

WITH THE END IN MIND

KATHRYN MANNIX

PUBLICITY ROUND UP

**WITH**  
Dying, Death  
**THE**  
and Wisdom  
**END**  
in an Age of Denial  
**IN**  
Kathryn Mannix  
**MIND**

Caroline  
Sanderson

## EDITOR'S CHOICE

NON-  
FICTION

Forget December indulgence, the New Year, New You season has crept into December, with a raft of well-being and dieting titles

December is the new January. Well before you've popped the cork on that New Year's Eve bottle of champagne and pigged the rest of the Quality Street, bookshop shelves will already be full of books exhorting us to ban the booze, bin the processed food and get crunching those abs. The final month of 2017 boasts new titles by those bestselling champions of well-being—Joe Wicks, Kayla Itsines, Charlotte Crosby, Fearne Cotton and Tom Kerridge; and a sinewy selection of titles by up-and-coming paragons of health. You'll struggle to find the straightforward calorie-counting diet of yesterday. Now it's all about self-care, "science", eating and fitness plans tailored to the individual, and that abiding old adage, *mens sana in corpore sano*.

Another publishing year is at an end. Thank you, publishers, for all of your submissions throughout 2017, especially those of you who take particular care over each month's selections, highlighting and sending early proofs for the titles you are particularly excited about. With the number of books I have to consider each month ever-growing, this is a great help. I'm always happy to answer any queries about submitting books for this feature, and always delighted to hear from publicists and editors. Find me on Twitter @CaroSanderson.

## EDITOR'S CHOICE/BOOK OF THE MONTH

Personal favourite  
TOP SELLER

Likely to be the biggest selling titles of the month based on an author's sales history

ONES TO WATCH

Titles with strong sales potential and publisher support, regardless of sales history of the author

## BOOK OF THE MONTH

BIOGRAPHY &  
MEMOIRS

**KATHRYN MANNIX**  
**WITH THE END IN**  
**MIND: DYING,**  
**DEATH AND**  
**WISDOM IN AN**  
**AGE OF DENIAL**  
WILLIAM COLLINS,  
28TH, H/B, £16.99,

9780006210889

"We can all become beacons of compassion, living in the moment, looking backwards with gratitude and forgiveness, and focused on the simple things that really matter." Mannix, a pioneer in the relatively new discipline of palliative medicine, has spent four decades working with patients who have incurable illnesses. Here she tells riveting stories of some of those she has

cared for, to illustrate how quality of life can be optimised as death approaches. There's Holly, the young mother who saves the night nurse before dying peacefully; Sanjeev, an elderly man convinced he is on the night train to Delhi to meet his parents; a heartbreaking couple who think they are keeping bad news from each other.

*With the End in Mind* deserves to rank with *Being Mortal* and *When Breath Becomes Air*. But it's also unique in showing us the numerous paths a death can take: how it evolves, what a deathbed is actually like, what matters most to the dying, and to the bereaved. The stories—by turns touching, tragic and even funny—show that death delivers far less sting given the right planning, information and a dose of honesty. A book I wished I had during my own father's terminal illness. Read it, and you'll be better prepared for life, as well as death.

BIOGRAPHY &  
MEMOIRS

**MARGARET FORSTER**  
**DIARY OF AN**  
**ORDINARY**  
**SCHOOLGIRL**  
CHATTO, 7TH,  
H/B, £9.99,  
9781784742232

"Saturday 24th July. Bought a pair of shorts—white, very short with two pockets. Super but rather daring!" This 1954 diary of the late novelist, which vividly brings back that era, only came to light after her death, leading some to question whether it should be published at all. Her widower Hunter Davies set out his justification in an article in the *Guardian* earlier this year: "My main argument is that, unlike other material with which she was unhappy, she never destroyed her diaries, so must have known there was a chance they would be discovered." Whatever the ethics, Forster's writing is always a delight.

HEALTH, DIET  
& FITNESS

**CATHERINE GRAY**  
**THE UNEXPECTED**  
**JOY OF BEING**  
**SOBER**  
ASTER, 28TH,  
P/B, £8.99,  
9781912023387

Believe it or not,

sobriety is a growing trend: one in five British adults and a third of Londoners are now alcohol-free. What's more, 43% of British women and 84% of British men want to drink less. And what's not to like, given that drinking less will make you happier, healthier, wealthier, slimmer and sexier, says the author of this "new bible of sobriety", which aims to give you all the incentive and inspiration you need to find the joy in a sober life. Gray's fizzy writing succeeds in making this potentially boring-as-hell subject both engaging and highly seductive.





## Incredible courage

The Munich students who took on the might of the Nazis in wartime Germany

32



## Literary low point

How judging the Booker made David Lodge seek out a counsellor

36

# BOOKS

## A better way to die

Kathryn Mannix is a palliative carer with over 30 years' experience. Her wonderful book might change how you see the world

### SOCIETY

Christina Patterson

**With the End in Mind**  
Dying, Death and Wisdom  
in an Age of Denial  
by Kathryn Mannix  
Wm Collins £16.99 pp349

"It is time," says Kathryn Mannix in the introduction to this book, "to talk about dying." In her own life, it's a subject she talks about a lot. A consultant for more than 30 years in palliative medicine, and founder of the UK's first dedicated palliative care CBT clinic, she lives and breathes last words and last breaths.

But she is well aware that most of us don't, and that many of us won't even mention "the d-word". Modern medicine, she explains, has lengthened

lives, but it has also taken death out of homes, and daily life. Into emergency rooms, ambulances and hospital wards. In this process, she argues, "rich wisdom" has been lost. She is on a mission to bring it back.

The first time she saw someone die, in an ambulance, she was, she says, "perplexed" by the "lack of ceremony". The doctor on shift simply put away his stethoscope and picked up a new chart. The next patient, she adds drily, was a child "with a sweet stuck up her nose". During her training, she got more used to the patterns: the changes in breathing, the conversations with families, the sudden shift to the past tense. But it was a conversation with one patient that changed her life.

The patient, Sabine, was nearly 80. She had "a

distinguished billow of silver-white hair swept into a knotted silk scarf" and wore full make-up and a kaftan. On that kaftan, she wore the medal she was given for courage during the French Resistance to remind herself, as she waited for her bowel cancer to eat away at what was left of her liver, that she "too can be brave". Her biggest fear, she confessed one day, was that she would die in agony.

What followed, says Mannix, "has lived with me, as if on a cinema reel, for the rest of my career. It formed my future practice; it is writing this book." What followed, in fact, was a conversation in which a consultant told Sabine, in calm, clear detail, exactly what she could expect. And at the end of it, Sabine picked up the consultant's hand and drew it "to her lips".

The lessons Mannix learnt from that first masterclass run through the 30-odd stories that follow. As you would expect in a book so fine-tuned to medical ethics, names and details have been changed. But the life in each story shines through and the characters practically leap off the page. There's Holly, a thirtysomething mother of two teenagers, who can't stop moving, can't stop dancing, and is disturbing all the neighbours in her block with the loud music she won't

switch off. Holly has advanced cancer of the cervix. She "seemed to emanate a faintly yellow light, like a fading light bulb", but "is in constant motion, as though driven by an unseen force".

There's Louisa, who sinks into depression after she's admitted to a hospice, and Millie, a retired childminder in the same bay whose visits from Nigerian friends, complete with mounds of deep-fried plantain, are like a party. Both have broken their hips after breast cancer has spread to their bones. Louisa is heartbroken that she is likely to miss her daughter's wedding. Millie is relieved she hasn't got Aids and is enjoying the kind of tender care she has never had in her life. The friendship they form has profound effects on both their lives.

The stories read like fiction, from a writer well attuned to her craft. The dialogue sings. It captures the rhythms, tone and voice of her characters. Mannix has a writer's (and doctor's) eye for detail: for a "fluttering hand", for a "slight flicker of an eyebrow movement", for a "barking, rasping laugh". At times, the writing edges towards the lyrical: a "white mist... bathing the gardens beneath an autumn dawn", a "gauzy green veil of spring unfurling across the woodland along the river".

At other times, that



**Reaching out** The author lives and breathes last words and last breaths

**“She is aware that many of us won't even mention the 'd-word'”**





near-poetic precision is used to more shocking effect. The story of Alex, a painter and decorator who is also an artist, ends with "a huge, dark-red python" of blood that "slithers rapidly out of his mouth". Alex, Mannix observes coolly, "would appreciate the dense colour, the changing texture, the dark-meets-white on the bedding".

It is incredibly moving, of course. You are likely to spend much of the book in tears. But what it isn't is miserable. There's plenty of humour. It's there in the wry tone Mannix uses about some of her unspoken thoughts. It's there

in the dead goldfish her three-year-old places in a jug in the fridge for Mummy to see when she comes back from seeing her own dead grandfather. It's in the "polaroid" her grandmother talks about, instead of a haemorrhoid, which makes everyone around the bed rummage in their bags in order to avoid each other's gaze. It's there in the amaryllis by a bedside that "undeniably resembles an erect green penis" and has the patients opposite chuckling away all day. Yes, this is a book about death, but it is also a book about joy.

It is structured into

different themes: the patterns that emerge in death and dying, the individual coping strategies people use as they face it, the power unleashed in naming death, the need to re-interpret some situations, the yearning for transcendence or some spiritual dimension, and the near-universal desire to leave something behind.

Between the stories there are short pieces of commentary, sharing some of the insights Mannix has learnt. At the end of each section, there are "pauses for thought", encouraging us to ask our own questions and apply some of these

insights to our lives. These, presumably, are intended to turn the book into a practical tool. It doesn't need them. The stories are so powerful, they speak for themselves.

What emerges from all of this is the breathtaking care that Mannix and her colleagues put into their work. It's not just the interrupted evenings, holidays and weekends. It's not even the vast practical efforts, like the Christmas tree and dinner put on for one patient who wouldn't make it to the end of the year, or the kitten that was the centre of one patient's universe, which Mannix agreed to take in.

It's the listening. It's the imagination. It's the ingenuity. Oh, and it's the price. Mannix clearly loves her job. They all clearly love their jobs. But you don't watch young children lose their parents and not pay some kind of price. Mannix talks about being "rewounded in the light of duty". And every day, they go back.

There aren't all that many books that change the way you see the world. This book really might. It will make you want to do a better job of loving and living. It will make you want to be kinder. And it will make you want to cherish every precious moment of your precious life. **A**



**nonfiction***The Times*

# Why we are wrong to fear the Reaper

**Death is inevitable — and this ungloomy book helps to prepare us, says **Cathy Rentzenbrink****

**WITH THE END IN MIND**  
Dying, Death and Wisdom in an Age of Denial  
by Kathryn Mannix  
341pp; £16.99

**With the End in Mind**  
Dying, Death and Wisdom in an Age of Denial  
by Kathryn Mannix

William Collins  
341pp; £16.99

**M**y granny's last job was as a tea lady in a nursing home. One Sunday afternoon her employers said they had to go out and they asked her to keep an eye on a dying resident.

She had to pop in every so often and give her face a wipe with a flannel. On one such visit she realised the resident was dead. "There should have been someone there with her," Granny said. "It shouldn't just have been me."

My granny died when I was 12, so I have been pondering that story for more than 30 years. What do we owe the dying? And is this the fate that awaits us: a lonely room and an occasional wipe with the tea lady's flannel?

Kathryn Mannix in *With the End in Mind* gives us a "tiny glimpse" into the deaths happening around us. It may seem odd or presumptuous, Mannix says, to encourage a reader to want to spend time in the company of dying strangers, but her experience has taught her that there is little to fear and much to prepare for.

Mannix first saw a dead person when she was 18. It was her first term at medical school and the doctor she was shadowing was called to certify the death of a man who had died of a heart attack in an ambulance on the way to the hospital. The man's eyes were closed, but his eyebrows were

raised, giving an impression of surprise. The doctor was quick and deft in his certification, then noticed that Mannix was reluctant to leave the body.

"First time, eh?" he said, then told her to use her stethoscope. When Mannix finally untangled her shiny new stethoscope, got it the right way round, and placed it over the man's heart, she had never heard a silence so solid. "You'll get used to it," said the doctor, kindly. Mannix was perplexed by the lack of ceremony. Her next patient was a child with a sweet stuck up its nose.

Since then Mannix has encountered death thousands of times. She started out

**Death is not a dreaded party pooper, but the intended final event of our lives**

in cancer care and then became a palliative care consultant working in hospices and in patients' homes. Mannix did get used to death and learnt that she did not fear it, but was fascinated by "the ineffable change from alive to no-longer-alive". She relished the professional challenge of how to be both honest and kind when talking to patients and their relatives, and felt privileged to be present and serve people as they approached the end.

Over the course of the book we meet a wide variety of people who have vastly different concerns and preoccupations. Vronny worries about who will explain periods to her daughter, Billy attends his mother's death bed wearing handcuffs and with security guards, Fergus delays his chemotherapy so he can be well for his son's birthday, Joe and Nelly have been married for 50 years and both think the

other doesn't know that Nelly is dying. Often people are trying to hide the truth about their pain and their prognosis from their loved ones. Misunderstandings abound because the art of dying is a forgotten wisdom.

This is a conversation that needs to be had, says Mannix, because somewhere in the second half of the 20th century we lost the vocabulary and etiquette to cope with normal humans dying normal deaths. The death rate is still 100 per cent, yet technological advances have led us to an age of denial where the sickest people are rushed for treatment and we no longer want to accept that death is inevitable. "Instead of dying in a dear and familiar room with people we love around us, we now die in ambulances and emergency rooms and intensive care units, our loved ones separated from us by the machinery of life preservation."

The overall tone of this highly readable exploration is pleasingly brisk and largely unsentimental, as befits a busy doctor with an excellent bedside manner. Mannix is good company, with a sound eye for an interesting anecdote and a sure ear for language. It's not a gloomy book. I shed a few tears — usually over the love shown between the dying and their relatives — but it's not gut-wrenching and Mannix weaves the light and dark strands of her experience with finesse.

When I finished reading I felt informed and prepared. I did wonder how many of Mannix's patients have a good death precisely because she is present, and felt sorry that we won't all get to have her at our death beds, gently explaining everything and doing her best for us and our loved ones. Still, that's what the book allows and it's essential reading for anyone who will encounter death, and that means all of us.

We should not fear death itself, Mannix believes, or put up with the profoundly unhelpful conspiracy of silence that often surrounds it. Far better to shine a light on the process of dying: there are rhythms and patterns, as there are with a birth. Everyone feels better if they know what to expect.

There is something illuminating and beautiful in the way Mannix writes about death not as an inconvenient or dreary party pooper, but as the intended and inevitable final event of our lives. "There are only two days with fewer than 24 hours in each lifetime, sitting like bookends astride our lives, one is celebrated every year yet it is the other that makes us see living as precious."

It feels a long way from the tea lady's flannel.

Cathy Rentzenbrink is author of *A Manual for Heartache*



**DEATH BE NOT PROUD** Kathryn Mannix shines a light on dying



## Mortality

## How to make sense of an ending

Two very different books about death tackle the challenge of facing our final days with individuality, pragmatism and even the spirit of adventure, writes Nicci Gerrard

**From Here to Eternity: Travelling the World to Find the Good Death**  
Caitlin Doughty  
W&N, £14.99, pp272

**With the End in Mind: Dying, Death and Wisdom in an Age of Denial**  
Kathryn Mannix  
William Collins, £16.99, pp352

When John Keats

was dying of TB in Rome, just 25 and far from family and home, he wrote a series of beautifully judged, empathetic letters of farewell that deal lightly (yet never falsely) with his physical suffering and his emotional anguish. From the shrinking circle of his life, from his frail body drowning in itself, he reached outwards towards the friends he was leaving. In his final letter, he wrote of living a "posthumous existence"; his last phrase becomes his eloquent, courteous and self-effacing goodbye before he exits the stage on which he has had such a small parcel of time: "I always made an awkward bow." Dying as a performance, dying as an art and a practice, dying as something solemnly profound and sorrowful and at the same time as normal, natural; dying as physical and as spiritual; dying as the end of a whole world because,

as Oliver Sacks wrote, when dying himself: "There is no one like anyone else, ever."

We live in our bodies and die in our bodies. In previous centuries, death was familiar and not hidden behind institutional walls; before the 20th century, there would have been scarcely an adult who had not seen their parents, some of their children, and their friends die. Moreover, there was faith that it was not the end. People witnessed death, dealt with it, prepared for it, even embraced it (John Donne used to sleep in his own coffin; Jeremy Taylor wrote his 17th-century manuals for the soul, *Holy Living and Holy Dying*, which became the preeminent works of the *ars moriendi* tradition; in *The Tempest*, Prospero consigns himself to an old age in which every third thought will be of death). Now, although we live with the sense of our own ending, we don't really. We know we're going to die, but we don't know. Our body doesn't know, except in dizzying moments of terror, until the sentence has been uttered and the gallows are being built under the window. Even then, death is often held at bay and life prolonged at all costs: the fragile and disintegrating body is plugged into machines, pumped full of oxygen and blood and drugs, its gallant heart restarted and kept going, no matter the pain, no matter the hopelessness of the endeavour, no matter that at a certain point this isn't living, just a slowed-down, drawn-out, painful and undignified dying.

It has become easier to live longer, but harder to die well. Most people want to die at home; most die in hospital. Most want to be with family; often they are alone or with strangers. "Their death has been stolen from them," writes Seamus O'Mahony in his bracing and unsentimental account of dying, *The Way We Die Now*, which charts how something that used

to be public and acknowledged, with a common script, has become an aggressively medicalised and bureaucratic process placed in the hands of experts; sometimes banal, sometimes farcical, sometimes painful or undignified. Modern, sanitised death becomes a dirty little secret, almost embarrassing: our language circles round it, we don't like to name it, cross the road to avoid those recently touched by it, and shy away from the physical, squeamish fact of it, so that the dead body is whisked away, frequently embalmed (for fear of its smell), cremated in "facilities" that are often in industrial zones.

