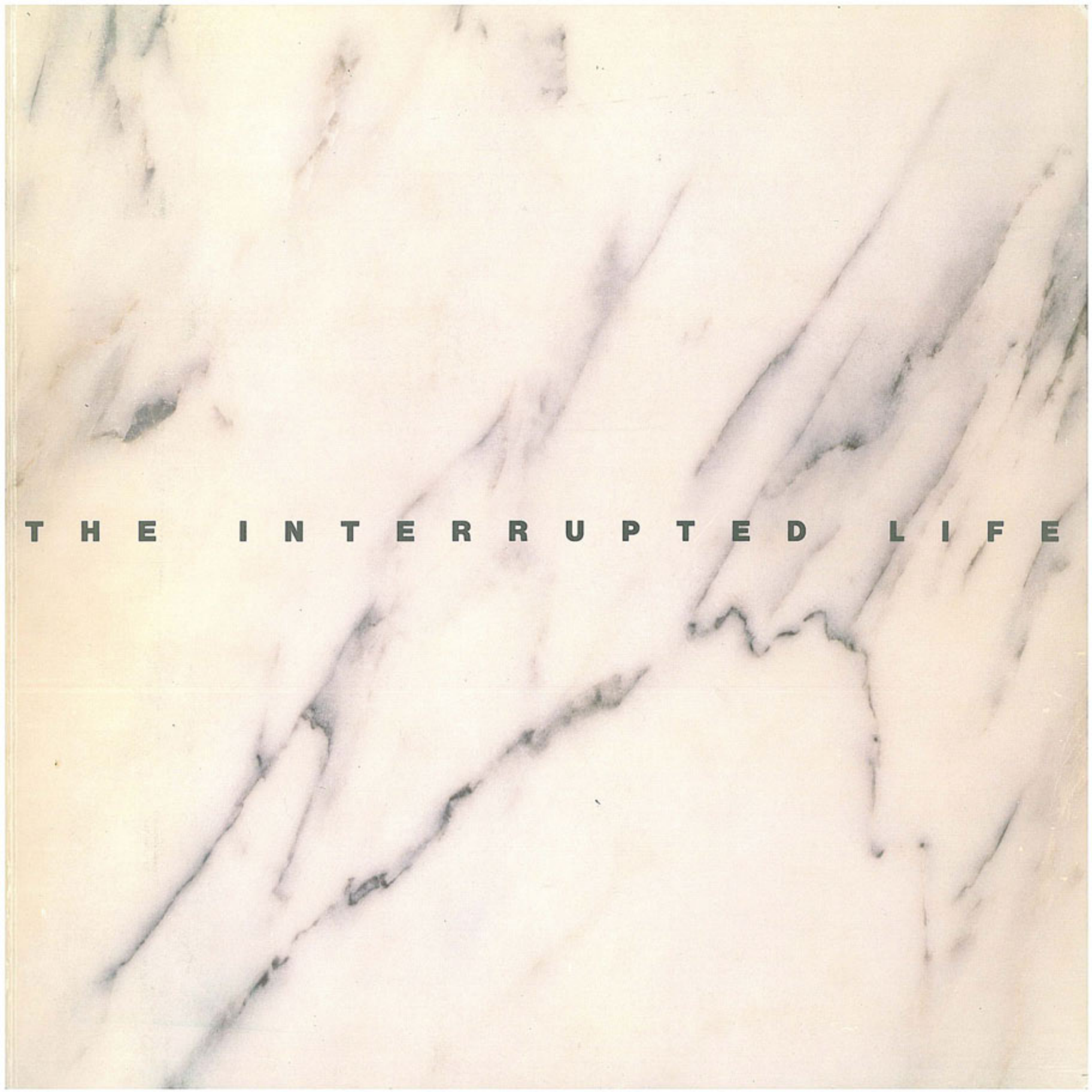
THE INTERRUPTED LIFE

France Morin

THE INTERR

Massimo Vignelli

U P T E D L I F E

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The New Museum of Contemporary Art, New York
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ARTISTS

This publication is dedicated to the memory of Lise Morin (1945–1988)

PREFACE Over seventy million people die each year, with death appearing in various guises and in different proportions—from the casualties of international wars and the victims of neighborhood violence to friends and family members who die from old age and illness. More than 100,000 Iraqis died in the recent Gulf conflict, and current statistics say that black men have substantially less chance of making it through their twenties than men in other racial groups. In the eighties, most noticeably, AIDS has brought death home to hundreds of thousands of people whose loved ones have died prematurely. And yet in Western culture most people are conditioned to deny death's existence by banishing it to spaces outside our everyday frame of reference. We cannot seem to see death as anything other than catastrophic, abnormal, terrifying, and foreign. We refuse it, identifying it as evil, because we cannot control it. But death is as natural as life, and it is inevitable. Ernst Becker, in his book *The Denial of Death* (1973), postulates that human beings transcend death by finding meaning for their lives; they establish spiritual dimensions apart from bodily reality—religion—and create those "culturally standardized hero systems and symbols" which we call art. Artists tend to make work that addresses, directly or indirectly, big issues, and death is certainly among the biggest of them. The New Museum has chosen to open its season with a thematic exhibition which opens out onto the politics and poetry surrounding issues of mortality. The artists in this exhibition have chosen to make work that confronts death, not necessarily in order to transcend it but in order to investigate life itself. This confrontation with death, so deeply feared in a culture that values youth, good health, and material gain above all else, can lead to an acute sensitization to and participation in our daily lives. In this sense, the exhibition is an act of affirmation. It is our hope that visitors will also find themselves affirmatively engaged with the communality suggested by these images and ideas. Our thanks to senior curator France Morin, who came to The New Museum almost two years ago with this particular exhibition proposal, and who has sustained her passion for it despite the slings and arrows of general museological activity. We are particularly grateful to Massimo Vignelli for his generosity in providing pro bono exhibition and catalogue design. A major exhibition on this topic is not easy to fund and our funders and supporters deserve much credit. For their funding of The New Museum's On View Program, through which several projects in *The Interrupted Life* are presented, we extend our appreciation to the Jerome Foundation, The Greenwall Foundation, and the National Endowment for the Arts. We would also like to express our thanks to The International Cultural Relations/External Affairs and International Trade Canada; the Canadian Consulate General in New York; (AFA) Association Francaise d'Action Artistique, Ministère des affaires étrangères; and the Yugoslav Press and Cultural Center, as well as Galerie de France, Galerie Paul Andriesse, Jack Tilton Gallery, and Fritz Dietl of Radix Group International for their special assistance. Finally we are grateful to the New York State Council on the Arts and the New York City Department of Cultural Affairs for their operating support for this exhibition year. Special thanks also to Alice Yang and Russell Ferguson of our staff for their work on the catalogue, to Susan Cahan and the education department for their vision in organizing the participatory projects, and to the many other people working at The New Museum whose skilled participation is, as always, both deeply appreciated and indispensable. Finally, our thanks to the many artists in the exhibition. By addressing the pain and complexity of death they provide us with a unique opportunity to acknowledge the joys of life. Marcia Tucker, Director

ACKNOWLEDGMENTS *The Interrupted Life* was a very rewarding project. A difficult one at moments that obliged all those who collaborated with me to reason their view on death. It is a project that I carried for many years, and to see it finally realized owes itself to many great people. I would first like to thank the artists included in *The Interrupted Life*, many of whom realized special projects for this exhibition. My gratitude also goes to their dealers and the lenders who have all been so wonderfully supportive. The distinguished group of essayists: Peter Greenaway, bell hooks, Sanford Kwinter, Sylvère Lotringer, Charles Merewether, Anthony Vidler, and Gerald Vizenor, each contributed a special voice to the subject. The special people who were interviewed for this publication shared with us their experiences and views. All of these individuals have provided a pertinent argument for the reading of this issue. For their collaboration we are most grateful. At the Museum I would like to thank, most of all, Marcia Tucker for her critical input and support, and my colleagues on the curatorial staff Laura Trippi, Gary Sangster, and especially Alice Yang who coordinated the exhibition and installation with such dedication. My appreciation also goes to Susan Cahan, Ellen Holtzman, Marc Kloth, Sara Palmer, Debra Priestly, Pat Kirshner, Opal Linton, and Jeanne Breitbart who have all made significant contributions. The interns who have worked at various stages deserve much credit: Luis de Jesus, Gigi Sharp, Lillian Cho for her work on the manuscripts, and particularly Lydia Yee who assisted with the details of the exhibition and publication so meticulously and energetically. The publication owes its realization to the dedication and brilliant work of Massimo Vignelli. Our collaboration has been a rewarding and illuminating process. To my two colleagues, Alice Yang, assistant curator, and Russell Ferguson, librarian/special projects editor, who worked with me in organizing the publication, as well as Jan Heller Levi and Elodie Lauten who helped at various stages with the difficult task of editing and translating the book, I would like to express my appreciation. I would also like to thank Stefania and Jamie McClennen for their insight as members of *The Interrupted Life* project team. Many other people have provided valuable suggestions and support at different stages of the project, including Rene Blouin, Ronald Feldman, Simon Watson, and Amalia Mesa-Bains. To three people, in particular, I owe my gratitude for introducing to me some of the most important collaborators on *The Interrupted Life*: to Ida Panicelli for Massimo Vignelli; Nicole Klagsbrun for Peter Greenaway; and Victor Bouillon for Sylvère Lotringer. Finally, on a subject as difficult as death, it was the constant dialogue with the artists, their insights, and support that made *The Interrupted Life* come to life. France Morin, Senior Curator

THE INTERRUPTED LIFE

France Morin

To obtain some sort of access to . . . sensibilities for comprehension and condolence, more than two thousand years of European cultural activity has produced a huge pictorial record of death, and those painters and sculptors and printmakers and draughtsmen who have pursued the investigation, have done so using what are, after all, technical processes to find technical solutions. How is Death depicted? How do you "picture" death? Through what pictorial imagery has Death been made most manifest? How do you significantly depict the moment of dying? How do you pictorially differentiate death from sleep? How do you show death arriving, how do you depict the pain and despair and relief of the dying? Do you show death by its after-effects? What do you observe and invent and paint to in order to pass along the experience? Pallor, rigidity, fear, rigor mortis, worms, bones, a small winged spirit ascending, tears, a seizure, a signed will, a black cross, a black edge, a black frame, a grimace, a cry, a silent scream, a hollow breath, a rattling, a convulsion, a beating of the breasts, a pale smile, special clothing, special gestures, a coffin, a brave face, the kith and kin, an armorial blason, a funeral, a wreath, a wake, a photographic representation of the corpse? —Peter Greenaway, *Death in the Seine* **I. TO OBTAIN SOME SORT OF ACCESS** The questions Peter Greenaway so eloquently poses in *Death in the Seine* are the questions I asked myself as I first began thinking about this exhibition. Death touches all of our lives. Yet the subject of death, what we might call the long hard look at death, is one that has become a "forbidden zone"; our private worlds of grief and mourning have been given little space.[1] Death is a personal event in one's life. But it is also a social and political arena of struggle in which differing definitions of the meaning and value of life (and lives) are contested, as attested to by our current debates on abortion, euthanasia, the death penalty, and a host of other issues. Consequently, through the emergence of bioethics and technological developments, like cryonics and genetic engineering, death as a biological fact is also being questioned. With the onset of the AIDS epidemic in the 80's—by the end of the decade more than 300,000 people had died of diseases associated with the AIDS virus[2]—and the inadequacy and irresponsibility of government and mass media response, death has become a major and visible concern of many activists and artists.

