p. 60). This phenomenon is consistent with the fact that medicine is not an exact science. In fact, broadly speaking, the first thing to cross the patient's

mind is that the diagnosis is false, both in its severity and prognosis. This is when a second medical opinion is sought. There are persons who, in the wake of an extremely traumatic experience, never get past this phase (Cohen, 2000: pp. 21-50). However, it is rarely the case that sick people remain in denial until the end (only 3 patients out of 200 in Kübler-Ross's study) (2002: p. 61). Kübler-Ross relates the case of a patient who, in her refusal to accept the situation, resorted to the application of make-up to camouflage the ravages of the disease. As her illness advanced, she overused make-up to such grotesque extremes that her face resembled a mask.

In a period of time which varies from patient to patient, this initial stupor dissipates as the morning mist gives way to the sun, until the crude reality is laid bare in front of the patient's very eyes. In this second stage, feelings of anger, rage, envy and resentment take precedence and the question arises "Why me?" (Kübler-Ross, 2002: p. 73). Given the degree of desperation experienced, this stage is a common sticking point and many patients have great difficulty moving on, or they even fail to do so. If they do progress, the third stage is *bargaining*. This process begins when patients, consumed with anger, realise that the only thing they have achieved is to deepen their feelings of disarray. So they decide it might be worth pleading to God for some extra time with which to accomplish a purpose or have a few days free of pain and physical discomfort. These bargains, explains the author, are made secretly with God or in the presence of a priest. Many offer to dedicate their life to God (Kübler-Ross: pp. 111-114).

In the fourth stage, the loss of all hope of the reversibility of the evolution of the disease combines with *depression* which can last for a shorter or longer period depending on a number of factors. One of these factors is the extent to which the people in the patient's entourage are able to help. According to Kübler-Ross, the discrepancy between what patients are feeling and the expectations of those around them is a source of further pain and confusion for patients. On the other hand, she states, if patients are allowed to express their pain and if they are helped to resolve any outstanding issues, they will have less difficulty progressing to the next stage (Kübler-Ross: pp.115-145).

Acceptance is the gateway to the fifth stage. The effects of this step vary depending on the time available and the time required for the transition between the previous stages. The more patients struggle to cling to their original hope, the more difficult it is for them to achieve acceptance. There comes a point, however, when even the most indomitable patients falter and finally recognise that they can fight no more (Kübler-Ross, 2002: pp.149). As mentioned above, the Stoics insist on making good use of time to die well. As a result of her work with terminally-ill patients, Kübler-Ross maintains that, in fact, the acceptance phase is easier for elderly patients who have worked and suffered, raised children and fulfilled their obligations. They will have found a meaning to life and they will feel satisfaction when they think about their years of work (Kübler-Ross, 2002: p. 156). However, when this is not the case and patients are not yet in a terminal phase, there is still hope that their moral conversion may take place no matter how short a time is left.

When patients speak of living life "to its fullest", they are not alluding primarily to filling their life with more time, which they obviously do not have to resign, but to filling their life with meaning. This is the hope that never falters. Han writes that a full life cannot be theoretically explained in terms of quantity, in the same way that narrative is not just the automatic result of a list of events. According to this author, a full life is more like a specific synthesis that is attributable to meaning (Han, 2018: p. 25). A long list of events does not generate tension in a narrative, but a very short story can create a considerable amount of dramatic tension. By the same token, a short life can achieve the ideal of a consummated life (Hahn: p. 26).

Terminal illness does not have to be an impediment to culminating a life, given that the last moments can be lived to the fullest. When hopes of healing have been lost and the sick person has accepted this, paradoxically a new and *a priori* undetermined hope is born, which finally materializes into a kind of mission.

5. Extreme situations and moral catharsis

In English, the metaphor "human flourishing" is usually applied to make reference to the idea of human development which is compatible with Aristotle's ethics. However, I believe that the maturity metaphor can also be useful. Aristotle dedicates some lines to immaturity, in connection with learning about politics, which are also applicable to ethical training. According to the Stagirite, the young make poor disciples in Politics because they lack the experience necessary for reasoning. In any case, as they are docile to passions they will learn in vain given that the end of politics is action and not knowledge. He clarifies that it makes no difference whether they are young in years or juvenile in character, since the deficiency is not related to age, but occurs because of their living and engaging in each of their pursuits according to their feelings (Aristotle, 1994: I, 3, 1095a3-11).