Have we lost our way with dying and with death? In the last few years, there has been a crowd of books by doctors, scientists, writers and people who are scrutinising their own departure that have sought to show us different, kinder ways of ending: Atul Gawande, Oliver Sacks, Henry Marsh, Jenny Diski, Tom Lubbock, Marion Coutts, Paul Kalanithi, the luminous final poems of Helen Dunmore... the list is long. Behind them all stands the austere, magisterial work by Sherwin Nuland written in 1993, *How We Die*. Now Kathryn Mannix joins this distinguished group and her voice, though quiet and calm, is distinctive. A palliative doctor (or "deathwife"), she spends her days with the terminally ill and their families, witnessing and supporting them at times of intense suffering, terror and loss. About a quarter of deaths are sudden and unexpected, but she usually sees the ones that come slowly, over months or years, and while much of her work is diagnostic and medical, one of her crucial tasks is to help those who are dying and their families find ways of dealing with life's final, great event.

*With the End in Mind: Dying, Death and Wisdom in an Age of Denial* is Mannix's account of ways of dying, through a series of vivid

Have we lost our way with death? The statue of an angel in Cologne. Getty Images



This  
week

**Laura Shapiro**  
Rachel Cooke reviews  
*What She Ate*, a study of  
food's impact on six  
notable women



**Dave Eggers**  
Tim Adams hails the  
remarkable story of how a  
Yemeni immigrant became  
a coffee king



**Matthew Collin**  
How did Goa beach  
parties become playpens  
for the super-rich,  
asks Kitty Empire



*Animals  
perish; only  
humans die –  
because we are  
creatures who  
are aware of  
our own  
mortality*

stories, most of which disguise the protagonist, some of which are composite tales stitched together from several cases, and all of which are heart-wrenching testimonies to human courage and love. Her purpose is to describe many forms of death – the young man with testicular cancer treated in the room dubbed "the Lonely Ballroom", the dying mother in the hospice who manages to walk her daughter up the aisle, the 22-year-old with cystic fibrosis, the teenager with leukaemia – and to show how in each case, while a death may be emotionally harrowing, it need not be intolerably painful; while it may be tragic, it need not be ghastly or full of the chaos that accompanies too many ends.

**L**ike those romantic portraits of Florence Nightingale holding her lamp aloft as she walked between beds of maimed and dying soldiers, Mannix's aim is to shed a soft, clear light on a subject she feels is too often avoided. She wants us to think about what dying and death mean for others and for ourselves and take the fear and recoil out of the subject. Mild, tender and conciliatory, she is punctiliously even-handed. If one story shows how denial is toxic and the truth needs to be gradually and gently revealed, in another she demonstrates the usefulness of denial; if one describes how precious time can be won for a patient, another is an example of how prolonging life can be cruel and death a necessary kindness. One person's good death is not another's – we all need to find our own way to take our bow and leave the stage.

I agree with almost everything Mannix says; I would like her, or someone like her, to be my compassionate, wise doctor when I lie dying, easing me out when my time has come. Yet in her desire to show that death can be well managed, she leaves out the mess, fear, pain and unpredictability of so much dying – its scandal, its wildness and its impossibility. Not all passing can be gentle and not everyone can be brought to acceptance in the face of their own obliteration. However we dress it up and think about it, death remains blankly ungraspable and stark.

Enter Caitlin Doughty, American mortician, joyful member of the death-positive movement, who describes what happens to our mortal remains with bolsterous relish – "ya tell it like it is", she wrote in her first book, *Smoke Gets in Your Eyes*. Skin slip is skin slip; putrefaction stinks. The body

falls and the body rots and death is a tragedy and a farce, funny, bolsterous and unsentimental. Doughty believes that we in the west have made death and its aftermath into a corporate, perfunctory affair, in which the meaning of an ending is denied. Her mission is to "reclaim public understanding of dying" and to bring individuality and joy back into our dealings with the dead and so, in *From Here to Eternity*, she embarks on a journey of discovery to the only open pyre in America: to a sky burial in Tibet, where the body breaker slices the corpse into parts, pounds the flesh with a mallet, mixes it with barley flour and yak butter or milk, and leaves it to the shrieking vultures to consume; to burial towers in India; to the people of Tana Toraja in Indonesia, where mummified bodies are cared for in their home (offered food, dressed, even given a bed with the living) over months or years until the family can sacrifice an animal and put the dead to their final rest; to Barcelona's mass bone pits; Mexico's Day of the Dead. Skulls need as flowerpots, bodies made into compost on a body farm, corpses covered with rose petals, funerals conducted by men with dreadlocks and purple frock coats – what Doughty relishes are those rituals that acknowledge death, its bodily fact and its emotional enormity.

And although the book is in love with extremes, it actually shares Mannix's desire to be balanced: one culture's practice is another culture's taboo. We might not like the thought of ripping the rotting flesh from our loved one's bones, but for some, burning a body is equally repugnant. What is important is "to hold the space" – to banish our fear and shame, and create a ring of safety around the grieving family and friends where they can mourn, each in their own way.

Animals perish; only humans die – because we are creatures who are aware of our own mortality. This awareness, which can feel vertiginous, unendurable, is also what gives us selfhood, and life shape and meaning. "Death destroys a man; the idea of death saves him," wrote EM Forster. It is Henry James's "distinguished thing", Martin Amis's backing to the mirror, Rochefoucauld's sun that we must not stare at too long lest we go blind with seeing, it's the great nothing: the everything, which makes us and unmakes us, and to which we all come in the end. Nothing is more certain; nothing more bewildering, strange, scandalous, downright impossible, forever true.

To order *With the End in Mind* or *From Here to Eternity* for £12.74 go to [guardianbookshop.com](http://guardianbookshop.com) or call 0330 333 6846



# “We fear death but normal dying is less painful than normal childbirth”

## Kathryn Mannix

*Palliative care doctor and bestselling author*

THE  
MAGAZINE  
INTERVIEW  
LYNN  
BARBER



It seems extraordinary that the hot new international bestseller is a book about dying. With *With the End in Mind*, by an unknown author. The publishing doyenne Diana Athill called it the best book she'd read all year; our own Christina Patterson said it could change the way you see the world. It is being published in the UK, US, Canada, Australia, New Zealand, India, South Africa, and translated into eight languages.

Most books about dying are written by professional writers who have been diagnosed with a terminal illness and record their last months. I'm thinking of, say, John Diamond, Ruth Picardie, Jenny Diski, Tom Lubbock, all of whom wrote memorably moving accounts. But *With the End in Mind* is different because it is written by someone who is not a professional writer and is not dying. Instead she is a death expert, Dr Kathryn Mannix, who, as a recently retired Newcastle-based consultant in palliative medicine, spent most of her professional life working with dying patients. She writes about her encounters with them, not as case histories but as “stories” — her word — and they are entirely gripping.

We meet at my house and she asks for “strong brown tea” (she is a great believer in tea with sympathy), which I eventually manage to produce. She had read my article about my hip fracture and asked how it was going and I said fine, entirely better, though it shook my confidence. She is such a warm, smiley person, I can't think of anyone I'd rather find at the foot of my bed when I'm carted off to a hospice, but, unfortunately, she tells me she has already stopped seeing patients (how dare she? She is only 59) because she wants to spend her time campaigning for more public education about dying. Hence her book. She thinks it's something we don't talk about enough and nowadays seldom even see. Many adults have never witnessed a death until one of their grandparents or parents dies and sometimes not

even then. Consequently, we tend to fear it, she argues, much more than we need to. We imagine it is all about writhing in agony, whereas normal dying, she maintains, is actually less painful than normal childbirth — “And people choose to do that more than once, don't they?” But she has observed, over her many death-watch years, that patients often seem to die just in the minute when the nurse or relative has popped out of the room. It's as if they need a moment of privacy to “relax” into death.

Mannix tells a moving story in her book about how, when she first went to work in a hospice, she met an octogenarian Frenchwoman, Sabine, who had led an incredibly courageous life but was now afraid that her courage would fail in the face of death. The leader of the hospice comes to see her, and explains, very slowly and carefully, what will happen. She will get more and more tired; she will sleep longer and longer; at times she will be unconscious but she will think she has been asleep. And then she will be unconscious all the time, and her breathing will slow down until it eventually stops — “No feeling of fading away. No panic. Just very, very peaceful.” Mannix, still a trainee at that point, says the conversation has stayed with her all her life, and, she feels, “is writing this book”.

She never thought of herself as an author and waited patiently for someone else to write a book like hers, but they never did, so eventually she decided to do it herself. She assumed it would take years “because I'm a bit of perfectionist, I would want every sentence to be perfectly sculpted”, and then she would have to search around for a publisher. But in November 2015, by pure chance, she was asked to go on an episode of a Radio 4 programme called *One to One* about dying, and a literary agent got in touch and said: “You can clearly tell a story — have you got any more?” In fact, she had. Ever since she was a student, she had been in the habit of making notes — one page of A4 each — about ➤➤➤

PHOTOGRAPH  
ANNA HUIX





ANNA HUX FOR THE SUNDAY TIMES MAGAZINE. HAIR AND MAKE-UP: EMMA LEON

**MUST READ** Kathryn Mannix's book about her encounters with dying patients is an international bestseller





**DON'T FEAR THE REAPER** Mannix graduating from Newcastle University Medical School in 1982. She had encountered her first death during her first term, while shadowing a doctor in A&E

cases that particularly moved or troubled her or that presented ethical dilemmas. So she showed a couple to the agent. He said they were good but a bit short, and she should write them more like stories. This suited her fine. "I love storytelling. I'm from a long line of storytellers. My dad never read us stories, he *told* us stories. And his dad the same. So I tried very hard to write good stories." She is thrilled that many of the reviewers have praised her style as much as her expertise. "I knew I'd written something that was competent. But I hadn't expected to get literary praise at all, so that's been surprising and really lovely."

Her agent started showing her manuscript to publishers and many of them started making offers for the rights. "So then it turned into an auction!" Oh goody. How big was her advance? "I'm not going to tell you." Oh. This is my first, but not my last, encounter with her steely side. She smiles as much as ever but is completely adamant. I start fishing. Was it a life-changing amount of money? The sort where she could think of buying a new house? "It could have been, but that's not what I'm going to do with it. Our son's getting married [she is married to a retired pathologist and has two adult children], so I can give him a nice wedding present. But largely I'm giving it away to end-of-life charities. I've calculated that I can live on my pension. It's not about the money — it felt naughty, actually, to get money at all. What I'm really interested in is getting the message out there."

**M**annix always wanted to be a doctor. Growing up the eldest of five children in the Wirral, Merseyside, with a scientist father and schoolteacher mother, she used to arrange her toys in hospital wards — her mother still has a note she wrote saying "Teddy — broken leg and leprosy". She went to Newcastle University Medical School and encountered her first death in her first term when the A&E doctor she was shadowing was called out to an ambulance to certify that the patient inside had died of a heart attack. She was shocked by the lack of ceremony. She couldn't believe that the man was dead — he still looked so alive. But the doctor, realising she had never seen death before, urged her to put her stethoscope to his heart and she heard the silence. Then the doctor signed the death certificate and led her to their next patient — a child with a sweet stuck up her nose.

The term palliative care did not even exist when Mannix was a student, but she found right from the beginning that she was drawn to dying people. She worked in an adult haematology ward where there were a lot of patients dying from leukaemia ("We were bad at treating it in those days — we're spectacularly better now") and she found herself gravitating to them. "It was fascinating, but I realised even in my first week that doctors didn't do the thing that I really wanted to do, which was to get to know the patient. Nurses knew the names of their children and the fact that their wife was

worried about her mother's breast lump, whereas I just knew their blood count and whether their lymph nodes were swollen. Of course that was important, but this other stuff about their personhood seemed equally important to me. And I suddenly thought, 'Oh! I've made the wrong choice, this is the wrong course, the wrong profession.' And that was really tough."

In fact, it was so tough that she became unwell and seriously thought of abandoning her studies. "It was just stress, because I guess it was the first time I'd been confronted by all that human suffering completely unfiltered." A wise doctor persuaded her not to give up immediately, but to postpone her decision — "He said, 'You can just decide not to decide and see how things go' — that's been a really helpful mantra for palliative care."

By coincidence, the wise doctor turned up years later as a patient in her hospice. She found him in agonising pain from an abdominal tumour but refusing to take morphine because he believed it would make him confused and drowsy. "His first priority was to maintain his intellect so that he could continue to support his family emotionally, and he was prepared to accept any pain to achieve that." But Mannix was able to persuade him that pain management had improved exponentially since the knock-out "Brompton cocktails" he would have administered as a junior doctor half a century ago: nowadays we have drugs that can get rid of the pain while keeping the mind clear. He agreed to take a very small dose of morphine and the next day he agreed to take a little more and a few days later she found him walking cheerfully down the corridor, "glowing with the joy of freedom from pain". She remains grateful that he persuaded her to stick with her studies so that she was in a position to help him at the very end of his life.

The wise doctor, of course, knew that he was dying. But Mannix has often had to break the news to patients herself. She likes to do it formally, over cups of tea on a tray, with family present, "because this is a conversation they will remember all their lives". In her early days on the haematology ward she saw a classic case of how *not* to tell someone they were dying. As a trainee, her job was to follow the consultant and take notes and "I remember clerking a young man and the first thing I noticed was that his fingernails were different lengths and I recognised that he was a fellow guitarist, so we had lots of conversations about folk music. And then, one day, the consultant came to tell him that he had an incurable form of leukaemia. It was just terrible. Not that the consultant was unkind, but, now that I'm more experienced, I can recognise that the conversation wasn't paced properly and he should have been asked if he wanted his wife to be there. But the consultant was so sad for what he had to tell this man that it undermined his ability to do it tenderly. And I remember thinking there's got to be a better way. You couldn't *not* have him being devastated by being told that he was going to die in his early forties and not see his children grow up, but you must be able to do it in a way that doesn't destroy the patient and doesn't destroy the doctor. That poor consultant was on his own. Consultants were much more elevated in the 1980s than they are now — now we're all part of a team — but in those days the consultant was on a pedestal and he probably felt he just had to tough it out and do it."

After the haematology ward, she did a year on an oncology ward, but it didn't suit her because it was so hectic. "I can remember seeing patients back to back" ➤

**“I don't want a sudden death. I would feel so robbed. I quite fancy a proper deathbed”**



## This is the last bit of our lives. How can we make sure we've done the things that count?"

and being worried about asking 'How are you?' because they might tell me, and I didn't have time to listen. I needed to do their blood count, look at their wound, then get along to the next patient." But again she was drawn more to the dying patients than the ones who came in with a new diagnosis of breast or testicular cancer. "With them, it was more formulaic — you did this, that and the other and then they got better. But there were these other patients who were in the last months of living, but whose pain was difficult or whose itch was driving them mad and trying to solve *that* somehow seemed much more rewarding. You have to acknowledge that you're not trying to extend living but trying to make whatever living there is the best it can be."

**I**n her first month after qualifying she signed more death certificates than any other doctor. Years later, when she met the chief registrar, the registrar said she'd followed Mannix's career with interest because she'd seen her name so often in the records. Mannix worried that it made her sound like Dr Harold Shipman! But she volunteered to attend deathbeds because she felt it was a privilege to be there. "I found it strangely uplifting. I discovered that I was not afraid of death; rather, I was in awe of it." She believes that people, when dying, become "a nobler version of themselves", that they somehow achieve a measure of transcendence. She quotes the playwright Dennis Potter telling Melvyn Bragg in his last interview that he could see a blossoming plum tree outside his window, and it had "the whitest, frothiest, blossomest blossom that ever could be".

So it was natural that when Newcastle built a modern hospice, she applied for a job as registrar there and got it and was gradually promoted to lead all of Newcastle's NHS palliative care services. She was a founder member of the Association for Palliative Medicine, and also trained in cognitive behaviour therapy, which she thought could be helpful in treating dying patients. The great thing about palliative care is that the nurses and doctors seem to have limitless time. She writes about one patient, Eric, a retired head teacher dying of motor neurone disease, who was grimly hanging on because he wanted to spend a last Christmas with his family. But by November she and the nurses had realised he wouldn't last that long. They decided to hold a fake Christmas for him and his family, with a tree and carols and turkey, and he died happily a few days later. That couldn't have happened in a cancer ward where all the staff were rushed off their feet.

Her new crusade is to get everyone to have an Emergency Health Care Plan, so that big decisions about whether we want to end up in hospital or at home, and how much treatment we are willing to undergo, can be made in discussion with family before it comes to the crunch. The trouble — as I wrote in my last article — is that the young refuse to talk about dying. They think it's poor taste to discuss it. It is maddening. It is they, not the old, who are in denial.

And they are the ones who use appalling euphemisms like "passing" because they flinch from the word death. I remember someone once asking me when my husband "passed" and for a baffled minute I thought: 'Passed what? His A-levels? Degree? His driving test?'

Has working around death so much made Mannix a hypochondriac? "No, the only thing I do at all that's related to fitness is I run, and I'm not even very ardent about that." Has she thought about how she'd like to die? "Oh, absolutely yes. I don't want a sudden death. I'd feel so robbed, *so robbed*. I want to be sure that I've said all the goodbyes and all the thank-yous. I quite fancy a proper deathbed. Is that very Victorian of me?"

Hmm, it's certainly the opposite of me — my ideal death is assassination by a well-trained hitman. How would she *least* like to die? "Well, I probably wouldn't welcome motor neurone disease — I think that is really challenging. But I like to think that I have a sufficient cerebral life that I could live happily in my mind, even if my body becomes inactive." How would she feel about, say, lung cancer? "I'd feel pretty cheesed off! But look, I haven't sat and thought what I'd like to die of, I've never given it the time of day. I think at some point an illness that is likely to kill me will declare itself and at that point I'll consider how best to deal with it. And I don't think a mental rehearsal is going to help."

Again, that snap of steel. But when it really becomes apparent is when I ask about her religious beliefs. She speaks as if from a script. "Religion is something I've decided I'm not going to discuss. I think there's a lot of polarised and unhelpful discussion of issues around end-of-life care that is coloured either by people's religion or people's views on people who do or don't have religion. And I think that changes the way people interpret what is an entirely professional account of death and dying. So I've decided not to go there."