For *The Interrupted Life*, I could not, of course, cover the entire spectrum of issues and concerns related to the breadth and depth of the theme. It was my aim, instead, to bring together works that demonstrate how the significance of death is translated into a variety of contemporary artistic and cultural practices, through non-traditional visual representations. Many of these works seek to challenge both the biased representations of death fed to us by the mass media and the rampant fear of death that permeates all aspects of our culture. In organizing this exhibition, I was also interested in a larger question concerning the role and pertinence of works of art in addressing the private and public spheres of death. Can a work of art serve as an adequate mediator? How does it increase our understanding of death? Can art help us through the painful experience of death? How can we use works of art to obtain some sort of access? The answer lies, in part, I believe, in the viewer's personal experience with death and one's own cultural traditions. Some "obvious" choices of artists are not represented here—the works of Gerhard Richter, Jenny Holzer, Nancy Spero, Leon Golub, or Ross Bleckner, for example. But some lesser known artists do take their place in this exhibition: as with death itself, I wanted to bring to light the works of some artists which we have not had the chance to see and discuss. In the same spirit, *The Interrupted Life* also includes work by international artists: Antonin Artaud, Tadeusz Kantor, Mladen Stilinovic, Marlene Dumas, Hans Danuser, Mona Hatoum, and Geneviève Cadieux, among others, whose works are infrequently exhibited in the United States, as well as films and videos, such as Peter Greenaway's *Death in the Seine* and Frederick Wiseman's *Near Death*, and as an indication of a different historical manifestation, 19th-century postmortem photographs and daguerreotypes. **II. THE AUTHORITY OF PROXIMITY** *When all is said and done, we take photographs of the dead, and we look closely at them because of their authority. We simply want to see what death looks like. We do so in hope that closeness may attenuate horror, that knowing may come through seeing, and that from the authority of proximity may come understanding, even, eventually, acceptance.* —Jo. C. Tartt, Jr., *Taken: Photography and Death* Kafka wrote that "we

photograph things in order to drive them out of our minds."[3] Photography is something like embalming, an attempt to stop time. Is it primarily by trying to stop time, by trying to capture it and pin it down, that we best evoke the powerful feelings associated with death? Several artists in *The Interrupted Life* bring death into light with photography. They choose photography, perhaps as the cultural critic Benjamin Buchloh suggests, because of "the inability of painting to represent contemporary history [that] resulted . . . from the transformation of historical experience into an experience of collective catastrophe. It therefore seemed that only photography, in its putative access to facticity and objectivity, could qualify as an instrument of historical representation."[4] The artists who use this medium question both photography as "death"—the photographic still renders inanimate a single moment in the continuum of time—and the representation of death by addressing its different facets: the vulnerability of the body and the limits of medicine; identity and identification; collective memory and history; natural, accidental, and artificial deaths; death as a metaphor through the anonymous gaze; death as sleep. In the work of these artists, there is a double negation in that death is represented through photography and the photographic process itself is used as a kind of death. Photographs of death are often difficult and contradictory for the viewer, however. Photographs of war, for instance, often show moments of agony in order to elicit our concern, but a viewer may be so unnerved by such an image as to lose the ability to feel and react. The response to the photograph is, then, often experienced as a "personal moral inadequacy"; and so through the sublimation of morality, feelings of shock give way to feelings of guilt and insufficiency.[5] The fact of death becomes secondary to a rationalized response. Perhaps we cannot look at images of death because we cannot look at death itself. We do not believe in the power of images of death because death has lost all its authority in our culture even if it is everywhere, present at each moment of our lives. I believe we *can* transform this uneasiness and take a look, one that will hopefully free us from a socially codified and sanitized experience of death, and enable us to relate personally to the private world of mourning and grief. With the medicalization of death and the simulacra of disappearance in modern rituals of death, we are never given the chance to look at death, to really familiarize ourselves with it. However, if we can let the works of *The Interrupted Life* reveal their personal and collective histories and memories, perhaps we can begin to accept death as a part of life, and do more than only hear of it, like a distant voice in various languages: the language of truth and science, the language of economy, the language of religion and immortality. Perhaps, we will then be able to take a "long hard look" at death. III. JUNE 18 *Why is someone's death always some kind of scandal?* —Vladimir Jankelevitch, *La Mort* *All these moments will be lost in time like tears in the rain.* —David Wojnarowicz, *When I put my hands on your body* With the sudden death of my older sister three years ago, my personal confrontation with death joined the tapestry of so many other losses in our contemporary culture. Lise was 43. I saw her die. The concept of death and the experience of death are very different. I watched the cold entering her body slowly, her last breath. Ten days after Lise's arrival in the hospital, the doctors, considering her condition, had given her three weeks to live. I flew home shortly after that. I knew the doctors' verdict was right. From that moment, each gesture, each word, each look into her eyes became almost intolerable. Did she know? She never talked about it, nor did we, her family. Her determination in eating her last meal that Friday night, the night before she died—did she know that it would be her last meal, that she would fight for her life the whole night long, never sleeping, sitting up abruptly in her bed every time the urge to sleep became too strong; up, down, up, down, for eight, ten hours, until the early morning of what was to be her last day? Then she became peaceful, quiet, resigned. Her whole demeanor changed. Ordinarily a reserved person, she now sought our comfort and affection. We gave it to her, in total disbelief, as if in some kind of trance of duty and pure denial. I cannot forget the small chapel we visited next door when we had to leave the room, when the fear, pain, and confusion became too intense. Was life about nothingness? Elisabeth Kübler-Ross has said that you have to have a sense of history to die in peace. How is that possible when you are so young? *The Interrupted Life.* We are all gathered around her bed, holding her. It is around 8 p.m. My

mother talks to her with a courage I believe must only be given to a mother when she has to assist her child, at whatever age, into death. That moment, that second that separates someone alive and someone dead will obsess you for the rest of your life. This is true for me. It is Saturday night. The body becomes this empty shell and a presence, a soul, at that very moment fills the room. My older sister has just died, and we have to take her personal belongings and leave her alone in this hospital room, abandon her to the ritual of the dead in our culture. June 18. The next day was Father's Day. IV. THE PROCESS OF DISAPPEARANCE AND SIMULACRA *Procedures are so fragmented that no single person remains responsible. All actions are mediated by others or shared with others. Everything is done by administrative decree and court order, conveyed from person to person, down a chain of command and obedience . . . Murderers die, but no one man ever kills them.* —Michael Levy, *The Forbidden Zone* The reality of death has never been so removed from our daily lives. Though the spectacle of violent death comes rushing at us from the mass media—murders, famine, earthquakes, war, plane crashes—the parade of images has simultaneously served to distance us from the reality. Yet, how do we decide what images are acceptable when dealing with death? Whether they be images of radioactive clouds and rain when, on August 6, 1945, the first atomic bomb was dropped on Hiroshima and Nagasaki, killing 80,000 people in the blast and 60,000 more within a year; images of napalm raining down in the Vietnam War from 1961 to 1973; the mass graves of the Holocaust and World War II that killed more than 45 million, including 6 million Jews. Television is now taken as a proof of such events. For example, Ceaucescu's corpse was shown as a proof of his death. The recent Gulf war was staged on CNN during prime time with a massive display of fireworks, and after 42 days, an absence of dead bodies. Fear, violence, blood, pain, and death do not exist. The physical and emotional violence of the long years of Vietnam have to be erased by this electronic, high-tech war. The spectacularization of death, the glamorization of death accompanied by its standard narrative soundbites, does not concern us. It is the death of "others," not my death. Television reassures us that all these atrocities happen to others. The proximity of television screen brings death close to us in vivid colors, while at the same time it distances us from death, a remote event that happens to strangers. Watching death on the news, we consume it. Death becomes a commodity, and loses its content to the logic of advertising. When we see advertising for the car, we do not see the accident; when we see the American Express ads for our future travel, it is minus the plane crash. The language of death in the media and its "spectacularization" are part of the economy. Similarly, when our loved ones appear to us again after death, in funeral homes, who or what are we really seeing? The ritualization of death reflects a persistent attempt to transcend the horror death inspires. All the procedures that the corpse undergoes—from embalming to cremation to mummifying—before it reaches its final resting place, help to insure that this is indeed the end of the journey for the body, and forbid it from coming back. Nowadays, the corpse disappears only to reappear, sterilized, cleaned, properly prepared for viewing, in the funeral home. The body is processed with techniques that funeral personnel are hesitant to discuss. "The point is to keep, in death, the look of life, the *natural* look; he still smiles at us, the same color, the same skin, he looks like himself, beyond death, he is even somewhat fresher than when he was alive, he only lacks his ability to speak."[6] This, of course, is the luxury of a certain amount of money.