Continuing with the above metaphor, a comparison could be made between the young people with the unripe fruit, since they have not yet forged their character, and the immature older ones with the acrid fruit, because they have formed it, but poorly. Nevertheless, both age groups are ill-equipped to deal with the untimely nature of fatal illness which leads them to easily give way to despair. *They are desperate to find a cure and they are desperate to save their lives* (in the ethical sense, which is the one addressed here). As regards the former, they are right, and it is this kind of hope which is to be banished. As regards the latter, they are mistaken and this is where new hope lies, a hope *a priori* without tangible or definable content that anyone who has been desperately ill can raise. As Musschenga (2019: p. 435) affirms, disappointment is one thing and despair or hopelessness is another. It does not follow that when a tangible hope does not materialize, the void this creates should be filled with despair (Musschenga, 2019: p. 436). Despair and hopelessness are not the loss of a specific hope (intentional hope) but rather the loss of the capacity to hope (pre-intentional hope) (Ratcliffe, 2013: p. 600). According to G.Marcel, the very idea of being cured *is susceptible to purification and transformation* (Marcel, 2005: p. 57).

The film *Flight* (Zemeckis, R., dir., 2012) realistically addresses the issue of the immature adult, who could also be described as incontinent in Aristotelian terms. The hero, Whip Whitaker, an experienced commercial airline pilot with both alcohol and drug addictions is incapable of staying dry even when he has to pilot a plane full of passengers. One day, the plane he is piloting suffers a serious mechanical failure and goes into a steep dive. Had it not been for his professional expertise, the plane would have crashed without a single survivor. Miraculously, only six people die as he manages to right the plane and crash-land in an open field. However, the ensuing investigation to reveal the causes of the incident reveal evidence that indicates that the captain had been drinking during the flight, which puts his honour, popularity and career on the line. His lawyers do their best get the evidence voided and they urge the pilot to put an end to his compulsive drinking but he repeatedly falls off the wagon due to the strength of his addiction, the trauma of the incident and the appearance of even more problems. Eventually and as a result of some particularly testing times, he discovers that when he seems to be at the end of his life with his career in ruins, the hope of a fuller and truer life blossoms.

Unlike the case of immature youngsters who still have time to mend their ways, it is no less difficult for older, immature adults to give a new direction to their lives as it is to land a plane that is plummeting to the ground. However, it is not impossible. If there is time, the help of a psychotherapist can be sought, through which the psychological and behavioural processes of the patient can be adapted to a specific therapeutic plan. Alternatively, there is asceticism, through which the human spirit is liberated from its psychological conditions and purged through a strict behavioural plan including mortification and self-discipline exercises, such as those indicated by Foucault (see above).

However, both of the aforementioned cases require prolonged effort which might obtain results in the long term and so they do not seem to be an option for terminally ill patients. All the same, it would seem that some of these patients do undergo a kind of moral conversion, specifically those who have overcome the anger phase and accepted the probability that they are going to die. The point is to identify the trigger to a process which is generally lengthy, uncertain and arduous given the resistance generated by habit. Purging is a traditional medical practice, but can the psyche or the spirit be purged (if they can be considered two distinct concepts) while foregoing long-term procedures such as psychotherapy or asceticism?

The word κάθαρσις (catharsis) is illuminating because along with a general meaning of purification or cleansing, it has another more specific and ritual sense of expiatory sacrifice. In two well-known passages, Aristotle uses it in its general sense (and outside any religious context) to make reference to the purgative effect of two artistic genres: tragedy and music. In fact, in *Poetics* (2011:1449b25-30) the Stagirite contends that tragedy arouses sensations of pity and fear and then purges these emotions. Likewise, in *Politics* (1982: 1341b35-42), Aristotle mentions the idea that music is cultivated in the pursuit of education and purification. He refers to *Poetics* to broaden the concept of catharsis or "purgation". However, this presumably pertains to the now lost book II.

The basic premise is that the spectator is purged of certain passions through the act of contemplating tragedy or through music. As the playwright, T. Williams, states: "if there is to be any truth in the Aristotelian idea that violence is purged by its poetic representation on stage, my cycle of violent dramas might have a moral justification after all" (1962: p. 14). Saint Augustine, an avid theatre-goer, wonders what explanation there might be to the fact that, on the one hand, people wish to feel pain watching shows representing death and tragedy, but on the other hand, they do not want to experience that pain in their own flesh. He responds that although nobody likes to be miserable (individual suffering is termed misery), people do want to be compassionate and share others' suffering (suffering with others is termed mercy or compassion). For this reason, people enjoy going to the theatre to suffer (Augustine, 1997: III, 2). He goes on to say that the pain suffered during a play of this kind is nothing but a minor graze.