It is strange, though, to write a book about dying and not mention religion. I'd be prepared to bet good money she is a Catholic, partly because she mentions in the book that her dying grandmother asked for a visit from the Pope, but also because, in my experience, it's always Catholics who are secretive about their beliefs. And that, in turn, is why we atheists are wary of them.

Her book had an odd effect on me. On the one hand, it made me much more confident about dying — it convinced me that once I'm in a hospice I'll be tickety-boo — but on the other hand, it made me much more fearful about hospital treatment. She casually mentions side effects, such as nausea and ulcers and oozing sores, that terrify me. I've already seen with friends dying from cancer that they seem to go through torture under the guise of treatment. Mannix agrees that some hospital treatments seem to be more about prolonging death than prolonging life, and that perhaps there should be more discussion of that. "But that's not what I'm writing about. I'm saying, 'This is the last bit of our lives and how can we best decide how to spend it? How can we make sure that we've done the things that really count for us and how much more precious does that make it? Until we get to the point where it is OK to say goodbye.' And, so saying, she drinks up her strong brown tea and says goodbye. But later she sends me a sweet card thanking me for the tea and wishing me a full recovery from my hip fracture ■

*With the End in Mind: Dying, Death and Wisdom in an Age of Denial* by Kathryn Mannix is out now (William Collins £17)



A remarkable book by a top woman doctor will transform the way you think about the moment we all fear the most...

# Treasure the last day of your life as much as the first

**T**HE patient is bedbound, but her delight is palpable as a stream of visitors arrive bearing gifts of fruit and boxes of chocolates. Her hospital room is so full of life, it resembles a noisy and chaotic family celebration at times.

Yet her large and loving family have come not to herald a beginning, such as the birth of a baby — but to mark an ending.

Patricia, mother of three sons and three

by *Dr Kathryn Mannix*

daughters, and grandmother to a bevy of teenagers, is dying of heart failure.

Over the next few weeks her energy ebbs away, she starts to sleep for longer and then slips into unconsciousness. Eventually the end comes with Patricia

surrounded by her children, their partners and spouses, and her grandchildren. But it is so still and peaceful.

Patricia's family do a fantastic job accompanying her into death, and afterwards, I tell them so.

Later, my colleague and I are sharing a lift with a newborn in a cot, the little one's proud parents and a midwife on their way to the post-natal ward. 'What do you do?' asks the midwife curiously, searching for our roles on our name badges.

'Much the same as you,' replies my colleague as the doors open and we walk

out. And she is right — in a way. We don't bring new life into the world. But our job is to help people make the transition at the other end of life's journey. We help people leave this world — and it's a privilege every time.

Given my training as a doctor, a role that's become synonymous with the preservation of human life, it might seem strange that I find so much satisfaction in my work as a palliative care doctor and consultant. After all, I'm not finding cures

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## How to make sure you keep your New Year resolutions



THE fireworks are over, Auld Lang Syne has faded out, and now tradition states we should all head to the gym every day and eat nothing but kale smoothies. But if, like so many of us, you find New Year's resolutions hard

to stick to, in 2018 there is a high tech alternative to willpower and the slog of the treadmill.

To improve your fitness, try a phone app that offers tailored workouts in the comfort of your home. Not only are the workouts just 12 minutes long,

they claim to burn about 336 calories (8ft, plans from £4.50 a month, Android or iOS).

For healthy eating, use My Fitness Pal. It's a website that helps you track what you eat in a day, suggests healthier alternatives and it's free. Finally, to

stay motivated download hypnosis app Harmony.

Best Lifestyle App at the International Mobile App Awards, Harmony is said to strengthen willpower so you can stick to your goals (from £2.50 a month, Android or iOS.)





## KNACKERED MOTHERS' WINE CLUB



BY HELEN  
McGINN

### Bargain of the week

Seedlip Garden 108, £20 (usually £27.95), amazon.co.uk

IF YOU'RE planning on going dry for a few extra days this month, investing in a bottle of this will make it much more fun. This is a non-alcoholic 'spirit' and one of the simplest ways to enjoy it is over ice with plenty of tonic. It tastes lightly floral and, crucially, more grown up than the usual soft options.

### White wine

Most Wanted Albarino 2016, £8.49, Co-op

PEACHY Spanish white from north-west Spain, this is a great one to try if you like the freshness of sauvignon blanc but want something a little more subtle. Lively with lots of grapefruit flavours, it's one of the stars of this range. Most wanted, indeed.

FOOD PAIRING: Fish pie.

### Red wine

Taste The Difference Morador Malbec 2016, £8.50, Sainsbury's

PLENTY of juicy, black-fruit flavours, just as you'd expect from this grape when grown in Argentina. But this has more oomph. The vineyards are among the highest in the world. In other words, wine with altitude.

FOOD PAIRING: Sausage casserole.

### Sparkling wine

Graham Beck The Rhona Brut NV, £15, M&S

IF YOU want bubbles but can't face more prosecco, upgrade to this South African sparkler. Produced in the same way as champagne, it's made from the chardonnay grape. Expect bright citrus fruits with a whiff of toast and touch of creaminess. Fabulous.

FOOD PAIRING: Fish and chips.

■ **THE Knackered Mother's Wine Club** by Helen McGinn (Pan Macmillan, £7.99).

## £400 kettle? D&G darling!

EVER wondered what the world's fanciest kettle looks like? Us neither, but here it is: Dolce & Gabbana's collaboration with posh kitchenware brand Smeg. Consisting of an espresso machine, toaster, juicer and of course the kettle (all at £400), it's available only at Smeg flagship stores or at Harrods — naturally. Featuring classic D&G designs, this is the brand's second collaboration with Smeg, after the release of fridges last year which sold for up to £30,000. So spending £400 on a kettle may seem like less of a splurge, but it's still not for the faint-hearted.



### FROM PREVIOUS PAGE

for fatal diseases or performing miraculous surgical feats that bring people back from the brink. But, as I have come to realise, there is nothing more important than being able to assist someone to a peaceful, pain-free end.

Death is something that will happen to us all. Yet in the 21st century, it's something that we have become adept at putting out of our minds.

Whereas birth, love and even bereavement are widely discussed, death itself has become increasingly taboo.

Since the second half of the 20th century, better healthcare, new treatments such as antibiotics, kidney dialysis, early chemotherapy, improved nutrition and immunisation have all radically changed people's experiences of illness and life expectancy.

**W**HEN it comes to disease and infection there is expectation of a cure, or at least postponement of dying, that even 100 years ago was unimaginable.

Life expectancies have increased — and many lives have been enhanced and lengthened as a result. Of course, it's a cause for celebration that children no longer die from routine illnesses such as measles, cuts and grazes rarely turn into life-threatening infections and many cancers are curable.

Yet, ultimately, the death rate remains 100 per cent — no one's discovered a way to dodge it — and the pattern of our final days, the way we actually die, is unchanged.

What is different is that we have lost the familiarity we once had with that process. When grandparents lived in the extended home, families saw death often enough to recognise its patterns.

Instead, people now learn what to expect from TV, films, social media and the news, but these versions of death and dying are often simultaneously sensationalised and trivialised. It makes us more, not less, scared of what is to come.

And instead of dying in a familiar room with people we love around us, we now die in ambulances and emergency departments and intensive care units, often surrounded by technology designed to preserve life.

It's understandable that nobody wants to return to the days of high mortality rates. But the downside is that the rich wisdom around death, the vocabulary and etiquette that served us so well in the past, has been lost.

I believe that it's time to restart the conversation. Because what many of us have forgotten is that — with the right care and the support of those close to us — it is often entirely possible to have a 'good death'.

I saw my first dead person when I was 18 and in my first term at medical school. He was a man who had died of a heart attack in an ambulance on his way to hospital and the emergency doctor I was shadowing was called to certify his death. Aged in his 40s, the dead man was broad-chested and outwardly healthy looking. At first glance he could have been asleep.

Then the emergency doctor allowed me to listen to the man's chest. I had never heard a silence so solid, nor listened with such focus. There was no mistaking him now for sleeping. Afterwards I said 'thank you', to the dead man for showing me what death looked like.

Five years later and, newly qualified, I was working on a ward with lots of people with incurable illnesses. I found myself signing a lot of death certificates — in fact I earned the

hospital record for the number of death certificates issued.

While others joked that I should get an award, inside I was climbing a massive learning curve. Each of those certificates was about a person, after all, and each of those people had family members who needed to be told about the death, and who wanted to know why their loved ones had died.

In my first month of clinical practice I had 30 conversations with bereaved families.

To my surprise I discovered that I found these conversations strangely uplifting, and that I was not afraid of death. Families told stories about the dead person's talents and interests, their kindnesses and quirks.

I became fascinated by the ineffable change from alive to no-longer-alive; by the dignity with which the seriously ill can approach their deaths; by the challenge to be honest yet kind in discussing terminal illness; by the moments of common humanity at the bedside of the dying.

For some, death comes suddenly, and that is shocking and hard to accept for those left behind. Others are given plenty of warning that they are reaching their expiry date.

But often people are scared to think about death because they imagine dying to be agonising and undignified, when so often that isn't

# There are only two days in our lifetime that are shorter than 24 hours — the first and the last...

Support: Allin

true. There is often a pattern to those final days and hours, and knowing what to expect can be immensely comforting to the person who is dying, as well as to their family.

This was vividly illustrated to me as a young trainee in palliative medicine, working in a newly-built hospice.

Sabine was one of our patients. In her late 70s, she had advanced bowel cancer. As a young Frenchwoman she fought for the Resistance in World War II, and came to England after marrying a British officer who had been hidden by her cell for 18 months.

She had a medal for her bravery, yet she was terrified of dying.

One day my boss, a consultant of many years' experience, asked if she would like him to describe what dying was like. I was shocked — I thought this was the last thing she needed to hear, yet she nodded her agreement.

He explained that for any disease or condition that slowly shuts the body down (or simply when death comes due to old age), there is a predictable sequence of events:

there is a gradual loss of energy, then an increased tiredness that means people spend more time asleep and less time awake. Then they become more deeply asleep, so much so they slip into periods of unconsciousness. Sometimes they wake again and

say they had a good sleep, seems we don't notice they were unconscious. But at very end of life, a person is at unconscious all the time.

Then their breathing starts change. Sometimes deep slow, sometimes shallow faster, sometimes noisy, but very gently, the breathing slows down, and very gently stops

**H**E TOLD her there was no sudden rush, no pain, no feeling fading away, no p

— it's just very, very peaceful. When he'd finished, she gave a long, deep sigh and held his hand in hers before saying, simply 'Thank you'. Understanding the best gift he could have given her for a dignified end.

This pattern of dying is so common that I've witnessed time and time again. And once we all know what we need to know, we can relax with each other. It's surprising how relaxed a well-prepared family can be around a death.

But I've also learned there's no right way for a person to approach death. Some, like Sylvie, the 19-year-old I treated who had a rare and terminal leukaemia, look death straight in the eye. This teenager would inevitably be cut short, yet she had lived as fully as any woman many decades older.

Determined that her life would make a difference, she had made recordings with her band — was the drummer — that would be sold after her death to raise money for leukaemia research.

And when I met her three years into her illness — it was my job to go to her home to give transfusions of platelets vital for her blood to clot — she

Care for the dying: Dr Kathryn Mannix

## SAVVY SAVINGS

This year, keep on top of the latest craze from Japan. With sections each day, it can help you cut outgoings







(right) comforted by sister Amy in BBC drama *Little Women*

making a patchwork cushion from clothes she had worn through her life, from tiny baby-gowns to T-shirts. She planned it to be a surprise for her mother, a little bit of Sylvie for her to hold on to and cradle after her daughter was gone. I was in awe of her courage and dignity.

Not everyone is prepared to accept what is happening to them — and that is fine too.

Take Sally. Newly married, she talked excitedly of the babies she and her husband Andy would have together — she wanted at least four — and all the travelling they were planning for the future.

What she refused to talk about was the fact that she was dying from a melanoma that had been treated some years before, but had now spread inexorably, leaving her just weeks to live. Yet even though the doctors had been honest about her situation, even as she moved into a hospice, she seemed not to hear what they were saying, continuing to insist chemo would work.

Her attitude was one of positivity and complete denial and while, ironically, she looked surprisingly well, her husband appeared to be fading away under the strain of coping with his wife's inability to accept her imminent death.

Somewhat, I had to work with her family to manage her dying while preserving her denial. Eventually, we agreed that if this was the approach she wanted to take,

we had to respect her decision. Being able to say goodbye is an important part of the grieving process but in this case Sally's family had to say their goodbyes without actually saying goodbye.

But it is possible. So they told her what they loved about her, they shared treasured memories from her life so far and remembered kindnesses they had appreciated. But when she wanted to talk about the names of her children and the holidays she would take later in the year they went along with it and this was how it remained until she slipped peacefully away a few days later.

When it comes to death, more of us should be practical like Dan, a young man born with the muscle-wasting disease muscular dystrophy, which means he will almost certainly die before the end of his 20s. Unlike most of us, he has been forced to confront his mortality. But to help him feel more in control of his life he has written a detailed plan of the sort of treatment he would like, or actively doesn't want, when it comes to the end, and if he isn't able to articulate his wishes.

It's something we should all consider doing. Women often make birth plans that detail the sort of interventions they want during labour. More of us should have death plans.

In recent years death has become a politically hot topic — with the possible legalisation of euthanasia much debated by lawyers and politicians. Many people understandably fear the

possibility of unbearable suffering as a consequence of illness or an accident, and euthanasia is based on principles that have quality of life at their heart.

There is no doubt that campaigners on both sides of the debate are motivated by compassion, conviction and principle. Yet the discussion often bears little relation to what actually happens to people as they approach the last stages of living. And even the most carefully thought-through changes to the law can have perverse and unintended consequences.

A policy of euthanasia, for example, raises the risk that people can be left feeling under pressure to accept a premature death — as happened with one patient of mine who had spent time in hospital in the Netherlands before choosing to return to the UK where it's not legal, rather than enabling them to embrace life even as they're dying.

**B**ECAUSE — as you could see in Patricia's bedside family get-togethers — it is still possible to find joy and companionship at the end. I have seen many friendships develop in hospices, often between those who would not otherwise have ever met in life, and there is often laughter and joy. Death has its own beauty in a strange way.

And we have much to learn from people in their last days. There's practical wisdom: for example, I remember bonding with a 98-year-old former economics professor, who advised me how to deal with the menopause when I suffered a hot flush as I attempted to ease the symptoms of her crippling osteoporosis and Parkinson's Disease.

But we can also learn more fundamental lessons about the way we approach life.

I've noticed that people at the end of their lives often display extraordinary qualities — they tolerate their symptoms with courage and let go of worrying about the future to bask in the present. They focus on loving and that radiates on to everyone around them — their fellow patients, families and those of us who care for them. They appreciate the tiniest kindnesses and are the patients who notice a nurse looks tired or remember that a cleaner's daughter has an exam.

In this way, it often seems that it is only the best people who die. But they are ordinary, like the rest of us. It's just they are at an extraordinary place in their life journey. They are not 'saints' but they are examples of what we can all become: beacons of compassion who are able to live in the moment, look back with gratitude and forgiveness and who are able to focus on the simple things that really matter.

There are only two days in our lifetime that are shorter than 24 hours — the first day and the day we die.

One is celebrated every year, yet it is the other that makes us see living as precious. We should never forget that.

■ **EXTRACTED** by Clare Goldwin from *With The End In Mind: Dying, Death And Wisdom In An Age Of Denial* by Dr Kathryn Mannix, published by William Collins, £16.99. (Names have been changed.)

## Who knew?

In any given hour, more than twice as many people are born than die

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# THE TABLET



## And in the End

**Kathryn Mannix** listens to the dying and learns that life is precious

**David Bentley Hart** discovers both strangeness and immediacy when he translates the New Testament

**Timothy Radcliffe** finds signs of hope on his return to Iraq

**D.J. Taylor** wonders why George Orwell had such trouble with God

**PLUS** FRANCESCA BAKER • LAURA GASCOIGNE • MELANIE McDONAGH • MARTIN STANNARD • ROSE PRINCE





## 'I had never heard silence so solid'

After 30 years' experience, a palliative care specialist remembers her first encounters as a medical student and as a newly-qualified doctor, learning that it is in listening to the dying and the bereaved that we come to see life as precious / By KATHRYN MANNIX

**I** FIRST SAW a dead person when I was 18. It was my first term at medical school. He was a man who had died of a heart attack on his way to hospital in an ambulance. The paramedics had attempted to resuscitate him, without success, and the emergency department doctor whom I was shadowing was called to certify death in the ambulance, before the crew took the body to the hospital mortuary.

It was a gloomy December evening and the wet hospital forecourt shone orange in the street-lamps; the ambulance interior was startlingly bright in comparison. The dead man was in his 40s, broad chested and wide browed, eyes closed but eyebrows raised, giving an impression of surprise. The doctor shone a light in his eyes, listened over his chest for heart or breath sounds; he examined a printout of the ECG from the last moments that his heart was beating, then nodded to the crew. They noted the time of this examination as the declared time of death.

They disembarked. I was last out. The man was lying on his back, shirt open, ECG pads on his chest, a drip in his right arm. He looked as though he was asleep. He might just wake up at any moment, surely? *Perhaps we should shout in his ear; perhaps we should just give him a vigorous shake; he would surely rouse.* "Come on!" the doctor called back to me. "Plenty to do for the living. Leave him for the crew."

I hesitated. *Perhaps he's made a mistake. If I stand here long enough, I'll see this man take a breath. He doesn't look dead. He can't be dead.*

**THEN THE DOCTOR** noticed my hesitation. He climbed back into the ambulance. "First time, eh? OK, use your stethoscope. Put it over his heart." I fumbled in the pocket of my white coat (yes, we wore them then) and withdrew the shiny new tool of my trade-to-be, all the tubing tangled around the earpieces. I put the bell of the stethoscope over where the heart should be beating. I could hear the distant voice of one of the crew telling someone he would like sugar in his coffee – but no heart sounds.