Rituals have always existed in every culture, and they have a major role in grief and mourning, but our obsession today with denying death at any cost and creating the illusion of the "real" with our modern rituals of the dead only emphasizes our fear of death, of cadavers, and of decay. The reality and acceptance of natural, biological death has even become more clouded now that the definition of death is in question. Think, in contrast, of the bodies abandoned to the "rituals" of the potter's field or left in the cold drawers of the morgue. The anxiety and panic generated by fears of death sustain a culture that revolves around consumption. "I shop therefore, I am," declares an artwork by Barbara Kruger—I shop therefore, I am not dead . . . yet. The inevitability of death used as an inducement to buy, buy, buy: *In the capitalist system, each person is alone before the great equalizer. The same way, each person finds herself/himself alone in the face of death—and this is not a coincidence. For* the

great equalizer is death. *It is, from that point on, the obsession with death and the will to abolish death by accumulation that becomes the fundamental driving rationale of the political economy. . . . The accumulation of time imposes the idea of progress, as the accumulation of science imposes the idea of truth.*[7] The industry of death in itself opens up even more avenues for production and consumption: coffins, crematorial urns, embalming services, musical accompaniment, tombstones, cosmetic work on the dead. . . . V. "THAT'S IT," HE SAID. *Raymond rolled up his sleeves, slipped on an apron, pulled on a pair of latex surgical gloves, and took two bottles of fluid off the shelf of the kitchen cabinet. . . . It smelled like cherry cough syrup and looked like Pepto-Bismol. "That's the embalming fluid. . . . Mix a bottle of this with a bottle of cavity fluid . . . add two and a half gallons of water, and that'll do her." He poured the bottles into the glass reservoir of the machine, added water from a hose connected to the same plumbing fixture as the toilet, and then turned back to the old lady. . . . He cut open a V-shaped flap of skin on the left side of her neck close to the collarbone. . . . "The carotid's the way in; the jugular's the way out." He took an L-shaped probe, slipped it under both blood vessels, and tugged them out. . . . He . . . held up a long, stainless steel tube with a thin metal rod in it. "This is your drain tube." He snipped open the jugular and slid the tube down it. Then he pumped the metal rod up and down like a plunger. . . . Then you have to open up the other side and put your fluid in there. . . . He left the drain tube in the jugular, slipped an L-shaped metal catheter into the carotid, connected the catheter to a hose, and turned on the pump. . . . The machine hummed, and very soon a mixture of water, pink Pepto-Bismol, and blood was spurting out of the tube in the old lady's neck, and running down the table to a drain between her feet. "We'll give her a while, and then we'll aspirate her". . . . By the time he'd washed, rinsed, and dried her, the reservoir of the embalming machine was almost empty. . . . He reached over to the counter and picked up a polished metal tube. It was about two and a half feet long, and it had a sharp, hollow point at one end, rounded on the top, flat on the bottom, with three little holes like snouts drilled into the underside of its tip. At the other end were two fittings for hoses. He held it up in front of me. It looked like a lance. "This is what you call a trocar or an aspirator; it don't matter, it does the same thing." He connected one of the trocar's fittings to the hose he'd used to run fluid into the old lady. He connected another hose to the trocar's other fitting, and ran it over to the toilet. . . . He stepped beside her, and with two fingers he pressed down on her belly, just below her rib cage, to the right of the midline. . . . The sound of the machine changed from a hum to a rapid, steady thump-thump-thump-thump, and the contents of the old lady's intestines began to pump out of her, into the toilet. Raymond twisted and turned the trocar, pumping it up and down like a ramrod, rotating it, now in one direction, now in the other, puncturing the walls of her organs. "Sucks it all up," he said. "Otherwise she'd bloat and push everything up, out her mouth and nose. You don't do this, you got yourself a real mess". . . . Then he drew out the trocar, wiped it with a paper towel, and screwed a gray plastic plug into the hole he'd made. "That's it," he said.*[8] VI. WHAT REMAINS OF DEATH *Nowadays, there is more struggle to resist death than there was before to gain eternal life.* —Louis-Vincent Thomas, *Mort et Pouvoir* "That's it," he said. Or is it? As we approach the end of the 20th century, it is far easier to determine when embalming ends than when—and how—life ends. Obsessed with youth, our culture is also obsessed with technologies to postpone death, often at any cost. Stay-young and pharmaceutical products, medical, and "lifestyle" strategies for life extension together constitute a major industry in our society: the industry against death. *Traditionally, death was defined based on an "irreversible respiratory and cardiac cessation." Now, in our time, there are machines that push oxygen in and pull carbon dioxide out of the lungs, that rhythmically shock the heart into a physiologically normal beat, that keep the blood warm and flowing through the tissues of the body, and the skin pink and resilient. These machines can preserve the body in a life-like state even if human consciousness and sensibility are forever lost to an irreversible coma.*[9] Recent court cases attest to the fact that technological advances in artificially prolonging life are considered by many as an invasive tampering with the quality of life. New and painful questions arise about the very definitions of life and death. And who has the authority or right to make these decision: the individual

approaching death? his or her family or friends? physicians? medical administrators? the clergy? the new class of professionals we call bioethicists? There are more questions. There is, for example, the burgeoning industry of "body parts":

The body is rapidly becoming the raw material for the inchoate industry of biotechnology, which stands to earn millions of dollars from products derived from a freak spleen cell or an efficacious gene. . . . Do we own our own bodies, to do with them as we like, including selling them off?[10] Are our bodies becoming the field of technological experiments, are we contributing to the commodification of the body with organ transplants and new definitions of death? The other side of this coin is the new science of non-death, mapping the causes of aging and death, and much-desired immortality: cryonics; genetic engineering; molecular technology; miniature biosensors; futuristic nanomachines (themselves hardly larger than red blood cells); gene replacement therapy; protein engineering. The list can go on and on. There is also an array of new choices to be made, options for dealing with the body after death, or at the suggested onset of death. The DNA molecule, the elementary building-block for all life, contains within itself the blueprints for infinite self-replication, and thereby the possibility for its own immortality. And it is immortality that the people who have signed up for cryonic suspension hope for. Cryonics is the process of freezing dead bodies in hopes that science will bring them back to life in the future; the "patients" (referred to as such by the institutes that have frozen them, since they do not consider them dead) hope to be reanimated one day. At the onset of death, after having been declared medically dead, their bodies are put in cryonic suspension in liquid nitrogen, at the temperature of −320 degrees Fahrenheit. Those that have faith in the possibilities of cryonics believe that it is not far from the embalming notions of the Egyptians. However, one could argue that for the Egyptians, mummification had more to do with the respect and the ritual of the dead, whereas cryonic suspension may have more to do with the denial of death. In describing cryonics, Dr. Hans P. Moravec, a research scientist working in the robotics and computer science field, considers possible techniques for restoring and reanimating the body, thus revealing a recent shift in attitude toward the issue of death. He writes: *Cryonic suspension is the preservation . . . of a deceased person in the expectation that future scientific advances will eventually allow the repair of the condition . . . and thus permit the person to be restored to life. The speculative scientific literature contains a number of suggestions for how this repair might be effected. These include extensions of conventional medicine and microsurgery, enhancements of existing human cell repair mechanisms, the cloning of new body parts from single cells, introduction of micro-organisms genetically engineered to do microscopic repairs at the cell level, the use of ultra-miniature robots in a similar fashion, and methods for reading out the essential contents of a brain into a working computer model, creating, in effect, an artificial brain, analogous to an artificial heart.*[11] For those going into cryonic suspension, the hope of future technological breakthroughs is imperative, especially in nanotechnology and genetic engineering. Many of these "patients" have invested so much faith and belief in these new developments that they have opted for neuro (head) suspension, rather than that of the entire body, believing that when they are reanimated they will have the option of a new and improved young body, cloned through the process of genetic engineering. For those that have selected the full suspension, molecular technology and nanotechnology are the sciences they claim would repair the brain damage caused by freezing. If the idea of repair of biological materials, molecular engineering, cryonics, or sophisticated organ transplants offers an array of possibilities for some, for others basic quality health care is economically beyond their means. 37 million patients in the United States alone have no health insurance. For most, the future of science and technology and the chance to test the limits of life and death are still part of the folklore of science fiction. A kidney transplant costs about $50,000 and a heart/lung replacement, $200,000 or more, making these procedures beyond the means of many people. Those without health insurance may be confronted with "choices" such as harvesting organs, or selling body parts for money. Also, age and social status have a lot to do with the quality care that one receives: "The alcoholic, the drug addict, the prostitute, the drunkard, receives a diagnosis of 'dead on arrival' upon entering

the hospital. The probability for someone to be considered as dying or dead depends, in part, on one's place in the social structure."[12] Communication and cultural differences are a major problem in health care for a vast sector of the population: of the medical doctors in the United States, only 5% are Hispanic-American and only 3% are African-American.[13] VII. LA PETITE MORT *To speak of death makes us laugh a constrained and obscene laughter. To speak of sex doesn't produce the same reaction: sex is legal, only death is pornographic. Society, "liberating" sexuality, gradually replaces it with death through the function of a secret ritual and a fundamental prohibition. In an anterior religious phase, death is revealed, recognized, and it is sexuality that is forbidden. Today it is the opposite.* —Jean Baudrillard, *L'économie politique et la mort* *Eroticism is the approval of life all the way into Death.* —Georges Bataille, *Tears of Eros* In French, orgasm is referred to as *la petite mort*—the little death. The ideas of death and sexuality evoked by this colloquial saying are explored extensively in the writings of Sigmund Freud, Georges Bataille, and Marguerite Duras. In Freud's writings on the death instinct, he examines the relationship between desire and passion and the ultimate instant of life/death. Freud questioned whether Eros, the sexual impulse, is not just another step on the way to Thanatos, the self-destructive impulse of death: "Both impulses," he writes in *The Ego and the Id*, "the sexual impulse and the death impulse, behave like forces of conservation in the narrowest meaning of the term, since they both tend to revert to a state of being that has been disturbed by the appearance of life."[14] For Bataille, even more than for Freud, the taste for death, like the sexual drive, is an impulse towards a limitless state of being, outside of life. For most people in our culture, death is understood as the "end," the essence of discontinuity. Bataille, in contrast, links death with eroticism through the desire for a continuity beyond the self. He writes: *Between one being and another, there is a gulf, a discontinuity. . . . If you die, it is not my death. You and I are* discontinuous *beings. . . . We are discontinuous beings, individuals who perish in isolation in the midst of an incomprehensible adventure, but we yearn for our lost continuity.*[15] For Bataille, death and sexuality are interchangeable in the same temporal cycle: death is both continuous and discontinuous, aspiring to a time without time. Bataille was obsessed by the image of the Chinese "torture of a hundred pieces," which involves cutting the body of the torturee into numerous pieces. He had seen a photograph of this torture employed at the execution of the Chinese regicide Fou-Tchou-Li on April 10, 1905. He was fascinated by the sight of the "ecstatic" face of the tortured person, which he argued had a look of alternate pleasure, for "eroticism opens the way to death and this aura of death is what denotes passion and eroticism in the domain of violence."[16] If Bataille viewed death through passion, Marguerite Duras looked at the same equation from the opposite angle, seeing desire as death. For Duras, this space of darkness, violence, and passion, unredeemed by religion, is everywhere. But it is also a strangely liberating site, because passion and death are unbound. This is the sentiment expressed by a character in Duras' *Hiroshima mon amour*, who states to her lover: "I see my life. Your death. My life that goes on. Your death that goes on."[17] Duras is obsessed with the erotic appeal of death and the deathly allure of passion, because in both one reaches a state of fusion that transcends the boundaries of individual identity. There is continuity in death and desire: "I asked him to do it again and again. Do it to me. And he did, did it in the unctuousness of blood. And it really was unto death. It has been unto death."[18] VIII. TURN YOUR GRIEF INTO ANGER From eroticism to the tragedy of death. And from the places in our culture where they seem bound together to the places where they are torn radically apart. So many questions remain. In the last few years we have lost so many to AIDS. And with this, other losses. "Between mourning and militancy a new attitude towards death—and life—seems to be evolving," as Douglas Crimp proposes: *Public mourning rituals of course have their own political force, but they nevertheless often seem, from an activist's perspective, indulgent, sentimental, defeatist. . . . "Don't mourn, organize!"— the last words of labor movement martyr Joe Hill—is still a rallying cry, at least in its New Age variant, "Turn your grief to anger,". . . . Alongside the dismal toll of death, what many of us have lost is a culture of sexual possibility.*[19] Throughout the centuries the fear of epidemics has always intensified fundamental social and political