This is the very reason why the impact of this type of show is so limited, because they inflict little more than a superficial, epidermal graze on the soul. Other means of liberation, such as alcohol or drugs, have inadvisable side effects no matter how intense or "wild" the cathartic effect may be in the short term (Garrabé & Louis, 1971). Notwithstanding, the patients who participated in this drug study allude to two ideas which could be considered key in this present study: liberation and the voyage to the unknown.

Psychotherapy has therefore sought to express this liberating effect more effectively. Staying within the realm of theatre, which is where Aristotle originally situated us, the psychodrama school of psychotherapy bases its therapy precisely on making these liberating effects more long-lasting by placing theatre-goers in an acting role in their own drama. The main developer of psychodrama, J.L. Moreno, notes that the Aristotelian approach in fact illustrates a purgation or release of selfish passions which occurs through the awakening of certain emotions in the audience through art. However, this spectator-focused catharsis is merely passive or aesthetic in nature. In contrast, if the spectator becomes the actor, as inspired by the model of oriental religions, this catharsis can become active or ethical in nature (Moreno, 1978: pp. xvi-xvii). According to Moreno and the school of psychodrama, this model has significant therapeutic virtuality. Unlike psychoanalysis, it is not limited to inciting descriptions of past events and responding to pre-established questions, but it places the subject in a pivotal, dramatic situation (impromptu and without line-learning) in order to witness the spontaneous performance. In this way, the psychologist can proceed based on the subject's own conduct at the very moment it occurred (Moreno: p. 10).

Obviously, the intention here is not to put seriously ill patients in the position of either spectators or actors in a show, be it their own or that of others. The point is whether suffering itself, when it is sufficiently substantial, has any kind of cathartic effect on the subject as regards the releasing of passions. Jaspers states in his book *Essence and Forms of Tragedy* that catharsis is an opening to being which arises not so much from mere contemplation "but (more) from being affected by something; an appropriation of what is true through the purification of something that, though our experiences in life, binds us, undermines us, obstructs us, constricting and blinding us" (Jaspers, 1991: pp. 27-29). In *Philosophy*, he places suffering and death among a number of extreme situations *(Grenzsituationen),* which are those situations which put humans on the dividing line between being and not being. Jaspers argues that when we find ourselves in a situation of this nature, we are liberated of all conventionality, external regulations and generally accepted criteria which bound us before and which define the domain of "Man" – the reference is to the Heideggerian "Man" as a personification of the impersonal – and in this way, he considers himself an existence. The extreme situation allows man to go from a non-authentic

being to an authentic being. Everything that previously constituted the meaning of his life appears to be an illusory being or a world of appearances in the extreme situation. He adds that the extreme situation allows personality to come into contact with transcendence, with God (Jaspers, 1991: pp. 17-23).

6. A moment of glory

There is no space here to develop the Heideggerian theory of "Man" and even less still to tackle the ultimate theme of transcendence. However, it is clear that, as Jaspers affirms, what is at stake here is an existential matter.

From a strictly natural point of view, it is inconceivable that an extreme situation such as suffering or death should be effective in creating new habits which were not able to be created in a timely fashion and over time. There is no such thing as to automatically adapt to an environment, neither in the strictly biological sense nor in the distinctly human sense. In the case of the plane, this would amount to thinking that there were passengers who managed to become aware of what truly matters during the freefall and that these passengers, having got through the experience unharmed, were completely transformed and perfectly equipped with good habits which convert them into sources of prudence or Aristotelian φρόνιμοι. This is simply inconceivable. The phenomenon can be compared to that of smokers who lose *ipso facto* the desire to smoke upon being diagnosed with a serious illness, but no sooner do they discover that the diagnosis is incorrect than they continue with their old vice. It is also the case of the moral improvement of Monsieur de Charlus in Proust's aforementioned novel. He had abandoned vanity, railing, outbursts of evil and pride, only to realise that "this improvement vanished with the disappearance of the illness which had had the effect on him" (Proust, 2004: vol. 2, p.539). Zenon's κατάληψις could possibly have a role to play here due to its fleeting nature and thus it limited effects.

Under the premise that an Aristotelian perspective is accepted, even if the natural purpose of humans represents the ultimate threshold of meaning, this does not exempt individuals from seeking their own particular and individual meaning for their own lives. This situation, however, is played out at an existential level and it is here where the answer must be sought to the matter of the possibility of living the dying process (in a good way).