My observant trainer picked up the end of my stethoscope and rotated it, so that it would pick up noises from the patient and not from the world, and placed it back over the heart. Now there was utter silence. I had never heard silence so solid, nor listened with such focus. And now I noticed that this man looked a little pale. His lips were a deep purple and his tongue was visible, also dusky. Yes, he is dead. Very newly dead. Still working out how to be dead. "Thank you," I said to the pale man. We left the ambulance and walked through the orange rain back into A&E.

"You'll get used to it," said the doctor kindly, before he picked up a new chart and carried on with his evening shift. I was perplexed by the stark simplicity, the lack of ceremony. Our next patient was a child with a sweet stuck up her nose.

There were other, less vividly remembered deaths while I was a student, but in the first



month after I had qualified, I earned the hospital record for the number of death certificates issued. This was simply because I was working on a ward that had a lot of people with incurable illnesses, and not due to any personal responsibility for their deaths, please understand.

I quickly became on first-name terms with the bereavement officer, a kindly woman who brought around the book of certificates to be signed by the doctor who had declared the patient dead. In just the same way as I had seen in that ambulance five years earlier, I noted the deaths of 14 people in my first 10 days (or perhaps it was the other way round); the bereavement officer quipped that perhaps I should get an award.

**WHAT THE** bereavement officer didn't see, though, was the massive learning curve I was climbing. Each of those certificates was about a person, and each of those people had family members who needed to be told about the death, and who wanted to know the reasons their loved one had died.

In my first month of clinical practice I had 20 conversations with bereaved families. I sat with people while they wept or stared blankly into a future they could barely contemplate; I drank cups of tea-with-sympathy, brewed at Sister's instruction by one of the experienced auxiliary nurses and carried on a tray ("With a proper cloth, please!" "Yes, Sister") into Sister's office, which was only entered by doctors with Sister's personal permission. Bereavement visits were an exception: permission was assumed.

Sometimes I was the second fiddle, listening to a more experienced doctor talking to families about illness, death, why the drugs hadn't worked, or why an infection had torn the person away just as their leukaemia was responding. The family members nodded bleakly, sipped tea, dripped tears. Sometimes I was the only doctor available if others were in clinics, or it was after hours, and sometimes I brewed the tea-with-sympathy myself, finding the familiar routine a comfort, noticing the details of the flowery, gilded china cups and saucers that Sister provided for these most special visitors, before taking a deep breath and entering the room to give the worst news in the world.

**TO MY SURPRISE,** I found these conversations strangely uplifting. Families were rarely totally unprepared: this was a ward for people who had life-threatening illnesses. During these conversations I would learn so much about the deceased person, things I wished I had known while they were alive. Families told stories about their gifts and talents, their kindnesses and interests, their quirks and peculiarities.

These conversations were almost always in the present tense: there was a sense of their loved one still being present in some way, perhaps while the body was still tucked in the same bed, or was being cared for somewhere else in the hospital. And then they would check themselves, correct the tense, and begin

to rehearse their steps into the huge loss that was gradually, terribly, declaring itself.

Some time during my first six months I had to tell an elderly man that his wife had died. She had died suddenly, and the cardiac arrest team had been called. As is customary, her husband had been telephoned and asked to come as soon as he could, no further details given. I found him standing on the ward, outside her room, looking at the unfamiliar screen across the door and the sign saying: "Please do not enter, please see the nursing staff." The crash team had departed, and the nurses were occupied with their drugs round. I asked if I could help, and then saw the bewilderment and fear in his eyes.

"Are you Irene's husband?" I asked. He moved his head to say yes, but no sound came out of his mouth. "Come with me, and let me explain," I said, leading him to Sister's office and to yet another of those conversations that change people's lives. I don't remember the detail of the conversation, but I remember becoming aware that, with the death of his wife, this man now had no remaining family. He seemed frail and lost, and I was concerned that he might need support in his bereavement.

**HAD I BEEN MORE** aware then of the wonderful contribution that can be made by GPs and primary-care services, I might have asked his permission to let his GP know that his beloved wife had died, but I was inexperienced and in an unexpected situation: I had discovered him outside his wife's room while I was in the middle of administering the midday intravenous antibiotics for the ward. I was not prepared for a bereavement discussion.

As usual when terminating these sad conversations, I assured him that I would be happy to talk to him again if he found that he had further questions as time went by. Although I always said this, and I truly meant it, families never did come back for more information. And then I acted on impulse: I gave Irene's fragile-looking husband my name and telephone number on a piece of paper. I had never given out written contact details like this before, and his apparent indifference as he screwed the scrap of paper into a ball and pocketed it seemed to indicate that this might not be a helpful contribution.

Three months later I was working at a different hospital when I received a phone call from the ward sister of my previous ward, she of the tray-with-cloth and the gilded china. Did I remember that patient called Irene, she asked. She had had a call from Irene's husband, and he was most insistent that he make contact with me. She gave me a number, and I called him.

"Oh, thank you for calling me back, doctor. It's so nice to hear your voice ..." He paused, and I waited, wondering what question might have occurred to him, hoping I would know enough to answer it. "The thing is ..." he paused again. "Well, you were so kind to say I could phone you ... and I didn't know who else I could tell ... but, well ... the thing is, I finally threw Irene's toothbrush out yesterday. And today it isn't in the bathroom, and I really

feel she is never coming back ..." I could hear his voice breaking with emotion, and I remembered his bewildered face, back on the ward the morning she died.

**THE LESSON WAS** coming home to me. Those bereavement conversations are just the beginning, the start of a process that is going to take a lifetime for people to live alongside in a new way. I wondered how many others would have called, had I given them a name and a number in writing. By now I was more aware of the network of care that is available, and I asked Irene's husband for permission to contact his GP. I told him I was honoured that he felt he could call me. I told him that I remembered Irene with such fondness, and that I could not begin to imagine his loss.

Towards the end of my first year after qualification, I found myself reflecting on the many deaths I had attended in that year: the youngest, a 16-year-old lad with an aggressive and rare bone-marrow cancer; the saddest, a young mum whose infertility treatments may have been responsible for her death from breast cancer just before her precious son's fifth birthday; the most musical, an elderly lady who asked the ward sister and me to sing "Abide With Me" for her, and who breathed her last just before we ran out of verses; the longest-distance, the homeless man who was reunited with his family and transported the length of England over two days in an ambulance, to die in a hospice near his parents' home; and the one that got away – my first cardiac arrest call, a middle-aged man who was post-op and stopped breathing, but who responded to our ministrations and walked out of the hospital a well man a week later.

This is when I noticed the pattern of dealing with dying. I am fascinated by the conundrum of death: by the ineffable change from alive to no-longer-alive; by the dignity with which the seriously ill can approach their deaths; by the challenge to be honest yet kind in discussing illness and the possibility of never getting better; by the moments of common humanity at the bedsides of the dying, when I realise that it is a rare privilege to be present and to serve those who are approaching their unmaking. I was discovering that I was not afraid of death; rather, I was in awe of it, and of its impact on our lives.

What would happen if we ever "found a cure" for death? Immortality seems in many ways an uninviting option. It is the fact that every day counts us down that makes each one such a gift. There are only two days with fewer than twenty-four hours in each lifetime, sitting like bookends astride our lives: one is celebrated every year, yet it is the other that makes us see living as precious.

*Extracted from With the End in Mind: Dying, Death and Wisdom in an Age of Denial (William Collins, £16.99).*

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## Bryony Gordon

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### Only by accepting death do we learn to live



In her powerful book about dying, Dr Kathryn Mannix writes that just as midwives assist us in giving birth, so there should be professionals who prepare us for death.

Parents-to-be learn about the various stages of labour so that they are not taken entirely by surprise when things get going. "Similarly," writes Mannix, "discussing what to expect during dying – and understanding that the process is predictable and usually reasonably comfortable – is of comfort and support to dying people and those who love them."

And yet in the last national care of the dying audit of hospitals, it was found that fewer than half of terminally ill patients had been told of their fates. Dr Mannix is a palliative care doctor with 40 years of experience. But despite its subject matter, *With the End in Mind* is an oddly uplifting book; the writer has become intimately acquainted with death, and has made it her mission to bust the taboo that surrounds it, one that is only getting bigger and bigger as science helps us to live longer and longer.

"Yet these welcome healthcare advances can only remediate us up to a point," writes Mannix. "The pattern of the final days, and the way we actually die, are unchanged."

Previously, we were familiar with death. It happened in our homes rather than hospitals; we saw death, we touched death, we lived with death. Now, we barely even talk about it.

It is a brave soul who pipes



House of Lords speech: Dame Tessa Jowell spoke of the need for cancer patients to be able to live well with the disease

up and confronts the only inevitability that life has to throw at us. This week, one such person was Dame Tessa Jowell. It cannot have been easy to have stood in the House of Lords and deliver her speech on cancer care. The Labour peer has a rare and aggressive brain tumour with a poor prognosis; she is seriously ill,

#### Her refusal to go quietly will have helped many of the terminally ill

and yet as she spoke she exuded a calm dignity that so many of her colleagues lack.

Baroness Jowell made an impassioned plea for more sharing of information by doctors at the highest levels to combat cancer. But she also highlighted the need for a community to surround patients, being "practical and kind. For while doctors look at the

big picture, we can all be part of the human-sized picture".

The 70-year-old, who helped bring the Olympics to London, concluded by saying: "In the end, what gives a life meaning is not only how it is lived, but how it draws to a close. I hope that this debate will give hope to other cancer patients like me, so that we can live well with cancer, not just be dying of it."

Watching Dame Tessa, and listening as she was interviewed by Nick Robinson earlier in the week on the BBC's *Today* programme, one could not help but be moved – but also inspired. The dying are a group of people we are instinctively scared of – or perhaps that should be for. They are hidden away from public life, in part through physical necessity, but also because of modern cultural taboos. And yet there was nothing frightening about Dame Tessa, nothing at all. Inspiring? Yes. Life affirming, even? Yes. But frightening? No.

Her stance this week, her

refusal to go quietly, will have helped any terminally ill person who has wanted to shout to the world that they are not dead yet. She reminded me of the marvellous Lynda Bellingham, who filmed a farewell edition of *Loose Women* a week before her death of colon cancer in 2014. "Please don't cry," she told the assembled audience. "It will all be fine!" One must imagine that it was, given that she was able to die in the arms of her husband.

In her speech, Baroness Jowell quoted the last words of Seamus Heaney: Do not be afraid. This applies as much to those surrounding a terminally ill patient as it does to the patient themselves.

We have come a long way since the days when cancer was quietly referred to as the C-word, but we still tend to stick our fingers in our ears whenever the inevitable is mentioned. This does us all a disservice. It is only by accepting death that we truly learn how to live.



# Sunday Times Chart

## THE SUNDAY TIMES BESTSELLERS

Lists prepared by and data supplied by and copyright to Nielsen BookScan, taken from the TCM for the week ending 03/02/18. Figures shown are estimated sales for the seven-day period followed (in brackets) by the estimated total sale since BookScan records began in 1998. \*Includes sales of more than one edition in the same format and at the same RRP.

40 11 February 2018

### GENERAL HARDBACKS

		Last week	Weeks in top 10
1	 <b>Fire and Fury</b> /Michael Wolff (Little, Brown £20) The inside story of the most controversial US presidency of our time 9,995 (126,150)	1	4
2	<b>How to Be Human</b> /Ruby Wax (Penguin £14.99) Wax talks happiness and health with a monk and a neuroscientist 4,375 (12,550)	4	2
3	<b>12 Rules for Life</b> /Jordan B Peterson (Allen Lane £20) Psychologist offers principles for a meaningful life 7,285 (24,010)	2	3
4	<b>I Let Him Go</b> /Denise Fergus (Blink £16.99) Touching story from the mother of murdered child James Bulger 3,795 (8,305)	3	2
5	<b>Everything I Know About Love</b> /Dolly Alderton (Fig Tree £12.99) Author recounts growing up, growing older and navigating love 3,275 (3,290)	—	1
6	<b>Women &amp; Power: A Manifesto</b> /Mary Beard (Profile £7.99) Classicist examines how history has treated powerful women 3,145 (21,180)	5	13
7	<b>With the End in Mind</b> /Kathryn Mannix (Wm Collins £16.99) Palliative care pioneer discusses death in an age of denial 1,965 (7,325)	22	3
8	<b>Somebody I Used to Know</b> /Wendy Mitchell (Bloomsbury £16.99) Insightful memoir by someone living with dementia 1,845 (1,855)	—	1
9	<b>Eat Up</b> /Ruby Tandoh (Serpent's Tail £12.99) Author celebrates the fun and pleasures of food 1,595 (1,755)	—	1
10	<b>Brit (ish)</b> /Afua Hirsch (Cape £16.99) Writer discusses the nature of race in Britain today 1,245 (1,300)	—	1

### GENERAL PAPERBACKS

		Last week	Weeks in top 10
1	 <b>Sapiens</b> /Yuval Noah Harari (Vintage £9.99) A history of humankind and our cognitive development 6,505 (534,820)	1	91
2	<b>Why We Sleep</b> /Matthew Walker (Penguin £5.99) Professor explores the mystery of sleep and why it matters 4,465 (28,340)	2	8
3	<b>Homo Deus</b> /Yuval Noah Harari (Vintage £9.99) Examines our future and the challenges we face 3,520 (216,056)	3	48
4	<b>12 Strong</b> /Doug Stanton (Simon & Schuster £7.99) The American soldiers who took on the Taliban after 9/11 3,200 (5,136)	7	2
5	<b>Inside the Wave</b> /Helen Dunmore (Bloodaxe £9.95) Poignant poems about life and death; this year's Costa winner 2,810 (10,260)	—	1
6	<b>Fingers in the Sparkle Jar</b> /Chris Packham (Ebury £8.99) Memoir from the BBC presenter tackling life, death, love and nature 2,585 (41,165)	—	5
7	<b>Fire and Fury</b> /Michael Wolff (Little, Brown £14.99) The inside story of the most controversial US presidency of our time 2,545 (11,660)	4	4
8	<b>Prisoners of Geography</b> /Tim Marshall (Elliott & Thompson £9.99) Ten maps that tell you all you need to know about geopolitics 2,535 (298,710)	6	76
9	<b>Darkest Hour</b> /Anthony McCarten (Viking £8.99) How Winston Churchill brought Britain back from the brink of defeat 2,300* (13,250*)	5	4
10	<b>French Children Don't Throw Food</b> /Pamela Druckerman (Black Swan £8.99) Observations on why French children are better behaved 2,115 (44,405)	—	1





# Laying death to rest

An undertaker, a palliative care doctor, a forensic anthropologist and a former bishop on how dying offers us the chance of the fullest life

*By Rowan Williams*

People still sometimes discuss the question of how you could tell that you were talking to some form of artificial intelligence rather than an actual human being. One of the more persuasive suggested answers is: "Ask them how they feel about dying." Acknowledging that our lifespan is limited and coming to terms with this are near the heart of anything we could recognise as what it means to be human.

Once we discovered that Neanderthals buried their dead with some ritual formality, we began to rethink our traditional species snobbery about them and to wonder whether the self-evident superiority of *homo sapiens* was as self-evident as all that. Thinking about dying, imagining dying and reimagining living in the light of it, this is – just as much as thinking about eating, sex or parenting – inseparable from thinking about

**A single seed: the price of a humanity that grows and changes is death**

our material nature – that to have a point of view at all we have to have a physical point of view, formed by physical history. Even religious systems for which there is a transition after death to another kind of life will take for granted that whatever lies ahead is in some way conditioned by this particular lifespan.

Conversely, what the great psychoanalytic thinker Ernest Becker called "the denial of death" is near the heart of both individual and collective disorders: the fantasy that we can as individuals halt the passage of time and change, and the illusions we cherish that the human race can somehow behave as though it were not in fact embedded in the material world and could secure a place beyond its constraints. Personal neurosis and collective ecological disaster are the manifest effects of this sort of denial. And the more sophisticated we become in handling our environment and creating virtual worlds to inhabit and control, the looser our grip becomes on the inexorable continuity between our own organic existence and the rest of the world we live in.

It's a slightly tired commonplace that we moderns are as prudish in speaking about death as our ancestors were in speaking about sex. But the analogy is a bit faulty: it's not simply that we are embarrassed to talk about dying (although we usually are), more that we are increasingly lured away from recognising what it is to live as physical beings. As Kathryn Mannix bluntly declares at the beginning of her book about palliative care, "It's time to talk about dying". That is if we're not to be trapped by a new set of superstitions and mythologies a good deal more destructive than some of the older ones.

Each of these books in its way rubs our noses in physicality. Caitlin Doughty's lively (and charmingly illustrated) cascade of anecdotes about how various cultures handle death spells out how contemporary Western fastidiousness about dead bodies is by no means universally shared. We are introduced to a variety of startling practices – living with a dead body in the house, stripping flesh from a relative's corpse, exhuming a body to be photographed arm in arm with it... all these and more are routine in parts of the world. And pervading the book is Doughty's ferocious critique of the industrialisation of death and burial that is standard in the United States and spreading rapidly elsewhere.

Doughty invites us to look at and contemplate alternatives, including the (very



fully described) composting of dead bodies, or open-air cremations. A panicky urge to get bodies out of the way as dirty, contaminated and contaminating things has licensed the development of a system that insists on handing over the entire business of post-mortem ritual to costly and depersonalising processes that are both psychologically and environmentally damaging (cremation requires high levels of energy resource, and releases alarming quantities of greenhouse gases; embalming fluid in buried bodies is toxic to soil). Doughty has pioneered alternatives in the US, and her book should give some impetus to the growing movement for "woodland burial" in the UK and elsewhere. At the very least, it insists that we have choices beyond the conventional; we can think about how we want our dead bodies to be treated as part of a natural physical cycle rather than being transformed into long-term pollutants, as lethal as plastic bags.