divisions of society. In the United States the political system has not been fast enough to react to the AIDS crisis because it was thought that the majority of the population was not at risk. And those who did seem to be at risk "didn't matter." I think of Artaud: "One does not die because it is necessary to die, one dies because it is a habit of thought acquired one day, not too long ago."[20] Louis-Vincent Thomas expands on Artaud's thought: "It is the bourgeois society that had introduced into history the death instinct in order to better assure its domination-reproduction."[21] The activism in response to the AIDS crisis has grown to encompass and raise questions about the state of the health care, on a global scale, with all its disparities and deficiencies. AIDS—which infects about 10,000 people in the world monthly—now requires that we question everything: medical research, politics, race and class relationships. It is a political tragedy that also serves to illuminate other tragedies. Diseases without cures and terminal conditions continue to afflict great numbers of people. For example: "Malaria strikes 150 million people worldwide each year, causing some 2 million deaths. . . . Around the world, smoking kills about 2.5 million people annually. . . . 70 million Americans will develop cancer in their lifetime. Hundreds of diseases remain incurable, among them arthritis, multiple sclerosis, cerebral palsy. Alzheimer's disease, muscular dystrophy, amyotrophic lateral sclerosis (Lou Gehrig's disease), lupus, and the common cold."[22] When will it end? How will it end? Has it already ended? What do we mean by the end? These are just some of the questions *THE INTERRUPTED LIFE* attempts to address. Frederick Wiseman's 1989 six-hour, black-and-white documentary, *Near Death*, filmed in the Medical Intensive Care Unit of Boston's Beth Israel Hospital, shows us physicians informing families and friends of their terminal situations. Having to deal daily with the reality of death, perhaps physicians and other members of the medical profession become anaestheticized—become accumstomed to the habit of denial by treating patients and counseling their families. They immerse themselves in a relentless cure and speak the hypnotizing language of this new "medicalized" death: "Put the tube back in. . . . Take the tube out. . . . Meaningful recovery is remote. . . . I want what's best for him. . . . We have to see if we can get him to fly, and not re-intubate him. . . . Is he in optimal situation to maximize it. . . . Do something, please do something. . . . We're doing our best; it's a gray area. . . . We've buffed him out. . . . We don't know. . . . There is always hope, but he is not doing well. . . . Do you want us to resuscitate him. . . ." And over and over again, the doctors asking those frightened, sad people who are hoping for the best for their loved ones, *"What's your sense of what's going on?"; "Do you have a sense of what's happening?"; "Do you have an understanding of what's going on?"*

NOTES

1. The phrase "forbidden zone" comes from Michael Lesy's *The Forbidden Zone* (New York: Anchor Books, 1989). It refers to a "zone of death" in contemporary American culture.
2. Rick Smolan, Phillip Moffitt, and Matthew Naythons, M.D., *The Power to Heal: Ancient Arts and Modern Medicine* (New York: Prentice Hall Press, 1990), p. 163.
3. Franz Kafka as quoted in Roland Barthes' *Camera Lucida* (New York: Hill and Wang, 1981), p. 53.
4. Benjamin Buchloh, "A Note on Gerhard Richter's October 18, 1977," *October* no. 48, (Spring 1989), p. 97.
5. See John Berger's *About Looking* (New York: Pantheon Books, 1980), pp. 39–40.
6. Jean Baudrillard as quoted in Louis-Vincent Thomas, *Mort et Pouvoir* (Paris: Payot, 1978), p. 124.
7. Jean Baudrillard, *L'échange symbolique et la mort* (Paris: Editions Gallimard, 1976), p. 224.
8. Michael Lesy, *The Forbidden Zone*, pp. 243–246.
9. Margaret Clark, "The Body as Commodity: Ritual Dismemberment in Contemporary Biomedicine," paper given at the American Anthropological Association's annual meeting, Nov. 15–19, 1989.
10. Jack Hitt, "Sacred or for Sale?," *Harper's Magazine* (October 1990), p. 47.
11. Hans P. Moravec, Ph.D., Research Scientist at Carnegie-Mellon University as quoted in "What Scientists Say About Cryonic Suspension," a brochure printed by ALCOR Life Extension Foundation, a group that advocates and practices cryonic suspension.
12. C. Herzlich as quoted in Gérard Vincent's "Le corps et l'énigme sexuelle," *Histoire de la vie privée*, Tome 5: *De la Première Guerre mondiale à nos jours*, sous la direction d'Antoine Prost et de Gérard Vincent (Paris: Editions du Seuil, 1987), p. 343.
13. Rick Smolan, Phillip Moffitt, and Matthew Naylons, M.D., *Power to Heal*, p. 217.
14. Sigmund Freud, *The Ego and the Id*, Standard Edition (London: Hogarth Press, 1915), vol. xix.
15. Georges Bataille, *Erotism: Death and Sensuality* (San Francisco: City Lights Books, 1986), pp. 13–15.
16. Georges Bataille, *Erotism*, p. 22.
17. Marguerite Duras, *Hiroshima mon amour* (New York: Grove Weidenfeld, 1961), p. 63.
18. Marguerite Duras, *The Lover* (New York: Harper & Row, Publishers, 1986), p. 43.
19. Douglas Crimp, "Mourning and Militancy," *Out There: Marginalization and Contemporary Cultures*, eds. R. Ferguson, Trinh T. M., M. Gever, C. West, (New York: The New Museum of Contemporary Art, 1990), pp. 234–238.
20. Antonin Artaud as quoted in Louis-Vincent Thomas, *Mort et Pouvoir*, p. 61.
21. Louis-Vincent Thomas, *Mort et Pouvoir*, p. 61.
22. Rick Smolan, Phillip Moffitt, and Matthew Naythons, M.D., *Power to Heal*, p. 217.

TOUSSAINT'S LAST MIRACLE PHOTOGRAPHS BY JOLIE STAHL In the fall of 1990, under the direction of the New York Archdiocese, a team of forensic anthropologists went to work to exhume and verify the remains of a man buried more than a hundred years earlier in a cemetery in Little Italy. The remains sought after were those of former slave Pierre Toussaint, exhumed because some in the Catholic Church hope to canonize him as the first African–American saint. As Toussaint's remains now lie in St. Patrick's Cathedral uptown, evidence is being gathered to persuade the Vatican of his holy status. Born into slavery in Haiti in 1766, Toussaint was brought to New York in 1787 with his owners, John and Marie Berard du Pithon, who were fleeing from the growing unrest that would eventually lead to the Haitian Revolution. Shortly after the move, John du Pithon died and left his family destitute. Working as a hairdresser, it was Toussaint who supported the du Pithon family for the next twenty years. During his lifetime, he raised money to build orphanages and churches, nursed the sick during an epidemic of yellow fever, and purchased the freedom of dozens of slaves. Initiating the canonization process in 1989, John Cardinal O'Connor had declared, "It will be a wonderful thing for the City of New York. . . . It will be a great thing for the Church. It will be a fine thing for the Black community." (If successful, Toussaint's ascendence into the roster of saints may also help to boost the dwindling number of African–Americans in the Catholic Church.) Over the course of three weeks in the fall of 1990, photographer Jolie Stahl visited the cemetery in Little Italy to record the search for Toussaint's remains. In these photographs, first published in *The Amsterdam News*, Stahl chronicles the sequence of events: from the initial search guided by the old church cemetery map, to the retrieval of "holy" dirt from the site of Toussaint's remains, and the final discovery of Toussaint's spinal column and pelvis. In the article that appeared with the photographs, *Amsterdam News* writer Bob Danni characterized what he referred to as Toussaint's "Last Miracle": "his biggest one yet, to make everyone forget about the church and its role in slavery." —Alice Yang

THE PRISON DETAIL PHOTOGRAPHS BY JOLIE STAHL Potter's field is described in the Bible as a place to "bury strangers in." New York City's Potter's Field is located on Hart Island in the bay just east of Orchard Beach in the Bronx. It is here where the unclaimed dead—mostly the indigent and the homeless—are buried. Collected from city morgues and transported by ferry, they arrive at Potter's Field in plain plywood caskets that are buried three deep and ten across in open trenches. To keep track, serial numbers are used to label the boxes and simple markers placed at each mass plot. This notational system serves as a catalogue, in case there is an exhumation or if a relative or friend, previously unable to have or pay for a private burial, steps forward to claim one of the bodies. A single granite monument—with the inscription "He calleth His children by name"—stands on the island. For these last rites at Potter's Field, the city "hires" a special crew. The operation of the island is under the charge of the Department of Corrections, which pays inmates from Riker's Island fifty cents an hour to work on "the prison detail." In 1982 a work camp was set up at Potter's Field so that inmates need not be ferried to the island each day. Jolie Stahl went to Potter's Field in 1986 to document the inmates's work routine and the environs of the island in a series of photographs first published in *The Amsterdam News.* Currently forty to fifty prisoners live on site to care for and maintain Potter's Field under the surveillance of their guards. —Alice Yang

The following are excerpts from a series of interviews conducted by New Museum staff members France Morin, Alice Yang, and Russell Ferguson during the spring and summer of 1991.