V. Frankl founded a meaning-centred school of psychotherapy, denominated "logotherapy" in order to highlight that this therapy's principal aim is to help patients to pursue meaning in their lives (Frankl, 1995: p. 98). As opposed to psychotherapies based on the idea of self-fulfillment – it is useful here to recall Maslow's famous hierarchy of needs – logotherapy is founded on an idea that is the complete opposite of *fulfillment* (Frankl, 2006: p. 37).

When he becomes aware of his medical condition, Mr. Watanabe, mustering the courage he derives from the situation, decides to live his life once and for all and for the short time he has left. As he is unsure how to proceed, he experiments with different ways. He first takes the path of the incontinent man, which only leads him to a state of weariness and depression. Secondly, he follows the path of self-fulfillment, which he eventually abandons because of the untimely nature of the task. Finally, he gathers all his remaining energy and endeavours to make progress with a dossier which until now had been unsuccessfully presented by a group of impoverished citizens. Mr. Watanabe had merely remitted this particular dossier to colleagues on a number of occasions in the past but now he undertakes the arduous task of tackling the cumbersome bureaucratic machine that he used to be part of. The question is whether his posthumous glory will serve as an example and a reference for his colleagues in the Citizen's Advice Service or if each of them will have to await their own ordeal to react.

At an existential level, the hypothesis posed is that these patients undergo not so much a moral transformation but a moral *galvanization*—Broyard uses this same word to describe how he felt upon learning of his illness (2013: p. 65). This is a parallel phenomenon, albeit at a different level, to the biological reaction produced in a situation of perceived danger when the organism activates its adrenaline supply in order to focus all its energy on extricating itself from the situation. An example could be the

flagging cyclist who, rather than abandon the race, takes the opportunity to show her capabilities with the finish line on the horizon. It is not that the sight of the finish line gives the cyclist extra strength, but that she gathers all her strength in pursuit of the end.

When faced with an extreme situation such as that of Mr. Watanabe, individuals can voluntarily decide to gather all their energy in order to achieve one last mission which might (ethically) redeem their life. This final act does not have to be an epic gesture, but it can be relatively modest depending on the seriousness of the patient's clinical and personal situation. Neither is it the case that the patient is invested with the virtue of strength, such as a medieval knight whose strength is invested through the imposition of the sword. Instead, she gathers the necessary momentum to accomplish a mission through pure willpower, and not necessarily with the help of the virtue of strength (unless she already had it). She will find it harder, but she will be able to have her moment of glory.

However, it should be emphasized that heroes, as Polo notes, are not free for their own good, but rather they accept a task from which *not they but others will benefit.* In fact, the heroic myth presents four core elements: the individual, the struggle, the adversary and the task (Polo, 2003:245). When we think of heroes, we imagine young, brave and dedicated characters that triumph over their enemies. Evidently, it would be unreasonable to place the burden of responsibility of achieving Herculean endeavours on seriously ill patients who find themselves in the midst of a dramatic situation. Nevertheless, heroes are not necessarily characterised by their youth, but by their willingness to lay down their life in the service of others. In fact, the sick person is facing possible death and an enemy: the illness.

One further paradox is that it seems necessary that the patient renounces all hope so that the latter is reborn, transformed from its ashes in a dialectical process. . Thus, the hope for a cure is transformed into the hope that the last chapter of life should be significant and worthy, not only for oneself but also for others. The mission assigned to each patient does not have to take on epic proportions given that ultimately it consists of *bearing witness* and this must be adapted to the specific life circumstances of each individual. Glory can come in all shapes and sizes. Albom, Kleinman, Nuland, Kübler-Ross, Hennezel and thanks to all of them, their readers, acknowledge that they have learnt valuable lessons about life and death by contemplating the example shown by the patients whose testimonies are gathered in their works.

Patients will not have their moral character transformed by simply undertaking their mission. Embracing a realistic mission, however, will provide them with the necessary strength to carry it out; they might not be stronger, but they will have greater fortitude. Although a moral conversion which fundamentally transforms their character might not be observed, it is possible to detect a purgation of morbid emotions which would otherwise have prevented the patients who have not lived life (to the full) to fulfill their destiny. Thus, catharsis regains its ritual sense given that the oblative value of a victim is invariably based on his purity.

"That he not have died in vain": Family and close relatives of an individual who has been taken away too soon sometimes say this when they discover some kind of meaning in death. It is but another way of expressing the same idea. When patients fulfill their destiny, both they and their loved ones find peace.

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