Talking about choices and the reclaiming of death from anxious professionals takes us to Kathryn Mannix's extraordinary and profoundly moving book. Mannix writes out of many years' experience of end-of-life care and presents a series of simply-told stories of how good palliative medicine offers terminally ill patients the chance of recovering some agency in their dying. Those who are approaching death need to know what is likely to happen, how their pain can be controlled, what they might need to do to mend their relationships and shape their legacy. And, not least, they need to know that they can trust the medical professionals around to treat them with dignity and patience.

Mannix's stories are told with piercing simplicity: and there is no attempt to homogenise, to iron out difficulties or even failures. A recurrent theme is the sheer lack of knowledge about dying that is common to most of us – especially that majority of us who have not been present at a death. Mannix repeatedly reminds us of what death generally looks like at the end of a degenerative disease, carefully underlining that we should not assume it will be agonising or humiliating: again and again, we see her explaining to patients that they can learn to cope with their fear (she is a qualified cognitive behavioural therapist as well as a medical professional). It is not often that a book commends itself because you sense quite simply that the writer is a good person; this is one such. Any reader will come away, I believe, with the wish that they will be cared for at the end by someone with Mannix's imaginative sympathy and matter-of-fact generosity of perception.

Sue Black's memoir is almost as moving, and has something of the same quality of

### **Waiting for the Last Bus: Reflections on Life and Death**

Richard Holloway

*Canongate, 176pp, £14.99*

### **All that Remains: a Life in Death**

Sue Black

*Doubleday, 368pp, £16.99*

### **From Here to Eternity: Travelling the World to Find the Good Death**

Caitlin Doughty

*Weidenfeld & Nicolson, 272pp, £14.99*

### **With the End in Mind: Dying, Death and Wisdom in an Age of Denial**

Kathryn Mannix

*William Collins, 352pp, £16.99*

introducing us to a few plain facts about organic life and its limits. She moves skilfully from a crisp discussion of what makes us biologically recognisable as individuals and how the processes of physical growth and decay work to an account of her experience as a forensic anthropologist, dedicated to restoring and making sense of bodies whose lives have ended in trauma or atrocity. The most harrowing chapter (and a lot of the book is not for those with weak stomachs) describes her investigations at the scene of a massacre in Kosovo: it is a model of how to write about the effect of

feeling on these occasions has been what Black articulates: a moving mutual gratitude and respect. And the book is pervaded by the sense of fascinated awe at both the human organism and the human self that comes to birth for her in the dissecting room.

Richard Holloway writes not as a medical professional but as a former bishop, now standing – not too uneasily – half in and half out of traditional Christian belief, reflecting on his own mortality and the meaning of a life lived within non-negotiable limits. His leisurely but shrewd prose – with an assortment of poetic quotation thrown in – is a good pendant to the closer focus of the other books, and he echoes some of their insights from a very different perspective. Medicine needs to be very wary indeed of obsessive triumphalism (the not uncommon attitude of seeing a patient's death as a humiliation for the medical professional); the imminence of death should make us think harder about the possibility and priority of mending relations; the fantasy of everlasting physical life is just that – not a hopeful prospect, but the very opposite.

He has some crucial things to say about the politics of the drive towards cryogenic preservation. Even if it were possible (unlikely but at best an open question) it is something that will never be available to any beyond an elite; any recovered or re-animated life would be divorced from the actual conditions that once made this life,

## Many medical students develop a sense of relatedness and indebtedness to the cadavers they learn on and from

human evil without losing either objectivity or sensitivity.

Perhaps what many readers will remember most vividly is her account of her first experience of working as a student with a cadaver. For all the stereotypes of the pitch-dark and tasteless humour of medical students in this situation, the truth seems to be that a great number of them actually develop a sense of relatedness and indebtedness to the cadavers they learn on and from. Black writes powerfully about the sense of absorbing wonder, as the study of anatomy unfolds, of the way in which it reinforces an awareness of human dignity and solidarity – and of feeling "proud" of her cadaver and of her relation with it.

For what it's worth, having taken part in several services for relatives of those who have donated their bodies to teaching and research, I can say that the overwhelming

my life, worth living; how would a limited physical environment cope with significant numbers of resuscitated dead? The book deserves reading for these thoughts alone, a tough-minded analysis of yet another characteristic dream of the feverish late-capitalist individual, trapped in a self-referential account of what selfhood actually is.

Odd as it may sound, these books are heartening and anything but morbid. Mannix's narratives above all show what remarkable qualities can be kindled in human interaction in the face of death; and they leave you thinking about what kind of human qualities you value, what kinds of people you actually want to be with. The answer these writers encourage is "mortal people", people who are not afraid or ashamed of their bodies, those bundles of rather unlikely material somehow ►



► galvanised into action for a fixed period, and wearing out under the stress of such a rich variety of encounter and exchange with the environment.

None of these books addresses at any great length the issues of euthanasia and assisted dying, but the problem is flagged: Black says briskly that she hopes for a change in the law (but is disarmingly hesitant when it comes to particular cases), while Mannix, like a large number of palliative care professionals, strikes a cautionary note. She tells the story of a patient who left the Netherlands for the UK because he had become afraid of revealing his symptoms fully after being (with great pastoral sensitivity and kindness) encouraged by a succession of doctors to consider ending his life. "Be careful what you wish for," is Mannix's advice; and she is helpfully clear that there are real options about the ending of life that fall well short of physician-assisted suicide.

Like all these authors, she warns against both the alarmist assumption that most of us will die in unmanageable pain and powerlessness and the medical *amour propre* that cannot discern when what is technically possible becomes morally and personally futile – when, that is, to allow patients to let go. The debate on assisted dying looks set to continue for a while yet; at least what we have here goes well beyond the crude slogans that have shadowed it, and Mannix's book should lay to rest once and for all the silly notion occasionally heard that palliative care is a way of prolonging lives that should be economically or "mercifully" ended.

The most important contribution these books make is to keep us thinking about what exactly we believe to be central to our human condition. It is not a question to answer in terms simply of biological or neurological facts but one that should nag away at our imagination. How do we want to be? And if these writers are to be trusted, deciding that we want to be mortal is a way of deciding that we want to be in solidarity with one another and with our material world, rather than struggling for some sort of illusory release.

Richard Holloway doesn't quite say it in these terms, but the problem of a humanity that doesn't need to die is that it will be a humanity that needs no more births. The price of a humanity that actually grows and changes is death. The price of eternal life on earth is an eternal echo chamber. As someone once said around this time of year: "Unless a grain of wheat falls to the ground and dies, it remains only a single seed." ●

Rowan Williams, former Archbishop of Canterbury, is a lead book reviewer for the *New Statesman*



## Playing it over and over again

How the movie that sums up the movies was made

Tom Shone

**Casablanca: the Life, Legend and Afterlife of Hollywood's Most Beloved Movie**

Noah Isenberg

Faber & Faber, 352pp, £25

**Michael Curtiz: a Life in Film**

Alan K Rode

University Press of Kentucky, 704pp, £38.50

For many, *Casablanca* is not just any old movie but *the* old movie. When Woody Allen was looking for a heroic exemplar for his nebbish cineaste in *Play it Again, Sam*, it was to Bogart's Rick Blaine that he turned. When Nora Ephron wanted to illustrate the practicality of women in *When Harry Met Sally*, it was Bergman's example she held up ("I don't want to spend the rest of my life in *Casablanca* married to a man who owns a bar"). The source of endless spin-offs, parodies and skits, from the Marx Brothers' *A Night in Casablanca* to *Saturday Night Live*, *Casablanca* is the movie we go to when we want to invoke movieishness itself, the dream factory at full tilt, a heroic foil to our mock-heroic age. As Umberto Eco put it in *Casablanca: Cult Movies and Intertextual Collage*, "It is movies".

This cultural ubiquity has entailed a certain sniffiness from critics, whose estimation has tended to chime with the Warner Brothers script reader who first assessed the screenplay: "Excellent melodrama.

Colourful, timely background, tense mood, suspense, psychological and physical conflict, tight plotting, sophisticated hokum." The *Cahiers du Cinéma* crowd, fully paid-up members of the cult of Bogie, none the less preferred his films with Howard Hawks and John Huston. Even Pauline Kael called it "a movie that demonstrates how entertaining a bad movie can be". And that is how most approach it: as camp, endlessly screened in revival houses such as Harvard's Brattle theatre, where it played from 1957 to audiences of student activists thrilling to its dramatisation of doing the right thing in a world turned upside down. At one screening in the late Sixties, according to the *New Yorker's* David Denby, during the final reel the sound failed and the audience, speaking as one, recited the actors' words for them, finishing the film up to its famous last line, "Louis, this could be the beginning of a beautiful friendship."

That kind of quasi-religious devotion is not, generally, inspired by hokum. "Despite



As we age, or as our health deteriorates, we can make plans for what treatments we would wish to avoid or where we would like to be cared for. As a palliative medicine pioneer explains, it's often a surprise to patients and families that a frank discussion of dying can feel so helpful / By KATHRYN MANNIX

# A natural end

**I**T'S SURPRISING how many people make plans for after their death, yet avoid planning the way they would like to die.

Ignatio has planned his funeral. The plan is in an envelope in his sideboard cutlery drawer, marked, "For when I die". He sees it every time he sets his table for his daily meals for one. Ignatio has written a will. Henry, his nephew and carer, will inherit the flat and its contents.

Ignatio can only walk around his small flat as long as he wears his oxygen tubes up his nose; he trails a long tube behind him that connects to an oxygen concentrator, a box the size of a dog kennel that sits on his balcony, humming and whirring. His bed has been brought into his living room because the pipe won't stretch any further. Ignatio likes the trees outside his window.

Today, Ignatio is expecting a visit from his nurse specialist, an expert in lung diseases. She has known Ignatio since his long-term chest complaint limited him to his home. It was she who explained that his condition cannot be cured; explained the link between breathlessness and panic; taught him the relaxation exercises that help him when he feels he is drowning and the air is too thick to breathe; and who recently arranged for him to have oxygen at home.

Ignatio has a booklet that describes how to make the best of living with breathlessness. The booklet helps Henry to know that sending for an ambulance may not be the best response when Ignatio loses his breath.

**INSTEAD, HENRY** talks Ignatio through a coping response: make sure your oxygen is on, use a mask instead of the nose tubes. Sit on a tall chair and lift your back straight. Relax your shoulders. Distract yourself; the booklet suggests counting backwards from 100 in sevens, but Ignatio prefers to say the rosary. Both help. So does the calming attention of Henry, either in person or on the phone. Without Henry, Ignatio thinks he would have died of breathlessness months ago.

Today, the nurse has some new forms to fill in. She sits down and chats to Ignatio while he potters in the kitchen to make her a cup of tea. She always says no, but he always insists. Mustn't drop the courtesies. He serves the tea, and sits beside the nurse to look at the paperwork.

"Let's talk about it first," she suggests. "It's about planning ahead. Thinking about what might happen if your chest gets worse



PHOTO: JEANNE TAYLOR

in the future." She pauses. Ignatio nods.

"Do you think about that?" asks the nurse. Ignatio considers. *Yes, he does. Yes, sometimes he wonders whether Henry will arrive and find him dead on the floor.*

"Yes..." he responds, cautiously. *Where is this going? Does she want to put him in a home?*

"And when you think about it, what goes through your mind?" she asks. *Drowning, he thinks. Panic. Choking. Loss of control. Wetting myself. Henry finding me looking undignified – and dead.*

"What would happen if I couldn't get my breath back," he replies, tucking all his fears away as cowardice. The oxygen hisses quietly through his nose tubes.

"And what *would* happen, do you think, Ignatio?" she asks, gently, watching his face carefully.

Ignatio sips his tea. He considers his response. "Perhaps I could collapse," he says, eventually.

This experienced nurse waits in case Ignatio has anything to add, then asks: "Collapse? Or worse than that?" and waits attentively for his answer.

*She's reading my mind. Or maybe she's met other people like me...*

"Worse..." he admits. "Perhaps I might die." She nods, and sips her tea. She waits. *What else does she want me to say?*

"Is that the worst thing that could happen?" she asks at last. He is surprised. *Could there be something worse?* But yes, of course, all the

other things he worries about would be worse than simply dying. *A lot worse.*

"They might take me into hospital. Stick needles in me. Hook me up to one of those respirator machines. Take me away from Imelda..." Ignatio gazes across the room to a large, framed photograph of his beloved wife, who died many years ago.

"And if they took you to hospital, Ignatio, would that make you feel safer? Or just overwhelmed?"

Tears start to his eyes. She has named a fear he didn't even know he had: being taken away from his familiar rooms, becoming overwhelmed by the technology of the hospital, feeling lost.

"I don't like the hospital," he confesses, "and they can't make my lungs any better. But if I collapse, I guess they will have to take me there."

"Are you telling me that, if you had a choice, you wouldn't choose to go to the hospital?" she asks. He nods his head, relieved and surprised at the relief. *Yes, I hate the noise and the waiting and the masks and the hospital-ness of it all.*

"Well, these forms are for us to make sure that you can plan ahead. We can make plans to keep you at home, if that's what you would prefer," she says. "If you want to, we can even make plans to keep you at home if you were sick enough to die."

**OVER THE NEXT** half-hour, Ignatio learns all about Advance Care Planning. He and the nurse discuss his preferences; everything that a GP or an ambulance crew need to know if they are called to him in an emergency. She writes out a plan for managing increased breathlessness (oxygen; drugs to calm the panic; check for a chest infection); a plan for a chest infection (Ignatio wants to stay at home; paracetamol for fever; antibiotic tablets; no escalation to hospital); a plan for being so sick that he seems close to death (Ignatio wishes to die in his own home; drugs for breathlessness and for panic in case of need; Ignatio would prefer to be awake but if his symptoms are severe, he would accept a little drowsiness in exchange for better symptom control; Ignatio would like his nephew Henry to be called; Ignatio would like his priest to attend; and the phone numbers of those important people in Ignatio's life).

"How does that feel?" she asks, after reading through the form with him.

"Like a big weight off my mind," admits Ignatio, somewhat surprised that such a frank discussion of dying can feel so helpful.

"Good," she says. "Now, if you don't want to go to hospital, then there's another very



important form to fill in. It's this one," and she produces a red-edged sheet of paper headed "CPR status."

"This form is about cardio-pulmonary resuscitation. Do you know what that is?"

"It's when they thump your chest and do mouth-to-mouth resuscitation, isn't it?"

"Exactly. It's treatment for when somebody's heart stops beating, when they are well enough for it to be restarted by an electric shock or special drugs. The ambulance crews use a tube in your mouth and an oxygen cylinder rather than mouth-to-mouth, but it's the same principle." She pauses.

"The thing is, that's a sensible, useful treatment for someone who is expected to get better. But it may not be a useful treatment if someone's heart stops because they are dying of something we all knew they would die of..."

She looks at his face. *Yes, he nods, yes. That's me.*

"If an ambulance crew came and found you collapsed, they might take a while to read this other form we have filled in, and they would start that pressing and blowing stuff straight away. And you've said that's not what you want or need. So this other form, the 'CPR status' one, is a quick and easy flag that says 'No CPR.' Then we have to say why not."

"There are several possible reasons why not, and we can tick any that apply."

**"SO, LOOK, WE** can tick this one that says you don't want CPR, even if you would die without it, because you want to stay at home, as peaceful as possible. And we can tick this one, that says you have another health condition that is progressing, and your natural death should not be mistaken for reversible cardiac arrest. 'No CPR' status does not mean you would not get other treatment at home; it really is just about CPR. Shall I tick both forms?"

Ignatio feels a huge, heavy lump of anxiety slide off his shoulders, down his legs and away to the floor. He can stay at home, among his memories of his wife. He can die here. He won't be taken away by an ambulance to the hospital where no one can pronounce his name and where he can't see the trees. He won't be prodded and pummelled in a terminal event that can't be reversed. If strangers arrive to help, they will send for Henry and for Ignatio's priest.

The nurse smiles and rolls up the papers; she places them in a pink, see-through plastic zipper bag and tells Ignatio to keep the bag in the door of his fridge – it's the place local ambulance crews will always look first for instructions. She explains that Ignatio's preferences and his "No CPR" status will be logged by his GP, with the ambulance depot and at the hospital: everyone will be aware of his plans and preferences.

"Thank you," he tells the nurse. "Thank you for talking to me about this. I feel so much better. We should have another cup of tea."

**Kathryn Mannix** is the author of *With the End in Mind: Dying, Death and Wisdom in an Age of Denial* (William Collins), which was shortlisted for the Wellcome Prize.

## I'm still just able to take pleasure in denouncing an inanimate paving stone



“THERE WAS a good deal of scratching and fiddling in church by guests at the wedding of the Duke and Duchess of Sussex, as we must learn to call them. (Interestingly – to me – the previous holder of Prince Harry's subsidiary title of Earl of Dumbarton wanted to be a monk, but had to settle for ambassador to St Petersburg, before dying at Douai in 1749.)

Anyway, wherever the camera turned, it soon shied away as some celebrity checked that his trousers were done up or investigated an urgent signal from his left nostril. Yet, because the National Curriculum omits training in sitting still, for most people fidgeting is subconscious.

The lovely Duchess confined herself to consoling hand-holding with the groom. I don't know if she learnt not to fiddle at her convent school or in her drama studies. The Queen, of course, left her own face untouched, disturbing her composed posture only to ease her poor old shoulders against the even older woodwork of the Garter stall she sat in.

When an invitation to a televised event arrives, it's too late to resolve not to pick, fiddle and poke. By then, the more you remember not to scratch, the more it itches. The Dalai Lama has sound advice that he likes to quote from an old Buddhist master, Nagarjuna: "If you itch, it's nice to scratch it. But it's better to have no itch at all."

BEFORE THE seventeenth century, children, one often hears, were regarded as small and inadequate adults, with no special culture or play, and, since so many died in infancy, the bonds of affection with parents were looser than in the modern West. This version of the past is largely that of Philippe Ariès' book from 1960, published in English as *Centuries of Childhood*. It influenced other historians, notably Lawrence Stone, who saw relief from unkindness to children only when Puritanism faded.

I'd felt uneasy about this caricature every time I came across contrary evidence, such as the moving fourteenth-century dream-poem about a lost child, *Pearl*. Now I have learnt who most effectively overturned this slur on medieval parents. The credit goes to Nicholas Orme and his *Medieval Children*.