RUBY MCNEIL

RUBY MCNEIL is the seven-year-old daughter of an artist and a curator. This interview was conducted in Ruby's bedroom.

THE NEW MUSEUM: *Do you remember the first time you actually thought about death? That you were asking yourself what it meant?*
RUBY MCNEIL: I don't know. But I think, yeah, it was a long time ago.
TNM: *Do you remember if it related to something that happened?*
RM: I think so.
TNM: *What do you remember?*
RM: Well, I remember I had a dream about a mother and she had to choose which people had to die.
TNM: *In her family?*
RM: Uh-huh, and not in her family.
TNM: *How long ago did you have this dream?*
RM: Last night.
TNM: *Really? Is it because you were thinking about this interview?*
RM: No. I just was thinking about something else and it just went into this. I don't know why. I have very strange dreams, and I don't know why this happened.
TNM: *And who did the mother choose?*
RM: Well, she choosed three boys and she choosed the husband . . . and a man. And that's it.
TNM: *Was the mother in your dream somebody you knew?*
RM: Umm . . . I was in the dream.
TNM: *You were in the dream? And was it your mother?*
RM: No.
TNM: *Do you know why she had to choose?*
RM: Well, because these ghosts came and said "You have to pick which people have to die." Because the house was haunted, and they slept there. The ghosts chanted magic to get them dead, and at the end they just came alive and this is something that is wonderful in one way, but bad in some ways.
TNM: *In what ways is it wonderful?*
RM: Well, you get to rest. And rest is wonderful, because you get to rest from being this way.
TNM: *What way?*
RM: From, you know, when you stay alive and you stay alive for a long time, then you kind of get tired, and then you have to die and then you can rest from being alive.
TNM: *So you think that it's good because people get to rest?*
RM: But in a way, that's bad. Your friends can't really see you and you miss your friends and you might be sad to miss them or something.
TNM: *In the dream, did the mother have any girls, any daughters?*
RM: Yes, she had a daughter. She had me . . .
TNM: *She had one? She had you as a daughter?*
RM: She had two.
TNM: *And she decided it would not be the daughters who died?*
RM: Yeah, no daughters, no daughters!
TNM: *So she decided that the people who had to die were the three*

boys and her husband, and another man. Who was the other man?
RM: He was just a man somewhere and the mother didn't know him. But he wanted to get married because the husband was dead. And the mother said no, but maybe you should come because there's ghosts around here, and I have to pick who dies, and I don't want to kill my daughter, so maybe I will have to kill you because I don't want to go dead.
TNM: *And then you woke up?*
RM: No, not until the end of the dream, when all the people come alive.
TNM: *They weren't really dead?*
RM: THEY WERE DEAD! But there was some way, magic, that they could come alive. . . .
TNM: *Did you have a friend named Stuart who died?*
RM: Yeah.
TNM: *What do you think it means when somebody dies?*
RM: Well, it means that you have to die. Because if you didn't die, it would be too crowded in the world. But death means sometimes a punishment for something, or it might be that you are tired and something happened, or just you were going around and something happened.
TNM: *What do you mean by a punishment?*
RM: Maybe a punishment from something that you did to a person.
TNM: *With your friend Stuart, was it a punishment?*
RM: It wasn't a punishment. It was just that something came in his body and killed his cells. But sometimes death is wonderful, or it is not wonderful, or it may be . . .
TNM: *Why do you think it is wonderful?*
RM: Well, if you need a rest or something you can go get one. But only if you are dead, because your body gets slower and slower, and from that life and energy you can die and feel relieved. But, in some good ways, you can have a spirit or something, or something would come out, or something new would happen.
TNM: *Some children and even lots of grown-ups get upset when they talk about death. They find death very sad, they feel death is all about losing people they love. But you talk about death like it was a very natural thing—people live, people die. Do you believe that it is a natural thing?*
RM: Well, not really. But, sometimes you can miss someone because if someone wakes up and dies in the middle of the night, you may be sad because you want to see him die. . . .
TNM: *To say something to them before they die?*
RM: Yeah, or you wanted to go over to their funeral, but you missed it or something, and you really feel sad, or you may miss a person.
TNM: *Do you get afraid sometimes? Let's say that the people around you, your mother, your father, your grandparents, or people very close to you, died. Do you think about that sometimes?*
RM: I may think about it, but I'm scared about when I die. Because I don't know what it feels like, I'm really scared.
TNM: *You're scared. What do you think it feels like?*
RM: Well, I think it feels like you're slowing down.
TNM: *You're slowing down?*
RM: Yeah. And you don't have very much energy and you feel like you can't get up. I think it's like that, but maybe that's not right. But I'm just afraid that I'm going to die, and I just don't want to die. I wish my mommy and daddy and me didn't die.
TNM: *Have you known many people who died?*
RM: Not really. I know this guy who smoked and I know this person, Stuart, who had blood put in, and you know those dangerous things that put blood in different parts of thousands of people, and one person has AIDS and they didn't know and they put it into Stuart's blood.
TNM: *Were you with these two people that you know when they died?*
RM: I don't think so. No. But, I've known other people, an uncle, and a friend, and an aunt, and lots of people. I feel sad for them and sorry that they died because they got sick. I don't feel that they should do that. I don't feel like that should happen, because they might be sad or they don't think it's really good that they don't want that to happen. But my mom's not afraid of death. I'm a little afraid.
TNM: *What about your father?*
RM: Well, my father? He's a little afraid of death. He's not that much. . . .
TNM: *And what do you think happens to people after they die?*
RM: Well, once they're dead they have a spirit and the spirit comes out and goes up. I don't know if there is a heaven or not, okay? I don't know if there's a God, so I don't believe in God. So, uhmm, they go someplace or whatever, or they can go in the world. They can go round.
TNM: *Are you telling me that the body is not too important, because once somebody dies, there is a spirit?*
RM: No. Because a body is important, because you can tell and see and smell and touch and do stuff.
TNM: *That's when people are alive.*
RM: Yeah, that's important. But what's important when you're dead is that you can rest, or in someways, what's important is that people miss you.
TNM: *And what happens to the spirit you're talking about?*
RM: It goes all around. I knew another person named Dennis, and he had AIDS too. He had AIDS and he died. But, um, see, in a way, you can miss people. Because Dennis was really nice, he took me to the Plaza Hotel and he gave me some treats and I love him, but it was really bad that he didn't remember that that happened when he died. And those people I really love.
TNM: *Do you think about Dennis sometimes and feel that his spirit is with you?*
RM: Yeah, yeah, I feel like that. If you think of a person, they're next to you and their spirit is next to you. And you

can think that they're really next to you forever.
TNM: *Is the spirit like a very nice ghost then?*
RM: Yeah, in a way. But, its really . . . when you die, you're young again.
TNM: *Why, when people die, do they get young again?*
RM: Well, because when something dies you can't be old, because that's the way I believe. And your spirit when you die, your spirit is young. It's not old.
TNM: *Is it young, or are you saying that your spirit stays the same?*
RM: It's old, and it's young and free.
TNM: *So the body can get old, but the spirit stays young? How about other things that die? Do you think about animals or plants? Do you think it's different for them?*
RM: Yes, because the head might rip off. Because in our backyard we have a buried pigeon, which is dead and the head is cut off a little and it's leaning on the side and cut off and kind of swinging.
TNM: *And you buried him?*
RM: Uh-huh. It's a she.
TNM: *Were you alone when you found the pigeon?*
RM: No, I was with a friend.
TNM: *Were you scared?*
RM: No, we were sad.
TNM: *You started to say that you think it's different for a pigeon to die than it is for a person to die.*
RM: Yeah, because it has different parts, and if it has different parts it dies in a different way. It may get a different disease that no human being can get.
TNM: *Have there ever been any children that you knew that died?*
RM: I didn't know this kid, but there was a kid. He was standing out on a window, and then he jumped down and he killed his self.
TNM: *How old was he?*
RM: Four.
TNM: *How do you feel about that?*
RM: Pretty sad. And pretty scary.
TNM: *Are you careful when you cross the street and things like that? Do you think about death?*
RM: I think very careful, if I'm going to run out. Because in Santa Barbara I can cross the street by myself.
TNM: *Because there are less cars.*
RM: And I look both ways.
TNM: *How else do you learn about death?*
RM: Well, my mother and father speak to me about death.
TNM: *How about stories on TV? Do you ever see TV shows about death?*
RM: I seen a book about death.
TNM: *What does it talk about?*
RM: There are these haunted stories, about ghosts and things, and this girl gets blind and then she gets run over by her father. So she's blind and her father doesn't recognize her. Then she dies.
TNM: *Do you think that's a scary book?*
RM: I like it.
TNM: *What do your parents tell you about death?*
RM: About death? They tell me that, um, don't be afraid about death, and they tell me death is a way of believing things sometimes. Like you can believe you're going to God, or you can believe you're going to heaven, or you're going anywhere.
TNM: *And where do you think you are going, if you were to die?*
RM: If there was a heaven, I would go there, but if I didn't want to go there, I could go around the world.
TNM: *That's good. But you still prefer to stay alive?*
RM: Yeah.
TNM: *Is there anything else you would like to tell us about death?*
RM: I don't think so . . .
TNM: *Is there anything you want to know?*
RM: Yes. Um, well, when something dies . . . have you ever had a pet that died? Who was it?
TNM: *A cat.*
RM: The cat that I met?
TNM: *No, those cats are still alive. (Laughter.) Another cat, when I was younger.*
RM: How old were you?
TNM: *I was about twelve.*
RM: Is your cat still buried?
TNM: *Yes.*

TYRONE SOTO

TYRONE SOTO describes himself as an "out-of-the-ordinary Puerto Rican from the Bronx." While attending John F. Kennedy High School in the Bronx, he participated in The New Museum's High School Art Criticism course, and subsequently worked as an intern at the museum. He graduated from high school in January of 1991, and plans to enter college in the fall. This interview took place at The New Museum.