I am not jumping the gun in saying that a section about the work of Professor Orme forms one of the many enjoyable

highlights in the forthcoming book by Eamon Duffy, *Royal Books and Holy Bones*, to be published next month. This section was originally published in the *New York Review of Books*, which I missed. It certainly deserves its place between hard covers.

Professor Duffy saw the "resolute empiricist" Orme's "sheer exuberant abundance of material" as an "almost overwhelming refutation of Ariès". Orme marshalled visual evidence of medieval children being born, bathed, fed, having their nappies changed, learning to walk, rocking a sibling's cradle, riding hobbyhorses, watching puppet shows, walking on stilts or singing carols. The picture he built up was of childhood in its essentials recognisably the same as our own. He offered "the least theorised, most comprehensive, most informative and, by a long way, the most humane and enjoyable historical treatment of childhood in English".

*Medieval Children* came out in 2001, but one still hears trotted out Ariès' demonstrably false conclusions from slim evidence. It's Professor Orme's birthday on the first Sunday of June. He has the grateful good wishes of all who enjoy well-written, evidence-based history.

I FEAR I might make a good busybody – if I weren't so busy. An enabling step towards this unattractive role was logging on to Westminster Council's website, with a special password and everything, in order to denounce a million-decibel party in the small hours the other week. The site now allows me to act like a renaissance Venetian, condemning enemies with anonymous delations posted into the marble lion's mouth.

I'm still just able to take pleasure in denouncing an inanimate paving stone. It was rocking and would soon have tripped some innocent old person and broken a hip or two. Within two days, a white cross was sprayed on the condemned block. Within a week it had been reset, its white cross remaining, like the Sanbenito of a reprieved heretic, lest it relapse into recidivist rocking. I don't know about my moral future, but the pavements of Westminster are in blessed good sorts.

**Christopher Howse** is an assistant editor of *The Daily Telegraph*.



# We ALL deserve a

**P**ROFESSOR Paul Cosford is director for health protection at Public Health England, the man responsible for the control of infectious diseases, immunisation and for developing the emergency medical response to major incidents such as the London terror attacks.

But last summer, looking at an X-ray of his own lung, he learned that he is also a cancer sufferer and that the disease, which has spread to his liver is incurable.

'I thought I probably had a year, or maybe less, to live,' he told the Royal Society of Medicine in February, in a talk about end-of-life care.

Treatment with new, targeted biological therapies — which stimulate the immune system to fight the cancer — has given him a life expectancy of three or four years.

Professor Cosford, 54, a father of four, decided to approach the near future with scientific rigour. 'I knew

By **CAROLINE SCOTT**

I should stay physically active because there is good evidence it prolongs life, even in incurable cancers like mine,' he said.

'I wanted to try to maintain a positive mindset and to continue working, while spending more time with people important to me.'

But despite his best efforts, he found himself worrying constantly about his death, and he spent sleepless nights imagining different, horrific scenarios. 'The mode of death that worried me most was the tumour invading a major vessel, causing unstoppable bleeding into my lungs, drowning in the blood.'

He realised he could only focus on living well now if he faced the fear of dying upfront. 'I cannot, of course, predict how I might die,' he said. 'But I started thinking that I could focus on living well if I knew I would be able to have some control at the

time I need it.' Six months since his diagnosis, he is sure of one thing: we need to be much more open about how we help each other to die well, and what we mean by that.

'It seems we have created a climate in which the prevalent belief is that pain and death are avoidable and wrong. We know this isn't true, but it means that when pain is there, when imminent death is faced, we often don't know how to handle it.'

The end of life was something former Labour cabinet minister, Tessa Jowell, who died on Saturday aged 70, had spoken about after being diagnosed with brain cancer.

'In the end, what gives a life meaning is not only how it is lived, but how it draws to a close,' she said in a speech to the House of Lords.

Her daughter, Jess, told Radio 4 yesterday that Tessa's peaceful death had been 'beautiful', adding: 'To the last moment, she was the most magnificent person and mother we all know and adore.'

Tessa's daughter-in-law, Ella Mills, revealed that Tessa died in the arms of her husband, David, and grown-up children, Matt and Jess.

Sadly, not everyone dies in a familiar place surrounded by loved ones. People die in emergency rooms and intensive care units, where the machinery of life preservation creates a sham loved ones feel they cannot cross. On wards where staff are focused on cure, sensitive palliative care can be overlooked.

While we are able to openly discuss birth and loss, few of us know what to expect as death approaches: it makes families anxious, and creates fear and uncertainty for the dying.

New research by the charity Sue Ryder suggests we would like to know more about death and dying, but we don't know whom or what to ask. A survey of 1,000 bereaved adults in the UK found that some of the main worries people have when someone close to them is dying is not knowing the physical and mental changes to expect as death draws near, or how to make loved ones more comfortable.

**T**HE findings have prompted the charity to call for a 'national conversation' and greater openness between health and care professionals and families about what to expect.

'There's a specific need for more information and communication about the physical and mental signs that indicate death is near,' says Heidi Travis, chief executive of Sue Ryder.

'This would help to prepare families with different ways they might respond and comfort their loved one. It could also prompt discussions about their last wishes and different ways to help them have a good death.'

Doctors and nurses who are trained to help may unconsciously collude in this fear about the moment of death; working to prolong life, they may not always recognise the need to support their patient to die.

Barry Ward, 85, a retired golf writer, from Ockham in Rutland, found the experience of the death of his wife, Christine, so traumatic, that three years later he still struggles to talk about it.

'She was the love of my life,' he

It's a taboo subject. But as Tessa Jowell and her loving family so bravely demonstrated a dignified end to a life well lived can be planned, but can't be left to chance... as these stories reveal

says. 'From the night we met, we knew it would be for ever. Our marriage was filled with love.'

In April 2014, Christine, a care home administrator, then 68, was diagnosed with a brain tumour which was treated successfully with chemotherapy. But shortly afterwards, she developed a rare gut infection which caused internal bleeding and was admitted to intensive care on Christmas Day.

'On January 12, 2015, a young doctor took me to one side and told me there was nothing more they could do for her,' says Barry.

'But the following day, amazingly, she began to show signs of recovery. The day after that, her heart rate and blood pressure were better and she was no

tine's bedside making plans for their 41st wedding anniversary.

At about 7pm, he drove home but had just sat down when the phone rang. 'I was told to come back quickly. I found her unconscious, ghostly white and with her mouth agape.'

At 2am on January 18, Christine died. 'The shock, when she'd been so well hours before, was appalling, and it has affected my ability to grieve,' says Barry. 'I wasn't prepared for the end, and I don't think she was either. I would have liked the chance to say goodbye.'

Half of all deaths in England occur in hospitals — and 50 per cent of all hospital complaints relate to end-of-life care, according to 2008 figures.

Many people die without them or their family knowing the end is coming. Death is often seen as a failure of treatment, and this can mean missing out on preparations for a good death.

Debbie Riordan's parents, Wendy, 76, a hairdresser and Rodger, 78, a pharmaceutical salesman, died in 2015 within four months of each other. Wendy had undergone successful chemotherapy for bowel cancer when she developed an infection, and Rodger died from lymphoma, 18 months after he was diagnosed.

'Mum had terrible sickness, so it was quite upsetting, but we were sure she would make a full recovery,' says Debbie, a yoga instructor from Coventry.

'There were moments when Mum would say: 'I've never felt this ill. I know I'm not going to make it.' Debbie recalls. 'But

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# 'good death'



Pictures: ALAMY/ANDREW  
WATSON/i-Images

the nursing staff batted her concerns away. So we'd say: "Don't worry Mum, it's just a bad day."

"But over a period of two weeks, she got worse and worse."

The medical team must have known she was dying, says Debbie, yet no one ever said: "She really is poorly; now is the time to say what you need to say."

By chance, Debbie had heard palliative care consultant and author Kathryn Mannix talking on Radio 4 about the signs that someone is dying: "I could see Mum was at that point," she says. "She wasn't eating, she didn't want to drink, she was unconscious a lot of the time, and her body was filling up with fluid."

"We asked the nurses to stop clearing her airways and doing blood tests, but the focus was still on treatment, not how to spend the time she had left."

**D**EBBIE feels that as a result of hearing Dr Mannix, she was lucky she was able to have precious last conversations with both her parents. Fortunately, she was there when her mother died, but missed the moment of her father's death.

She feels it would have been helpful if, instead of ordering more tests, doctors had asked gentle questions such as: "How do you think your mum is?"

"That would have helped us realise sooner what was happen-

ing," Debbie says. Her dad died early one morning when she and her sister had gone home. "If we'd known how close he was to death, we would have stayed."

"I think doctors and nurses are frightened to initiate a conversation about death for fear of upsetting people. But you'll never have another chance to tell someone how much you love them or say goodbye."

Dr Mannix, who has spent the past ten years leading a palliative care team at the Newcastle Hospitals NHS Trust, says that when a patient is "morally sick, but saveable, it is absolutely right that everything should be done to treat them."

She adds: "Intensive care medicine buys time, so dying is delayed long enough for healing to take place. But intensive care doctors are not always comfortable with difficult conversations and that's where we come in."

"I encourage acute care teams to acknowledge that while recovery is hoped for, death is possible, and to let us work alongside them."

Hospital palliative care teams manage physical symptoms such as breathlessness and pain, but also emotional distress.

"One of the most important things we bring is candour. We need to ask whether this is the end of the line for this patient and should we be having those difficult conversations about what needs to happen next."

Not all hospitals have palliative

care consultants, but all staff should be trained in end-of-life care. A palliative care consultant might ask: "Have the doctors explained things so you understand what's happening? And: "What do you fear the most?"

"The family is often doing everything to avoid the conversation going to "the worst place" in case it gets emotionally horrible," says Dr Mannix. "But actually it becomes a lot calmer once you start asking: "If she's so sick she cannot be saved, what sort of things should we be doing now so we don't regret anything?"

"I don't want them to wish in two weeks' time, when they are suffering agonising grief, that they'd had that conversation at the deathbed."

Sue Ryder's advice on what to expect when death is near was in the top three most viewed pages on their website in 2017, which suggests that as a society we

have become so protected from death, we don't know what normal dying looks like. This finding resonates with Elise Hoadley, a palliative care nurse for 28 years and now director of Leckhampton Court Hospice in Cheltenham, Gloucestershire.

She has spent her entire professional life looking after the dying. "I have witnessed countless families facing the death of a loved one, not knowing what to expect," she says.

"People think it's going to involve blood and guts and gore. Yet normal dying is incredibly peaceful and gentle. Most people experience longer and longer periods of unconsciousness when they'll think they've been asleep. Breathing becomes shallower, and eventually fades until it finally stops altogether."

But if people are terrified of the physical unknowns, we're even more frightened of all the emotions that go with death.

"Patients sometimes don't want to talk about their own death because they don't want to upset their loved ones. And loved ones don't want to talk to the dying person about it for fear of upsetting them," says Elise.

"If we can facilitate the conversation, an element of honesty comes in and everything is less traumatic for the family and patient."

**W**HEN your loved one is dying in hospital, you can ask for the palliative care team to be involved. If they are not available, Kathryn Mannix suggests asking the question: Is there someone I can talk to who can explain what is happening?

"The more patients know, the better they can plan the end," agrees Elise Hoadley.

A rule of thumb in palliative care is that if a patient gradually declines over months, they will usually have months to live; if it's weeks, they'll have weeks, and if you see a decline over a period of days or hours, then death is usually only days or hours away.

"How wonderful would it be if more people knew that? Because then they could really plan how, and where, they want to die."

Dr Mannix says deathbed patterns repeat over and over again. "The two things people want to say are, "I love you" and, "thank you". Don't wait for the last day of someone's life to say either — say it now."

"The two biggest regrets people have are not saying, "I'm sorry" and, "I forgive you". Those are difficult things to express, but deathbeds give you permission to have conversations that don't happen at any other time."

■ **FOR further information and advice for families on what to expect, go to [sue Ryder.org/facingloss](http://sue Ryder.org/facingloss) With The End In Mind: Dying, Death And Wisdom In An Age Of Denial by Kathryn Mannix is published by William Collins, price £16.99.**



Peaceful end: Tessa Jowell, who died on Saturday



at the end of the prescription?

It was only after my retirement that I had time to read medical journals other than by skimming them and gathering their conclusions as a bee gathers pollen. Only when I read each paper carefully did I come to realise how bad and, in some instances, corrupt much of the medical literature is. I now recognise the logical errors, legerdemain and confusion

between what is statistically significant and significant in other ways, all of which vitiates so much of what is published – much of it, incidentally, funded by pharmaceutical companies.

There are little cavils one could make about this book. Le Fanu misses publication bias – the predisposition towards publishing the results of studies with statistically significant findings over those

with less attention-grabbing outcomes – as a source of error. He also overestimates the accuracy with which admissions to hospital because of side effects of drugs are measured. But *Too Many Pills* is above praise for its clarity, its elegance of argumentation, its humanity and its uncommon common sense.

*To order this book from the Literary Review Bookshop, see page 16.*

WENDY MOORE

## Facing the Void

With the End in Mind: Dying, Death and Wisdom in an Age of Denial

By Kathryn Mannix

(William Collins 341pp £16.99)

When my husband's father was admitted to hospital with lung cancer in 1974, his doctors made no attempt to tell his family that the condition was terminal. His death came as a complete shock to his wife and her two teenage children – my husband, then eighteen, and his younger sister. Five years ago, when my mother was diagnosed with cancer, the members of her medical team were unfailingly honest about her terminal condition and went out of their way to ensure that she died at home, peacefully, surrounded by her family.

Those intervening four decades have seen a wholesale transformation in the medical profession's approach to death and dying. Most healthcare professionals today are fully committed to ensuring their patients' final days are tranquil and pain-free. A 'good death' is now the order of the day.

As a consultant in palliative medicine with forty years' experience, Kathryn Mannix has played a critical role in this gradual revolution. But she believes we need to go further. Mannix argues that we should all prepare for our own deaths by developing plans for our last days and opening conversations with our nearest and dearest about how we want to die. Her book – a kind of self-help manual for a good death – is not a comfortable read, though it makes a powerful case for openness.

As a society we have become less familiar with death and dying due to people living longer and the development of treat-

ments for previously incurable diseases during the last seventy or so years, Mannix explains. Death, she says, has become 'increasingly taboo': we have lost the vocabulary to discuss the inevitable and the 'art of dying has become a forgotten wisdom'.

Encouraging us to begin those conversations, Mannix describes real-life death scenes with matter-of-fact candour. Most deaths follow a predictable pattern, with a gradual descent into more frequent sleep, followed by unconsciousness and ever-slower breathing until it stops altogether. 'In fact, normal birth is probably more uncomfortable than normal dying,' she says. To illustrate her argument, she describes some thirty case studies drawn from her long career – 'offering the reader my eyes and ears, my seat at the bedside' – with empathy and humour.

These stories are poignant testimonies to the way professionals can work

together with families to ensure the end of life is managed in the best possible way, though they are no less heart-rending for that. One patient, a retired head teacher, is anxious that his family will not be able to cope with his death too close to Christmas, so the hospice team brings Christmas forward to November and arranges a traditional dinner, complete with party hats and flaming pudding. Another, a young father with end-stage cancer, is given help to manage his symptoms so that he can take his sons on a final fishing trip. In other cases, hospice staff help patients to deal with their anxieties, talk to their families and arrange practicalities – from homing a reclusive man's beloved cat to buying a wedding dress for a patient's daughter.

Reading these accounts, it is hard to avoid the conclusion that fate deals some people an unutterably rotten hand. There is little cheer in the story of a smiley teenage girl with leukaemia who sews a patchwork memory cushion to console her mother after she has gone, or of the young man who has had to prepare for his death since the age of twelve. Mannix closes the door when each patient dies, but the pain continues for those left behind.

Occasionally Mannix's advice on preparing for death, which includes a template of a letter to write to loved ones, can seem a little patronising. As her stories eloquently demonstrate, everyone is different in death as in life – there is no template for dying. But with its combination of reassuring pragmatism and clear-sighted honesty, her book will make a valuable contribution to our understanding and acceptance of the certainty that awaits us all.

*To order this book from the Literary Review Bookshop, see page 16.*

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Daniel Miller

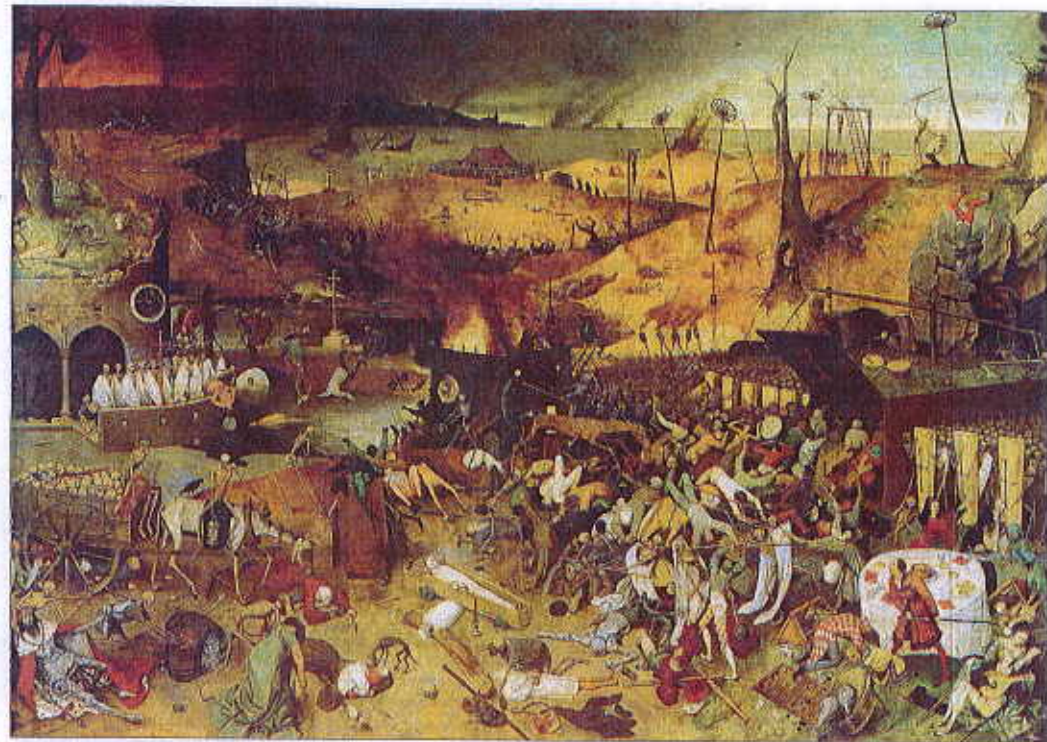
THE COMFORT OF PEOPLE

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James Turner was twenty-five when his four-year-old daughter Annice died from a lung condition. She died at home with her parents and grandmother; her sleeping siblings were told of her death the next morning. James did everything to soothe Annice's last days but, never having encountered death before, he didn't immediately recognize it. He didn't know what to do or expect and found it hard to discuss things with his wife Martha. The family received many condolences but kept the funeral private. Losing a child, often described as the hardest bereavement to bear, changed James Turner forever.

Death in the twenty-first century is typified by the paradox contained in this story. Although we greedily consume death at a distance through fiction, drama and the media, we are hamstrung by it up close and personal. In 1955 the commentator Geoffrey Gorer declared that death had become more porno-



"The Triumph of Death" by Pieter Bruegel the Elder, 1562

graphic than sex. It was, he said, the new taboo and mourning had become "indecent". Since then, matters have arguably got worse. The decline in institutional Christianity left a spiritual and existential vacuum, while the rise in individual materialism has fragmented family networks and communities. Shared rites of passage that publicly validated grief have receded, and the space of death has moved increasingly from the home to the hospital.

Focusing on the US and, to a lesser extent, Northern Europe, Haider Warraich's *Modern Death: How medicine changed the end of life* identifies how far-reaching these changes are. A physician and clinical researcher, Warraich is well placed to observe the dubious implications of an expanded medicalization of death. Most people want to die at home, but the majority continue to die in hospital, surrounded by medical equipment. In general, life expectancy in the past century has increased, but so has the use of medicine to prolong it artificially. Definitions of death have grown more complicated – does it lie in brain function or in the heart and lungs? – and are openly contested. And despite what Warraich calls medicine's "obsession" with preventing or delaying death, there is no clear provision for bereaved families. That task waits to be taken up. Kathryn Mannix agrees in *With the End in Mind: Dying, death and wisdom in an age of denial*, suggesting that it "has become taboo

to mention dying". Through a "gradual transition", Mannix says, we have lost the vocabulary for talking about death and depend instead on euphemism, lies and ambiguity; she wants us to "reclaim" a language of death.

This is a recurring theme among these seven books. For some, our inability to talk straight about death and dying is partly about the mystery of the end. Andrew Stark, in *The Consolations of Mortality: Making sense of death*, identifies the decline in religion in the West and the idea of the afterlife as pivotal to our lack of confidence in confronting death. Robert McCrum, in *Every Third Thought: On life, death and the endgame*, speculates that ageing and death present a particular conundrum to self-assured baby boomers, who try to give death the slip ("let's talk about it another time..."). In *From Here to Eternity: Travelling the world to find the good death*, Caitlin Doughty expands the problem into a generic Western culture of death "avoidance" – we duck awkward conversations with the dying, hand our corpses to corporate professionals and, worst of all, treat grief with embarrassment and shame. Kevin Toolis, in *My Father's Wake: How the Irish teach us to live, love and die*, describes a veritable "Western Death Machine", in which public services, health professionals, the media and corporate bodies all conspire towards the removal of death and dying from the purview of ordinary

people. A former war correspondent, Toolis has seen more than his fair share of death and is here to shake us out of our complacency.

The measure for our current climate of denial is typically set against an assumed past where we were collectively better at death. The pinnacle of this "Golden Age", the so-called Celebration of Death, was the nineteenth century, when religions helped to explain death and provide a set of shared practices for marking our passage into it. Consumer culture provided a public medium for expressing loss and offering condolence, from the burgeoning trade in mourning – exemplified by the rise of the mid-Victorian death superstore Jays' Mourning Warehouse, on Regent Street – to the birth of the "With Sympathy" condolence card where ready-made sentiment overcomes the awkwardness of finding something meaningful to say. Most important of all, high death rates and low expectations of medicine (beyond palliation) meant that families commonly experienced death within their home. It is the loss of this familiarity with death that is most lamented by Toolis, who relates the story of his elderly father's peaceful death at home in rural Ireland, contrasting a disappearing world of traditional community-based rites of passage – keening, the help of a death (or soul) "midwife", washing the corpse, and the "steady stream" of visitors who arrive with simple words of condolence ("Sorry for your



loss")—with our "modern" culture of hygiene, individualism and emotional reticence. The author isn't subtle about which culture he prefers. Over in "Anglo-Saxon land", we whisper about death, "putting our hands over our ears, blinding ourselves with the Western Death Machine", but it doesn't change anything: "it just leaves you naked and exposed".

Doughty finds something similar to the Irish way in nineteenth-century America, where death was a family and community affair, while Mannix identifies a pre-1950s culture in the West of accumulated "rich wisdom" garnered from observing death and dying at close quarters. Stark, however, draws on a more generic "wisdom of ages" to outline four propositions that might provide solace in a secular age (again, the assumption is that religion once provided the consolation that we postmodern "bundles of ego and anxiety" now lack): death is benign; mortality can imitate the good things about immortality (notably, technology facilitates the preservation of treasured memories granting us virtual immortality, at least); immortality would be grim; and life, suffused with repeated loss and suffering, might not be terribly different to death anyway. Stark concludes that none of the propositions really provides much consolation after all, and suggests that perhaps the only real consolation comes with the knowledge that we are continually moving towards death. But is it even true that, as all these authors suggest, people in times past did not face the same difficulties?

At the end of the nineteenth century, only 2 per cent of the UK population had a non-religious burial service. In 2010, in the UK, only 27 per cent of respondents to an ICM poll wanted a religious funeral. In the past, public narratives of death were heavily inflected with heavenly reunion. The Victorians spent vast amounts of money on death, propelling the humble carpenter into big funeral business and changing the urban landscape with magnificent cemeteries. Mourning was a fashion extravaganza, from shroud couture to ear trumpets in black crêpe. Framed post-mortem photographs hung over glass-domed "immortelle" displays, while the bereaved wore elaborate jewellery made of the deceased's hair. These practices clearly favoured those with money, but a creative culture of improvisation and exchange meant that even the less affluent could participate in some tokens of mourning. A combination of consumerism and spirituality provided a range of vocabularies for communicating death. Undoubtedly, most people died at home and, until the rise of the mortuary (or "Chapel of Rest") in the early twentieth century, most corpses remained there until burial.

Gorer set the tone for holding this culture as death par excellence. It received strong endorsement from Philippe Ariès, whose *The Hour of Our Death* (1981) was the first comprehensive survey of Western death cultures from the Middle Ages to the present day. Both Gorer and Ariès saw the nineteenth century as offering tangible psychological support to the dying and those who mourned them. Modern death, in contrast, was privatized, medicalized and emotionally stunted. Toolis is a clear heir to this ideological view of two divergent death worlds. The real villains in his story are less the health practitioners, coroners, or funeral directors, than Western capitalism as a whole with its obsession with material success and longevity. The irony for Toolis is that amid all this "eager capitalism" there isn't more cut-

throat competition: a FixUpYourFuneral.com price comparison website or an UberHearse app. And, writing from the frontline of Toolis's "Western Death Machine", Doughty, who runs a funeral parlour in Los Angeles, agrees. America is home to the most commercial, corporate death culture in modern times. In Doughty's words, the US is now the best in the world at separating the grieving from their dead. Americans have become "squeamish", which makes death both expensive and emotionally unsatisfactory. Doughty is on the side of angels: her funeral home enables mourners to do death in the old style, involving friends and family in traditional rites such as washing and dressing the corpse and building the coffin.

Criticism of, and attempts to row back on, the commercialization of death and its seemingly fake emotion isn't new, though; it was just as prevalent in the nineteenth century, when Dickens railed at the skewed sense of priorities whereby "everything that money could do was done", so "feathers waved, horses snorted, silk and velvets fluttered", but weeping with genuine grief, as old Chuffey does at his master's funeral in *Martin Chuzzlewit*, was mawkish and embarrassing. To eulogize traditional death rites is problematic in other ways, too. Getting more people to die at home has been a stated goal of successive British governments. But the idea is founded on romanticized notions of what dying at home involves. It is cheap for the state but exacts a heavy cost on family life. It is also heavily gendered. Even with access to palliative care nurses, caring for the dying involves a lot of gruelling work, which has historically fallen to women, who also undertake the majority of emotional labour for the bereaved, not to mention the catering. Toolis, in his account, smokes, drinks and eats the sandwiches the women have made. Most of these "traditional" rites were, in their own time and place, contested, too. Religion brought recrimination as well as consolation. Elaborate codes of mourning created an oppressive regime of sentiment that some people did not feel. For others, the location of personal loss in a public context was intolerable. Some bereaved families felt supported by visitors; others deeply resented the intrusion and the effort required to be hospitable. If the public nature of mourning created material expectations around what grief looked like, it also provided scope for the cruellest social exclusion. Families who could not buy grave space, for example, were humiliated by having to surrender their dead to a public grave. The clue is in the name: public in that they contained multiple corpses unrelated except by poverty, and public in declaring the family's shame.

Finally, the idea of community is deeply ambiguous, too. Fear of contagion militated against communality, while some families were afraid of the dying who, extremely sick, could change beyond recognition. As Daniel Miller shows, plenty of people died lonely deaths at home in the past and where community did exist, it was often born of necessity, not choice. Against this backdrop, Miller explores social relationships at the end of life through a collation of patient narratives taken from one hospice and biased towards people from rural communities now. Some of his narrators appear relatively lonely and socially

isolated, partly from preferences for privacy, independence and a desire not to impose on others. Miller, an anthropologist, is one of the few writers here to confront our nostalgic view of the good death and to question the extent to which the challenges we associate with dying and isolation are manifestations of recent social fragmentation. For one thing, as *The Comfort of People* reminds us, "community" was often the result of poverty and the need to share resources; it compromised privacy and independence. It did not necessarily correlate to emotional succour and support.

In short, there was never a time when we did death well. James Turner lost his daughter in Halifax in 1882, not 2018. An unskilled labourer living in a context where children were expected to die before the age of one, he might have been expected to be au fait with death. But he wasn't. He didn't know what death looked like, he didn't want to talk about it, he didn't want neighbours prying, he didn't go to church, and only his immediate family attended the funeral. We know this because he wrote about it in his diary. And he was not an exception. At the other end of the social scale, families were equally caught between a social script that demanded spiritual contrition and "celebration" and their private processes of anguish, rage and religious doubt. Some of the authors here tacitly acknowledge that we might cope better with death if we unshackled ourselves from nostalgia for cultures that didn't really exist in the first place.

For Doughty, then, the challenge is not how to recover the past, but rather how to engage with the "spectacular" rites of passage she finds now: including the periodic cleaning of unwrapped mummified corpses in Tana Toraja (Indonesia), the *Fiesta de la Natividad* (the veneration of human skulls) in La Paz, Bolivia, and eco innovations, such as corpse composting in North Carolina—this last, still in the design stage, would transform human remains into nutrient rich soil within six weeks, reducing land use (burial) and toxic pollutants (cremation). Since Doughty is a funeral director, it is not surprising that her chief interest lies in what we do with the corpse, and her enthusiasm for the manifold options is all but infectious. While lamenting commercialization, her survey includes tech-savvy approaches to remains, notably the Ruriden columbarium in Tokyo, where smartcards allow visitors to identify individual sets of remains in an archive of thousands; once activated, an illuminated Buddha will signal the position of the remains, and give mourners something to focus on. If her aim is to demolish a culture of squeamishness, then her descriptions of such practices are the first blows. But Doughty's major point is that Western customs don't create what she calls a "holding space"—a temporal, emotional and spatial interlude—where the bereaved can "grieve openly and honestly without being judged". The practices of other societies illuminate the shortcomings, or absurdities, of our own.

Mannix doesn't suggest a return to the death practices of yore, either. Denial, she says, stems from fear and ignorance; when dying is demystified, it is less terrifying. It is notable that her manifesto for looking death in the eye is rooted in personal, rather than historical, experience. *With the End in Mind* collates case histories from Mannix's career in palliative care to elucidate patterns of physiological and psychological change that mark various stages of death,

including the emotional challenges of navigating conversations about dying, contemplating the legacies we leave and, most of all, learning how to live at the end of life. Mannix sets the stories in an explanatory framework, which could have come across as didactic; in fact, her tone is that of a wise storyteller, telling us about Dan, a young man with Duchenne Muscular Dystrophy who overcomes suicidal feelings in favour of making the most of life at the end; relating the resourcefulness of family and friends who carry fragile Holly, restless with manic energy in the hours before death, from her low-rise flat to an impromptu party; and introducing us to Nelly and Joe, married for fifty years, who believe that their individual refusal to name death is protecting the other from unbearable knowledge. Each narrative runs like a fable on the incredible resourcefulness of humanity in the face of death. Affecting in their simplicity, the range of stories support Mannix's contention that death has recognizable patterns from which we can learn strategies for managing better. Many of her stories are moving because they bear witness to the expansive emotional reserves of sick individuals and their families including, in some cases, their pets. In one account, Walter slips into death supported by his partner, adult daughters and faithful collie dog, Sweep, who has refused to move from under his bed for days. In another, Bob, an apparently anti-social man with cancer of the tongue, has refused medical assistance from fear of having to leave his cat. In the event, the cat to moves into the hospice and lies alongside Bob as he dies.

For all the references to a thriving death taboo, one thing these books make clear is that there is a long history of conversation about death—although it tends overwhelmingly to be in written form, as with James Turner's diary. And the literary critic McCrum's otherwise rather slight volume is worthwhile for locating conversations about dying now (including with the surgeon Henry Marsh and the neurologist Andrew Lees) in a cornucopia of vignettes from literature, including insights from Shakespeare's *Mistress Quickly* on the enigma of faith at Falstaff's death in *Henry V*, Donne's "bleak formula" that "No man hath affliction enough that is not matured and ripened by it" (apt given Robert McCrum's experience of having survived a stroke at the age of forty-two), and those recorded by the biographer James Boswell of the irreverent David Hume, who was unwilling to renounce the Devil on his deathbed because "now is not the time to be making new enemies". Could writing be our comfort now? *Modern Death* and *The Comfort of People* point to increased use of social media to access and discuss information about end of life and post-mortem possibilities, connect the dying with the world around them, and extend commemoration beyond time and place. This is a new kind of community, quite different to that problematized by Daniel Miller. As for Caitlin Doughty, she wants us to grieve honestly, which also means creating space for anger, ambivalence and resentment. It is deeply flawed but social media offers a platform for this, too.

So it seems we are open to talking about death, only that the language and spaces we use to do so shifts constantly. The mistake is to think that these spaces were ever uncomplicated; the lesson, that we should stop giving ourselves a hard time about it. Death is hard enough already.



## Doctors' orders

As the NHS reaches its 70th birthday, writers from the world of medicine offer their prescription for its future health

Kevin Fong

When I started as a house officer in 1998, the NHS was just turning 50. I remember those early days and the endless nights; struggling on the huge open wards with breathless, blue-skinned patients in tiny pools of light cast by bedside lamps, desperately trying to do the right thing while waiting for the cavalry to arrive. I was sleepless and scared, feeling I was the weakest link in my patients' chain of survival. In time, however, I realised that I was not, nor ever had been, truly alone; that I was instead part of something bigger.

The NHS is a complex success story. It has made enormous strides against disease over the past seven decades, through a blend of policy, public health strategy and medical research - coupled with the tireless endeavours of healthcare workers. This is how we have transformed our expectations of life and survival since 1948. It is about systems, not superheroes.

In search of lessons on how to improve safety in the NHS, we have looked to other high risk, high reliability industries; among them commercial aviation, automobile production and the space industry. Studies of these organisations have shown that senior executives with responsibility for budget and strategic vision must understand when to defer to on-the-job expertise and invest properly in both the staff and infrastructure that form the foundations of safe practice. Wherever these industries have failed to heed warnings from the front line, avoidable catastrophe has followed.

The NHS's stories of failure are equally complex, and if we are to learn from our errors we need to be honest about why things go wrong. We must eschew the idea of individual heroism. Not out of false modesty but because if we create lone heroes then we must also invent villains, when in fact neither character exists in isolation.

Very few incidents are the product of the wilful or negligent actions of an individual. Whenever avoidable harm occurs it is everyone's responsibility, from the people making decisions in the moment, to those shaping strategy and choosing how much resource to allocate. For the NHS to thrive all of us - politicians, the public, the media, as well as our healthcare workers - must be honest about what the NHS is, what it needs to guarantee its future, and how we will pay for it.

*Kevin Fong is the author of **Extremes: Life, Death and the Limits of the Human Body** (Hodder & Stoughton) and is a consultant anaesthetist at University College London hospital.*

Rachel Clarke

For children with cancer, the necessary separation from their parents during radiotherapy can be intolerably frightening. Sometimes, only a general anaesthetic can calm them. Recently, an NHS play therapist put her mind to this problem, devising an ingenious solution. Her "magic string" is simply a ball of multicoloured twine, one end of which can be held by the young patient, the other by their parent. The therapist invented something powerful and ➡

PHOTOGRAPHY Getty



♦ healing. A literal thread that is, simultaneously, a narrative thread - a story a frightened child can tell themselves, while lying alone behind a lead-lined door, that Mummy or Daddy are still there, loving and holding on to them. Cheap as chips and priceless, magic string was created not for profit or personal gain - but simply because someone cared.