THE NEW MUSEUM: *Many people think of the South Bronx as an extremely violent place where people are dying left and right. But you live there. How do you feel about it? Do you think of it that way?*

TYRONE SOTO: Well, people do die mostly about everyday. But it's not like you're going to be seeing it every minute while you're walking through the neighborhood or something. The neighborhood looks like people would be, like, infected with some diseases by all the abandoned buildings—abandoned buildings for blocks and blocks. When you go on the highway, you can just look down and it looks like something out of World War II.

TNM: *And the violence?*

TS: There's violence as far as little neighborhood or gang wars maybe. But most people don't litter where they eat, understand? They'll live somewhere else and come into the neighborhood since it has a bad reputation. They live in Queens somewhere in a better neighborhood, and come here and do their dirty work.

TNM: *I guess I was thinking that since you said people die everyday . . .*

TS: Yeah, well there's people dying everyday, but it's not like you would run into a pile of dead people right there. Sometimes you won't know that someone died until a couple weeks later or more. Go through the neighborhood and you overhear someone talking, "Oh, this guy fell off the roof. . . . "

TNM: *Is AIDS a big problem in your neighborhood?*

TS: I don't know if people die from AIDS or just a drug overdose. I try not to think about it much. But it's something to think about. Tell Spike Lee to make a movie about that.

TNM: *As you know, we're doing an exhibition on death. What do you think about death?*

TS: If I were to be dead, and still be able to see things and learn, I think it would be a privilege to die.

TNM: *Do you think that's possible? Do you think we can learn after death?*

TS: Well, death is supposed to be the opposite of life. What does it have? Advantage or something?

TNM: *So your question is "What does death have to offer us?"*

TS: Yes, that's a quote. With a question mark behind that one.

TNM: *Has anyone close to you died?*

TS: Oh, yeah. In 1989, my friend's mom passed away. She passed away a week before her birthday and mine. She had cancer. It was hard on my friend, because he's had a hard life. Then to have your mom pass away just makes things harder. Your guide just disappears. You have no one to guide you.

TNM: *Do you think death affects teenagers or young adults more now, or in a different way than it did before?*

TS: It affects us. But when it comes to a relative, it's different. Because when it's someone else, it doesn't really hit you, it doesn't affect you that much. I feel everyone has to die. If life isn't all that good for them living, then it's best for them to die. That's my personal opinion.

TNM: *So what you're saying is that death doesn't necessarily affect teenagers any more now that it ever did. But I was wondering about violence—access to guns, violent images on TV, that sort of thing.*

TS: Violence is realistic. TV is not trying to tell anyone to go and do violence, it just wants to be real. It has the violence which occurs in the world. In fact, I think TV should actually show death. Some TV programs—the only thing they show is the shootings. They don't show the aftermath, the death, whatever. I see a show and a cop gets shot, but you don't see his parents, you don't see his funeral, nothing like that. The show keeps on going. At the end, it's like, "Oh I'm sorry he got shot." Well yeah, then the show finishes. And then it comes on next Tuesday. TV doesn't let the kids see what violence really does, how it affects. So that's the problem with TV.

TNM: *Do you think that death affects teenagers in the South Bronx differently than it affects teenagers in other areas of New York, or in other cities?*

TS: No, not really. If someone sees their parent die, and that's one thing. But if it's some stranger, they don't feel anything.

TNM: *You're saying that the biggest thing that everyone experiences is the death of their loved ones?*

TS: Yes.

TNM: *Is death something that you think about in your daily life?*

TS: Yeah, I think about it. I think about how it would be. I wonder, as I said, if it would be a privilege.

TNM: *Do you think about your own death or do you think more about the death of other people?*

TS: No, I think about my own death. I think about how my funeral would be.

TNM: *How would you like it to be?*

TS: I want a lot of people there, about a thousand or more people.

TNM: *What do you want them to do?*

TS: Nothing, just come and respect me. To acknowledge the person I was while I was living. To say that this was a good man, always did the best he can.

TNM: *Is there anything else that you want to say?*

TS: Yeah. I want to call on a phrase that my friend told me: "When Death comes knocking at your door, give generously." It's true. And I want to recite a poem I wrote. It's *Untitled*, by Tyrone Soto. Ok, prepare yourself because it's short. And you could listen to it again and think about it. It goes:
We are specks of dust
With a world within us.
We live in a world
that lives in a world
that's a speck of dust.

YEHUDA NIR

YEHUDA NIR is an associate professor of psychiatry at Cornell University Medical College and is in private practice in New York City. He is the author of the book, The Lost Childhood, *a memoir which recounts his experiences as a nine-year-old Polish Jew during the Holocaust (Harcourt Brace Jovanovich, 1989; Berkley Books, 1991). It has recently been translated into Japanese, French, and Dutch.*

THE NEW MUSEUM: *You were an eleven year old living with your family in Eastern Poland when the Germans invaded Poland in 1941. You were exposed to the brutality of mass murder at a very young age.*

YEHUDA NIR: The terror started before 1941. For the previous two years, we had been living under Russian occupation. Under this occupation, my father, a well-to-do business man, a manufacturer of kilims, became an endangered species. The Russians wanted to banish all capitalists to Siberia. My father became one of their targets. He went into hiding, and they didn't get him. But the Germans, on the other hand, made no such mistakes letting a Jew escape their murder machine. After the invasion of my hometown, Lvov, the Germans gave the Ukrainians, known for their vitriolic anti-Semitism, a free week to do whatever they wanted to do to the Jews.

TNM: *You wrote in your book that hundreds of Jews were rounded up daily, marched to the woods, and executed by machine-gun fire.*

YN: Yes, my father was among them; it happened within a week of the arrival of the Germans. I never saw my father die. We only learned with certainty, after the war, that he had been among those slaughtered that day on a hilltop outside our town.
For years I harbored the dream that he had only disappeared, that I would see him again. It stayed only a dream. Thinking he was alive throughout the war, I felt safer, protected. As I wrote my memoir, one of the things I had to come to grips with about my lost childhood was that for me my father never really died—he just faded away.

TNM: *And when did this fantasy fade away?*

YN: Never! Thirty years later, I read the words in a newspaper advertisement—"Dr. Gruenfeld, head of the department of medicine . . ." (My name was originally Gruenfeld. After the war I changed it to a Hebrew surname as I didn't want to continue having a German name.) For a moment I thought this was my father—and of course he wasn't even a physician.

TNM: *As a child did you understand that you were in danger of dying?*

YN: I knew I was. It didn't matter how young I was; the Germans weren't making any distinctions, to the extent that they were even murdering babies. I think I understood very well that no one was safe—not even a

child.
My sister's boyfriend, Ludwig Zelig, came up with the idea that if we were to survive, we would have to assume Christian identities. Through subterfuge, we got information from a Catholic neighbor, Mrs. Glowacka, who was my mother's age, about the church in which she was baptized.
Once we had all the identifying information, mother wrote to the church, using the ruse that she was Mrs. Glowacka, claiming that she had lost her baptismal certificate and requesting a replacement. Within a week, my mother received an original certificate. My sister did the same thing with a Catholic friend of hers. Getting my documents, however, was somewhat different. In order to travel through Poland with my mother and avoid arousing suspicion, I needed a certificate with a matching name. So, I bought my papers from an enterprising Catholic priest.
TNM: *And then?*
YN: And then we moved to another city, and continued to move for four years, never really trusting anyone because there was always the threat of the Poles—not necessarily that they would murder us, but definitely would not protect us from the Germans. We were human prey. It was a very hostile environment. At one point, I dyed my hair blond because I thought I would look more Aryan. When I walked in front of a church, I always crossed myself. At one time, I lived with a Catholic family. They didn't know I was a Jew. They had a son my age who wanted to be an altar boy. So we both started to train. When we auditioned, I got the position. For me, it was a question of life and death. I was perfect; the priest had tears in his eyes. I knew exactly how to behave. So from a very early age, I was on guard. I compared myself to a juggler, always focusing on the next ball, because once the ball is down, it's over.
TNM: *Has that changed over the years?*
YN: Not really. I've carried that with me to this very day. I think I'm very perceptive of minute nuances of change. It's terribly important for me to know where I am and where I stand, which is probably a reflection of the past. I don't think it's paranoia, but I don't miss a trick.
TNM: *The epigraph in your book is a quotation from Samuel Beckett's* Malone Dies: *"Let me say before I go any further that I forgive nobody. I wish them all an atrocious life, and the fires and ice of hell and in the execrable generations to come . . ."*
YN: That's right. Once I was talking to another survivor and he said that one of the things that he can't forgive the Germans for is that they deprived him of the ability to forgive. And I think there's something to that. I think that the world now, in the last five years, has been willing to deal with the Holocaust. But it took years, you know. For years, nobody asked a single question. I've been in the U.S. for thirty years. People have known me—you know, I have an accent, they know that I'm not American. But nobody asked me a single question about my past. People were afraid to ask.
I think now is just a beginning; the full implication of what really happened is still to be told.
TNM: *Do you feel hostility towards Germans born after the war? Or the German nation as a whole?*
YN: Not hostility, but disappointment. The young Germans have not done anything to confront their parents or grandparents with what happened. Nobody's pointed a finger: "How could you have done it? " You see, somebody has said—and this is a very perverse statement—that the Germans will never forgive the Jews for the Holocaust since it unleashed the beast in them. I'm really disappointed in the young Germans. I don't have faith in them. I feel sorry for them, because they are the children of murderers. They owe it to themselves to take charge and confront their past.
TNM: *Having survived the horrors of the Holocaust, are you less afraid of death now?*
YN: It will always be a very scary idea. But somehow it's not as scary to me as to many other people. I don't know, maybe I'm deceiving myself. It's very difficult to really be in touch with one's deep personal feelings. I think that everyone is obsessed with death, and the denial of it. The fear of confronting it, the fear of accepting it. . . .
TNM: *But is there any sense for you, or for other survivors that you've met, of a renewed appetite for life?*
YN: I think this was so immediately after the war. Many of the Holocaust survivors who came to America after the war did very well. These was a terrific kind of drive to make up for lost time, to pursue things. Also, to act as if nothing happened—to deny the Germans the pleasure of having ruined, destroyed the Jewish people.
TNM: *You're a psychiatrist. And with the publication of your book, many Holocaust survivors have come to you as patients. Are there certain common feelings that come up?*
YN: Depression. A feeling of loss. Even in the second generation, in children of survivors. Most of them never had grandparents. Often, their parents were distant because they were preoccupied with their experience. Many parents who are Holocaust survivors tried to protect the children by not telling them what had happened, and what happened to them. But children experience such withholding not as protection, but as deprivation.
TNM: *And as those survivors reach the age when they must face their death?*
YN: Many avoid doctors or don't want medication. In a sense, it's their last attempt to take charge of life, once again.
One of the most tragic things that happened in the last few weeks was Jerzy Kosinski's suicide. I don't know whether you read his book, *The Painted Bird*, which

describes a child experiencing the Holocaust in Poland. Somebody said that his death was not a suicide but a homicide, implying that the way he committed suicide was really like killing somebody else. He put a plastic bag over his head. He also did not have a funeral; it was as anonymous as in Auschwitz. His death—the way he died forty-five years after the Holocaust—shows its enduring effects on all of us.