For 70 years, the lifeblood of the NHS has been basic, glitz-free, humdrum humanity. Kindness isn't loud, it doesn't grab headlines. Yet all of us, NHS staff and patients alike, know that what heals is more than doctors' drugs or scalpels. It is the quieter, smaller things too - being heard and shown you matter - that make patients feel cherished, and hospitals humane.

Right now, the magic string that binds the NHS together has never been more threadbare. Overstretched staff are burned out. Compassion fatigue is rife. If ever a birthday present mattered, it is sufficient frontline staff to preserve kindness at our NHS's core. *Rachel Clarke's Your Life in My Hands: A Junior Doctor's Story is published by Metro.*

#### Gavin Francis

Caring for others remains the most rewarding of jobs; to work in medicine or nursing is to engage your intellect, your curiosity, your compassion, yet we're seeing crises in recruitment and retention. If the government refuses to fund the health service to the levels enjoyed by Denmark, France or Germany, there are still ways we might build an NHS to last another 70 years.

Gains have been made in ethnic diversity and gender discrimination, but in terms of socioeconomic diversity we're going backwards. Bursaries for medical and nursing students from modest backgrounds would be a start, with admissions procedures that take account of the significant barriers those students face. Healthcare has been undergoing gentrification for decades, and it's been shown that the more privileged your background, the less likely you are to want to work among the people who need you most. Both medicine and nursing need a return to faith in professionalism, ending systems of assessment based on adherence to centrally dictated guidelines that have seen a tripling of NHS drug prescription in 15 years, with little benefit for the patient and even some anecdotal evidence of harm.

Our most experienced doctors and nurses are retiring as soon as they can - to hold on to their skills and experience we need new patterns of flexible working and an overhaul of onerous and bureaucratic systems of appraisal. Finally, commercial health providers have long benefited from an NHS that will pick up the pieces whenever they fall short - we need a reliable mechanism that bills them for their failures. *Gavin Francis is a GP in Edinburgh, and the author of Shapeshifters and Adventures in Human Being (Profile).*

#### Adam Kay

"Gawd bless the NHS" might as well be our national anthem. But just saying it isn't enough; it's conversational slacktivism, as pointless as canonising the dead.

We need to do something. We need to lobby our elected representatives, we need to go on frequent, noisy protests and ultimately we all need to pay more taxes. Realistically, very few of you are going to do any of that. So here's something you can do just by talking.

You all know someone who works for the NHS - a friend, neighbour, relative will be one of the 1.5 million people who keep the health service alive, keep us all alive. Ask them how their day was. They'll say "fine" and change the subject. But let them understand they've always got someone to talk to. Someone who understands that the days are never actually just "fine", that the nature of illness means that more bad things happen than good, that they're not superhumans with some kind of emotional force field.

Give them that opportunity to offload at the end of every shift, whether it's a tiny irritation, a rant or a full-on sob. Chip away at the ingrained notion that healthcare professionals shouldn't talk about these things - because that same ingrained notion is partly responsible for the huge rise in people leaving the NHS, the rise in stress-related absence and illness among those who stay, and the tragic rise in suicide among those who find it just too much. Don't let them bottle it up. Let them know you're there. Care for the carer.

*Adam Kay's This Is Going to Hurt: Secret Diaries of a Junior Doctor is published by Picador.*

#### Christie Watson

At a time when we need more nurses than ever, they are leaving the NHS faster than they join. We are short of 40,000 nurses in England alone - the highest vacancy level since records began. We often hear the roar of doctors, see their visible representation across all forms of media, and rightly so, but nurses outnumber doctors in the NHS two to one. They are perhaps too quiet, too soft, too kind - whatever the cause, we don't hear nurses' voices. Nursing students have even less of a voice and yet are a vital part of the NHS. The removal of the student bursary was sold as a way to increase nurse training numbers, but since the government scrapped it, the number of applications has fallen by a third. Student nurses work twelve and half hour shifts, nights, weekends. They can't get part time jobs to support their studies. They can't pay off student debts on a nurse's salary: (NHS staff are among the biggest users of payday loans). I would never have been a nurse without the bursary. I think of all the patients we must have cared for over the decades, those of us who - in this political climate - would simply have been unable to train in the first place. Perhaps governments depend on those quiet voices; they trust that the public won't hear about

**Care for the carers. Give them that opportunity to offload at the end of every shift, whether it's a tiny irritation, a rant or a full-on sob**  
Adam Kay





the plight of nursing. How nursing is in real danger, and what that will mean for patients.

I would prescribe the NHS a reinstatement of the nursing training bursary - immediately. We do not have enough nurses. Unless we all shout about that, it is patients who will pay the real price.

*Christie Watson's The Language of Kindness: A Nurse's Story is published by Chatto.*

#### Stephen Westaby

Contrast the contemporary developments in medical science with what our precious NHS can afford. I was born in the backstreets of a northern steel town in July 1948. The splendid new NHS was a blessing for the poor but what it was asked to provide was limited. In 1958 I watched my grandfather's horrific death from heart failure. His loyal GP came to the house and put an end to his suffering with morphine. At the time cardiac surgery was new and exciting, so I decided to pursue that career to find a solution. Heart transplantation began in 1967 but never fulfilled its promise. Annually in the UK 15,000 patients under 65 could be helped, but there are only 150 donors.

I decided to find an alternative. Cambridge tried pig organs without success. In Oxford I came up with "off the shelf" mechanical hearts. In 2000 I implanted a thumb-sized turbine left ventricular assist device (LVAD) into a dying patient. As a result he had no pulse in his circulation, which drew huge scepticism. He survived for almost eight years, with excellent quality of life. LVADs provide equivalent outcomes to transplantation, but without needing someone else to die first. Now we have pacemakers for heart rhythm problems and blood pumps for heart failure. This will soon include a revolutionary British LVAD.

Six years ago my Greek trainees saved a dying heart attack victim with a temporary circulatory support device. When he relapsed into severe heart failure I joined them to implant a permanent LVAD and inject

the scarred heart muscle with genetically engineered stem cells produced by a British Nobel laureate. This patient remains symptom free. We discovered that the cells remove scar tissue, which offers enormous promise for heart failure prevention in the future. It distresses me that none of these three components of heart failure treatment are available for NHS patients. Sixty years later NHS patients still suffer my grandfather's fate. When my charitable funds expired so did many patients whom I could have saved.

The NHS is run by politicians so smoke and mirrors are to be expected. It may well be cost effective and free at the point of delivery, but it is not patient focused. Who can justify spending a fortune publishing surgeons' death rates while denying us the equipment to save lives? Things must change. The 70th anniversary is the end of the beginning. We must be honest about what the NHS can afford and allow insurance to cover innovations deemed unaffordable. It is wrong to pretend that they do not exist. *Stephen Westaby's Fragile Lives: A Heart Surgeon's Stories of Life and Death on the Operating Table is published by HarperCollins.*

#### Kathryn Mannix

The success of the NHS has had an unanticipated dark side: reducing deaths in childhood and mid-life established a public expectation that sending even our frailest people to hospital would always save their lives. Death became a "medical failure". People experience escalating hospital treatments despite likely futility. Without discussion of or preparation for dying, patients endure multiple, often unhelpful hospital admissions in the last year of life. We mistake medical prolongation of dying for appropriate care.

The prescription may be difficult to swallow. We should de-medicalise dying. For practitioners to recognise diminishing returns of medical treatments, and offer timely discussion with compassion and honesty, we need to challenge both societal denial and medical paralysis. This is not only a prescription for the NHS, then: it involves all of us recognising our mortality.

A skills set for NHS staff training includes conducting end of life discussions and understanding the process of normal dying. They should establish what care the patient finds acceptable, and put in place a coordination system to enable access to the patient's preferences whenever a decision must be made, so they receive the right care quickly, and are not repeatedly subjected to unhelpful interventions or distressing end-of-life conversations. This may result in less medical treatment, but will encourage more appropriate, skilled care and real patient choice.

Bad deaths follow poor planning. And that is a failure. We need to re-establish that dying is simply what happens at the end of every life, and recognise that a peaceful death is a good outcome worth striving for. *Kathryn Mannix's With the End in Mind: Dying, Death and Wisdom in an Age of Denial is published by William Collins.*



## ANCIENT AND MODERN

### Transgenderism and the Iliad



A couple of weeks ago a reader (Emma

Lyons) queried Taki, the High Life professor of ancient Greek culture and society, who had argued that Achilles and Patroclus, heroes of the Trojan War, were not gay, and implied that Greeks did not do transgenderism. On both counts a little clarification is required.

The 5th-century BC Athenian playwright Aeschylus indeed represented Achilles and Patroclus as lovers, as many ancients did. But professor Taki was talking about the situation in Homer's *Iliad* (c. 700 BC), in which they were no such thing. The wrath of Achilles, with which the *Iliad* opens, was down to Achilles's loss of his captive woman Briseis, taken from him by the Greek leader Agamemnon. Achilles replaced her in his bed with another captive, Diomedes, while Patroclus bedded down in the other corner of their hut with 'fair-girdled Iphis, whom Achilles had presented to him after he captured Skyros'. QED.

As for transgenderism, the professor merely suggested that modern novelists like Madeline Miller, eager to catch the prevailing winds, might soon be introducing sex-change couples into the story of the Trojan War. Ms Lyons rightly highlighted two myths about sexual deviancy, but these simply reflected a real world rich in such possibilities. While the deranged emperor Elagabalus was a rarity in offering vast sums to any doctor who could kit him out with female sex organs, freakish sex-changing was thought credible in the ancient world. We hear of two examples of Greek girls with tumours of the lower abdomen which burst to reveal a male organ complete with testicles. Doctors tidied it all up, and turned both into healthy males. Worshippers of Cybele had to castrate themselves, and there was plenty of transvestism. *Monstra* such as hermaphrodites were taken as dire portents and put to death, but fashions changed and Pliny the Elder said they were now seen as good for a laugh.

No scope, then, for a transgender *Iliad*, but plenty for a rollicking self-castrating, transvestite, freak sex-changing, hermaphroditic one. The Millers of this world will already be sharpening their coloured pencils.

— Peter Jones

# Good grief

Death isn't something you just get over

MARK PALMER

*The Spectator*

Just over a year ago, my best friend dropped dead. He was in his early sixties and many of us expected him to die, because he was hugely overweight and desperately unhappy — and the ciggies can't have helped. 'If you don't look after yourself, we're going to lose you,' was the polite refrain from those who knew him well.

Chris had no money, no real job, precious little hope. We first met as new boys aged eight at our boarding school, where he went on to become one of the best sportsmen the school had ever had and sat a scholarship for Harrow. Early success might have played a part in what was to come. We all know people who peak prematurely.

On leaving school, Chris and I and then shared a tent while hitchhiking through Canada and America. For the next four decades, we would speak most weeks on the telephone, latterly at length as loneliness gripped him like a cancer.

I say that Chris was my best friend, but he was also deeply infuriating: bombastic, unreliable, ill-disciplined. If I had come across him when we were in our thirties or forties, I would have grown weary of his wild money-making schemes that always came to nothing; and if I had met him when we were in our fifties I would have given him a wide berth.

But I miss him terribly. Yes, we all know that when a close friend dies, a part of us dies with them, but I don't go along with all this guff about time being such a great healer. I feel Chris's death more now than I did a year ago, not least because so much has happened in these past 12 months which we have not been able to discuss. And I feel guilty that I did not do more to sort him out.

Come to think of it, I miss my father more in 2018 than in 1989, when he died shortly after his 70th birthday. Our conversations would be far more interesting today than they were 30 years ago, and he would have got to know my children. We could have sat together in the pavilion at Lord's.

And yet it's the guilt and the sorrow that won't go away — the not quite getting over it — which keeps Chris and my father alive. Death and life belong to the same coin and that's just as it should be. 'It takes an entire lifetime to learn how to die,' wrote the Roman Stoic philosopher Seneca, who also coun-

selled to 'study death always'. The post-war generation has never quite done that. While our Victorian forebears died at home surrounded by members of their family, along with some close friends and most likely a vicar, death today means a hospital bed and tubes, wires and bleeping machines. Until my father died, I had not seen a corpse.

The problem now is that we don't mourn enough. 'Moving on' is one of those modern conceits designed by well-meaning psychologists and social workers that makes you feel wretched if you can't do it. There was a time when women wore black and men sported black armbands or a black tie for a while after someone close to them had died, and it would be no bad thing to bring back that tradition if we really want to address death.

Because life expectancy has increased, so too has the expectation of longevity. Which makes someone's premature death all the harder to deal with. The mother of a young child who dies suddenly is never going to 'get over it', nor should she be expected to.

I'm pleased that a number of recent books on the subject have been well-received. Kathryn Mannix's *With the End in Mind* is especially affecting because of her experience working in a hospice. She is all for talking about death but recognises that for some people, denial is a tool that helps them cope.

Julia Samuel, a grief psychotherapist for 25 years, who works in the NHS at St Mary's, Paddington, also warns against putting a brave face on loss. In her enlightened book *Grief Works* she says that she does not believe in 'closure' and argues that pain can be 'the agent of change'. 'Our culture is imbued with the belief that we can fix just about everything and make it better ... grief is the antithesis of this belief,' she writes. 'It eschews avoidance and requires endurance, and forces us to accept that there are some things in this world that simply cannot be fixed.'

My own lament is that so many funerals are now private, with friends, cousins and acquaintances of the deceased being encouraged instead to attend upbeat memorial services followed by boozy drinks parties. Talking about the dead and grieving for the dead are two very different things. And it's the grieving — not the talking — that hastens the healing.



# Sunday Times Summer Reads

## SUMMER READING

### ► Enlightenment Now by Steven Pinker Allen Lane £25

Pinker, the Mr Positive of modern philosophy, argues that, in almost any area you care to mention, mankind has never had it so good.

### Our Place by Mark Cocker Cape £18.99

The prizewinning nature writer Mark Cocker delivers a devastating polemic about what he sees as our wholly inadequate care for the countryside.

### With the End in Mind by Kathryn Mannix Wm Collins £16.99

A palliative carer with more than 30 years' experience sets out to change the way we look at death in this inspiring book that has been a surprise but deserved bestseller.

### Seeds of Science by Mark Lynas Bloomsbury Sigma £16.99

A fervent anti-GM crops activist reveals how, thanks to science, he turned from pioneering protestor to passionate advocate for the benefits of this controversial technology.

### MUSIC

### Unmasked by Andrew Lloyd Webber HarperCollins £20

This look back at Lloyd Webber's life up to the mid-1980s proves that the creator of umpteen hit musicals can write stylish and witty prose, too.

### To Throw Away Unopened by Viv Albertine Faber £14.99

Sibling rivalry and sexual abuse were rife in punk musician Viv Albertine's family, as this devastating follow-up to *Clothes, Clothes, Clothes, Music, Music, Music, Boys, Boys, Boys* shows.

### Senior Youth Step on My Floor by Dave Haslam Constable £20

The Hacienda DJ Dave Haslam looks back with great fondness on the Manchester club scene of the 1980s and 1990s and his varied and colourful career.

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In full roar From Jurassic World: Fallen Kingdom

### ARTS & SPORT

### Dolce Vita Confidential by Shawn Levy Weidenfeld £9.99

An immensely colourful look at Cinecittà, Fellini, Sophia Loren and the "swinging high life" of the Roman cinema world in the 1950s.

### In Search of Mary Shelley by Fiona Sampson Profile £18.99

If we see another literary biography this year as perceptive as Sampson's account of Mary Shelley and the making of *Frankenstein*, we will be fortunate.

### Modernists and Mavericks by Martin Gayford Thames & Hudson £24.95

This encyclopedic study of Francis Bacon, Lucian Freud, Frank Auerbach and the greatest generation of British visual artists since Turner's time is informed by a deep love and understanding of modern painting.

### In Byron's Wake

by Miranda Seymour  
Simon & Schuster £25  
A masterful portrait that looks at the effect that the cadid Lord Byron had on his wife Annabella Milbanke, and his daughter Ada Lovelace.

**“This collection of stories about sexual jealousy is a gripping read**

### A Forger's Tale by Shaun Greenhalgh Allen & Unwin £8.99

Greenhalgh's lively memoir of his 21-year career as the "Bolton forger" during which he knocked up everything from Egyptian figurines and Lalique glass to Renaissance drawings and Lowry paintings.

### Arlott, Swanton and the Soul of English Cricket by Stephen Fey and David Kynaston Bloomsbury £20

A fascinating look at two of cricket's great commentators, John Arlott and Jim Swanton, their contrasting lives and beliefs, and their shared passion for the game.

### SCIENCES

### The Incurable Romantic by Frank Tallis Little, Brown £18.99

A psychotherapist's astonishing collection of stories of erotic obsession, deluded desire and sexual jealousy makes for gripping reading.

### The Rise and Fall of the Dinosaurs by Steve Brusatte Macmillan £20

Brusatte's up-to-date survey of the current state of palaeontological knowledge is the best book on dinosaurs written for the general reader since the 1980s.

### Other Minds by Peter Godfrey-Smith Wm Collins £9.99

This brilliant and original book is not just a scientific study of cephalopods, but also a philosopher's account of scuba-diving and the wonders of the deep.

### To Be a Machine by Mark O'Connell Granta £12.99

O'Connell recently won the Wellcome book prize for this mordant, lucid and brilliant look at the weird world of transhumanism.

### AIQ by Nick Polson and James Scott Bantam Press £20

In an entertaining primer, two academic data scientists put the case for the defence on artificial intelligence, and show how we can harness its power for a better world.



## Spoilt for choice

There's something for everyone to enjoy in our fiction selection of prizewinners, big reads and screwball comedies

### FICTION

### LITERARY & POPULAR

### Lincoln in the Bardo by George Saunders Bloomsbury £8.99

Last year's Man Booker winner, a haunting, multi-voiced tale of Lincoln, his dead son and the ghostly inhabitants of a cemetery.

### Little Fires Everywhere by Celeste Ng Abacus £7.99

A book-club favourite, the compulsively readable story of a family in a placid, progressive suburb going off the rails.

### The Shepherd's Hut by Tim Winton Ploador £14.99

A modern Australian Huckleberry Finn, in which a