BARBARA SONNEBORN and KATHY BREW

BARBARA SONNEBORN, a photographer, is project director/co-producer/co-director, and scriptwriter of Regret to Inform, a documentary in progress on the widows of both American and Vietnamese soldiers of the Vietnam War. During the Vietnam War, Sonneborn's husband, Jeff Gurvitz, a lieutenant, was killed in action. KATHY BREW, associate producer of Regret to Inform, was also present at the interview. This interview was conducted in New York City three days after the June 11, 1991 "Welcome Home" parade for the troops who participated in the recent Persian Gulf war.

THE NEW MUSEUM: *How old were you when your husband left for Vietnam?*
BARBARA SONNEBORN: I was twenty-three, and he was twenty-four.
TNM: *How long had you been married?*
BS: For two and a half years. But we had been high school sweethearts from the time I was fourteen.
TNM: *How did you cope with it when he left?*
BS: Well, I think denial is a very handy mechanism, and I think I had a lot of denial—you know, about what could happen to him. Yes, I was fearful, and I had dreams and I had a tremendous amount of anxiety about his going. But at that age, I don't think people really believe that anything bad can happen to them. And I think that's one of the reasons that young men go to war. If they only took men who were over forty or fifty, very few would go.
TNM: *How long was he in Vietnam before he got killed?*
BS: Six weeks.
TNM: *How were you informed?*
BS: My husband was killed on February 29th, 1968. Two days later, on March 2nd, I was awakened by the doorbell, and I went to the door and there was a lieutenant standing there, and he told me my husband was missing in action in Vietnam. The next day he came back and told me that my husband had been killed in action. A lot of people found out in much more difficult ways from very rude people and so on. He could also have been missing for much longer, and being missing is, in many ways, worse than death.
TNM: *Did his death change your attitude about the war?*
BS: I don't think there are words to describe how politicizing it can be to have someone you loved killed in a war. It was a political enlightenment. I stopped trusting "the truth" that we are supposedly told. I stopped accepting authority as it's handed to us. Before he went, quite a while before he went, I was opposed to the war, and we fought about it. And I said, "Let's go to Canada, or let's go to jail." But he bought the warrior myth: if your country is fighting a war, you go to war. His father had gone to World War II, and it had been the high point of his life. I think a lot of men did it because of their fathers. A lot of men feel that if there is a war and they don't go,

they will never know if they could have done it, if they were brave enough to do it, if they were man enough to do it. A lot of other men don't subscribe to that at all. But it is an ancient myth and has tremendous power in our culture.

TNM: *You used the term "enlightenment" to describe your reaction to your husband's death. Could you speak a little more about that?*

BS: Well, the political enlightenment was pretty immediate and pretty straightforward. But the spiritual, emotional, and other levels of enlightenment evolved over time. Initially, I was so devastated I didn't think I was going to survive. And enlightenment was not even a word in my vocabulary. But as time went on, one of the things that struck me was how he and I had always been living in the future. It was always going to be *after* high school, college; and *after* college, graduate school; and *after* graduate school, the army; and *after* the army, settling down somewhere and having children and living happily ever after. And living happily ever after didn't happen, so what I really began thinking about was the present moment.

I began reading a lot of Hindu and particularly Buddhist literature. I began thinking more and more about how much of my life I had spent thinking about the next moment, or what I was going to do later, or what I was going to do tomorrow, or what I was going to do next year. The profound and explosive truth of his death in my life contributed to teaching me something that I would have learned much later, if ever.

TNM: *Which is?*

BS: Well, that we only have the present moment. Also a kind of misunderstood concept, the Buddhist principle of non-attachment. People think it means we should not become attached to those we love. But my understanding of it is that the important thing is to love and live most deeply in the present. For example, I would never have survived that period of time in my life had it not been for the love of my family and friends. I would have just thrown myself off a bridge. I was getting sick. I couldn't eat. The net of loving kindness that surrounded me pulled me through, and I made a vow at that point that my friends and family would always be the first priority. Work is deeply important to me, but people are more important to me. I realized that nothing is more important than our most meaningful relationships.

TNM: *Some people take comfort in the idea that their loved one "died for a cause."*

BS: I couldn't find meaning in the fact that he died in Vietnam. There was no meaning whatsoever. That was just a tragedy and a terrible, terrible waste.

TNM: *How long did it take for you to feel stronger?*

BS: I think our culture doesn't allow for how long grief goes on. There's this kind of rule that basically you're supposed to get back to work right away, because that's good for you. I couldn't work at all. I couldn't deal with people I didn't know. I couldn't be around people. And then there's the "year rule": that after a year you're just supposed to be better. But I wasn't better at all. I was really pretty unglued for a long time. I went through periods of claustrophobia. I really thought I was going to lose my mind for a long time. And I felt very guilty about that. But as I've talked with other people who have suffered large and tragic losses, they say they went through the same thing.

TNM: *You were told that your husband died in a mortar attack. Did you actually see his body when it came back to the States?*

BS: No. I made my father promise me that no one would look. I found out some weeks later that my husband's father and brother had in fact gone to the funeral home and seen him in the coffin. I was furious. I went crazy. And I think the reason I went crazy was that I really didn't want to believe he was in there.

Now I think my father-in-law and brother-in-law were actually doing me a great favor. In the Jewish tradition, it is not traditional to have an open coffin, so I grew up feeling that there is something barbaric about that. But now, I think it can do some people good to look and to see the reality. Even up until this day, occasionally I will get this flash that my husband is going to show up at my doorstep. There is something very bizarre about somebody dying so far away and you being so dislocated from that. I just couldn't believe he could die alone without me. I just could not absorb that.

TNM: *How did you, as a young woman in your early 20s, adjust to the role of "widow" in this society?*

BS: As a matter of fact, I remember wishing that someone would come and tell me how to do this. I really wanted another war widow to tell me how I was going to put my life back together.

One of the first things that I said after he was killed was that I hate this country and I want to get out of here. If President Johnson had walked in that moment, I probably would have killed him with my bare hands. I mean, that's how angry I was. People have asked me how it is different to be a Vietnam war widow than to have lost your husband from illness or an accident. I think it is different when you feel your government has colluded to murder the person who was your husband. I felt that, and several of the other widows that I have talked to have also felt that: that when your husband dies at the hand of your own government you become an enemy of the state. You feel like an outsider.

TNM: *I understand you came to New York this time partly because of the parade. What do you think about the war in the gulf?*

BS: I think the war in the gulf is a deep tragedy—completely politically motivated and a million percent unnecessary. And the burst of nationalism that has followed has been very frightening to me, and to a lot of

other people that I know. Suddenly this, "Rah, Rah, U.S.A." stuff which at the parade was horrifyingly present. There was a lot of "something" that I had never heard or seen before, and Kathy and I were struck by it. As the soldiers came marching down the street with various weaponry behind them and in their uniforms, there was this interaction between them and the crowd, particularly the men. A lot of the men were sort of reaching out with this kind of thing they do at sporting events where their arms kind of touch one another, and there were these sounds coming out of them, these deep bestial kinds of sounds. (Laughter.) I mean deep grunts and sounds. I'm hoping we got it on tape because I can't imagine that anyone could act that sound. It seemed like it was too primitive, too primordial to reenact, and it was very frightening. The energy was very frightening.

TNM: *Have you talked with Vietnamese women who lost their husbands in the war?*

BS: Not yet, but I intend to. Because, the problem is, we like to think, and we are doing a very good job of it now in the gulf, that the only losses are American losses and somehow these other people aren't dead. Or that it doesn't matter that they're dead. But the bottom line is that death and war don't really know any sides. When someone doesn't come home from a war, it doesn't matter what side you're on. I suppose some people feel excited that their husband died a hero. But I think that for most people it is simply a very sad and lonely loss.

TNM: *Kathy, you are working on Regret To Inform with Barbara. How has it affected your perception of death?*

KATHY BREW: I watched a friend die of AIDS over the course of a year. I had had all this mediated experience in our culture, from the J.F.K. assassination on, but that can become so removed and distanced that you start to wonder if it is real. And after having a very direct experience I feel compelled, but not in a morbid way, to help deal with issues that do address people facing it.

TNM: *Do you think that if women ran the world, there would still be war?*

BS: Well I would like to think that there wouldn't be, but the enthusiasm with which many women went off to the gulf was a little disturbing. We generally think of women as victims of war. In fact, woman are also collaborators if we let the men go. We don't stand in their way. We don't demand that they don't do this. We buy a tremendous number of things from the military industrial economy. If women were to take their economic power and say we just aren't going to put up with this anymore, they would have tremendous power in stopping the war-making machinery.

TNM: *I was wondering what you thought about the phenomenon in the recent Gulf war—the incredible phenomenon of the yellow ribbons in this country. It seems to me that there are so many different things going on with that and I wonder what your take on that phenomenon is.*

BS: Well I agree with you that there are many different things going on, and I think that they mean different things to different people. And I don't think anyone really knows for sure what they do mean. But I think that there has been a very bad spirit in this country since the war in Vietnam and Watergate and so on. This war gave—what seems to be a large percentage of the population—some new identity. I think that the yellow ribbon was the badge of that new identity. And that patriotism . . . I don't think that patriotism is even the right word—I think that the nationalism that exploded out of this war is symbolized by that yellow ribbon. People suddenly felt that they had a brotherhood with their neighbor with the yellow ribbon. People would go around and slap each other on the back and wear the yellow ribbon and feel like they were part of something. I think it has to do with belonging to something. And for a lot of people that has to do with belonging to the U.S.A. I personally found the display of yellow ribbons really disturbing. The lack of sensitivity to the hundreds of thousands of people we were slaughtering while we were having our big parties is really so sad and so disturbing. . . .

WILLIAM HARTGROVE

WILLIAM HARTGROVE is the night manager at Frank E. Campbell Funeral Home, located at Madison Avenue and 81st Street in New York City. Campbell's is referred to in Tom Wolfe's book The Bonfire of the Vanities *as Harold A. Burns's, "the most fashionable funeral parlor in New York." This interview was conducted in Mr. Hartgrove's office.*

THE NEW MUSEUM: *What is it that you have been asked about the most in your years in the business?*

WILLIAM HARTGROVE: Probably what people ask the most about—because it's the thing very seldom discussed—is embalming. I don't know why everybody's kept it such a secret over the years. There's such a mystique about this business, as though some secret little thing was being done. But that's not true. This business is very highly governed by the Department of Occupational Health and Safety, and the law states that the embalming room be off-limits, except to authorized personnel. But that's basically because of the chemicals we use. The law also says that a family member or a representative of the family can witness the process.

TNM: *But it seems that it's rarely said to relatives that they can witness the embalming.*

WH: That's true. Because it's not the type of thing that people typically. . . . But when families ask if a nurse or someone they choose can be with us while it's being done, we respect that. And on three occasions that I can think of, people have walked out saying, "I was afraid to come in, but I didn't realize it was as uncomplicated as that." You know everybody has an idea in their mind.

TNM: *Probably because nobody ever talks about it.*

WH: Right. And, many people confuse embalming with postmortem examinations, with autopsies.

TNM: *Is the embalming procedure different if there has been a postmortem autopsy?*

WH: Oh yes. Totally different. When you're embalming a non-autopsied body, you use the normal circulation system of the body; everything is flowing through the body as if the heart was pumping the blood. In the case of an autopsy, organs have been removed. So when it comes to embalming, you have to do it, to be very blunt, in sections.

TNM: *Embalming in sections?*

WH: Yes. An arm, a leg, whatever. Because you don't have the full, unobstructed circulation system.

TNM: *Is there a law in this country about embalming? Is there an obligation to embalm?*

WH: No. There are certain circumstances in which it is required, say, if the body is leaving the United States and going to France. The French government requires that any body coming into France be embalmed. But many religions do not believe in embalming. Orthodox Jewish people do not, Muslim people do not. When most people come to a traditional Christian funeral in the United States, the casket is open and the body is embalmed, so people think this is something that has to be done. It does not. There's no law that says this has to be done. Only in certain circumstances.

TNM: *Can you take us through the steps of what happens to the body after it arrives here?*

WH: First, the body is brought to our preparation room, where it is washed and disinfected. The eyes are closed and the mouth is closed. The embalming itself is a simple procedure. It requires a very minor incision of the major artery and vein. Then we inject the embalming chemical through the artery, and the circulation system takes the chemical through. It is drained out of the major vein to get rid of the blood and body fluids.

TNM: *What about piercing the organs?*

WH: Yes, that's necessary, too—to remove any fluids that might be in the stomach and bowels.

TNM: *That's a procedure that's rarely mentioned.*

WH: But everybody seems to have questions about that. Many times when I meet people, they say, "Oh, you're the first funeral home director I've ever met. Does such and such really happen?" The best way I've found to explain the piercing procedure is to say that it's basically the same process as liposuction. (Laughter.)

TNM: *And then?*

WH: Then we dress the body. Everyone is bathed, shampooed, manicured. For women, we'll do the hair, including, if it's requested, dye jobs, bleaches, cosmetics—either with their own or with ours—working from a photograph or description from the family.

TNM: *And how long do you typically have? A day? A few hours?*

WH: Usually, at least a day, sometimes a little longer. And we always ask the family to come in early to make sure that everything is fine. If they want anything changed, then our staff is here to make that change. Sometimes, unfortunately, because of illness, there are some things that are beyond changing.

TNM: *Can embalming make a person look younger?*

WH: Sometimes. If somebody has been sick, particularly with a fever, or has wasted away, there's a certain amount of dehydration. And we use lanolin-based embalming fluids that add a little bit more moisture. So the person might have a more youthful appearance.

TNM: *What are those fluids?*

WH: Basically, some formaldehyde-based fluid with additives such as lanolin. We also use some dye for cosmetic fluids that give natural skin tones. Because your color is basically given to you in life by your blood. We even have cosmetics and additives that can give you a suntanned look.

TNM: *Do you feel that this attention to the appearance of the body—to make-up, hair-styling, and the rest—is linked to the way we view death in our society, to the idea of death as a spectacle?*

WH: No. I think it's just a way of helping people get through the grief process—by giving family and friends a final memory that is one of something good. You can never get that out of your head—that final look, that last image. If someone looks well, if they look as you've known them—with their hair the way they wore it, with their coloring the way it was, your memory will be a better memory.

TNM: *When did embalming start in the United States?*

WH: Probably during the Civil War. When Northern soldiers were killed in the South, some families wanted the bodies brought back to their home. And in those days, it was by train or whatever; it could be days, or weeks before the body arrived. Embalming was the best way to preserve the body. But it's not a new procedure. It started with the ancient Egyptians.

TNM: *How has the procedure changed over the years?*

WH: Well, it's a much different procedure. As years go by, everything gets a little bit more scientific.

TNM: *How does one learn embalming?*

WH: There are several schools throughout the country. But as with most schools, they teach you knowledge and theory. One really learns one's profession by working under someone very good and experienced. Theory is wonderful, but practical experience is much better. Years ago, people came into this profession because their parents or some other family member was in it. But now, it's more like any profession. Most people choose it because it's something they think they'd like to do. Of course many people think they'll be wonderful funeral directors, until they start the business. Then they say, "No, this is not for me." You have to be emotionally able to handle just about every expression of grief, and those feelings can run the gamut—anger, hatred, love. You have to be able to cope with this. You have to like people and have a willingness to help. This is probably the most difficult thing that most people ever go through in their lives.

TNM: *How did you get into this business?*

WH: Well, I'm from a small town in upstate New York. And when you're a young person in a small town in upstate New York, and you want to make a few extra dollars, one of the things you can do is help the local funeral director open the door and greet people, park the cars, and line the cars up for the funeral, and that's what I did. And I decided that it's not such a bad business at all. I liked helping people and I found that this was a way that I could do it.

TNM: *You've now been at Campbell's for twenty-one years, and in the funeral business twenty-six years. What are some of the changes you've seen over the years?*

WH: At one time it was customary to have friends coming in and visiting at the funeral home for three days, and then on the fourth day, you would have the funeral. That was understandable because people would have to come from all around the country. They may have had to come by train. Traveling was not as fast as it is today. Over the years, those three days became two. And often, now, you'll find people will have visiting and receiving friends for a day, maybe a day and a half, and then the funeral the next day. Also, people don't always wear black, or wear black for a year. Things have changed and modernized with the times.

One of the biggest changes, though, is a kind of change in attitude. People now, more and more, think of a funeral as a celebration of that life. They're celebrating the existence, the life of that person who passed away. It is a sad occasion, an occasion of mourning, but it is also an occasion of rejoicing about that person's existence.

TNM: *In recent years, with AIDS, a lot of younger people have been dying. How do you see people responding to this?*

WH: That's very hard. One of the problems is that there's been a big press build-up that has made people afraid. They think that if you just walk by someone with AIDS, you're going to get it. Because of the stigma, some people are made to feel ashamed. And I think that's basically a crime. That's taking someone's life—a dignified, respected life—and taking that dignity away, because you don't understand.

TNM: *Have you experienced any of that lack of understanding among people who work in the funeral home?*

WH: I'm sure there are some places where it exists. I've known people who have called other funeral homes before they called us, and felt they had to ask, "Oh, will you handle an AIDS case?" I'm really proud to say it's a question that doesn't even have to be asked here.

TNM: *When was the first time you worked with a dead body?*

WH: I was sixteen, and helping that local funeral director in my hometown. You know everyone in a small town, so, of course, the person who had passed away was someone I also knew. When the funeral director was called out of the room, it was the first time that I had even been completely alone around anybody that had passed away. For about five minutes, I kind of had the shakes. But then I said to myself, "What are you afraid of? There's nothing there to hurt you."

TNM: *And in terms of the procedures?*

WH: Basically, I had very good teachers, very fine people. I was comfortably brought into what was happening, a step at a time—everything was explained to me. So I adjusted well.

TNM: *When you're embalming people, do you feel you're involved in some kind of ritual? Or does it feel very matter-of-fact, very medical and technological?*

WH: Not matter-of-fact at all. I'm always thinking this is somebody's mother or father or sister or whatever. If it becomes a routine job, if you're forgetting that there's somebody that's going to be coming into that room to

see that person and it's someone who they loved, then you'd better get out of the business. I've had death in my family and I know how I felt. I can imagine what other people are feeling too. And I remember that first.

TNM: *What are other kinds of services the funeral home provides?*

WH: Anything that we can. We help call the cemeteries. We contact the minister. If you do not have a minister or rabbi, we have people that we can call for you. We have a musical service that we can call to arrange for any type of music, from disco to Dixieland. It's what your wish and preference is. Nothing is strange if it's right for the moment and right for the person. We had services for someone that was a DJ in a local disco, and it was all disco music. That was right, and what it should have been. Someone that loves classical music can get string quartets. We have choirs. Again, it goes back to what I was saying before, about a funeral as a celebration of life, how the person lived, what he or she enjoyed. That's what it should be.

TNM: *What are your specific responsibilities now at Campbell's?*

WH: I don't do any of the physical work with the body, but I make sure that it's done right. In addition, I train our staff and supervise our receptionists to make sure that our families and guests are greeted and treated properly.

We're something like a very elegant but intimate little hotel. Many places call their rooms, "Room A, B, C," or "1, 2, 3," We have "the Mayfair, the Madison, the Orleans, the Library." We're trying very hard to take away—and we do succeed, I hope—from that commercial feeling of the funeral home. This building was converted by Mrs. Campbell in 1938 and her vision was to create a home-type atmosphere. Every one of our rooms are done up as a living room in a private home. There are no rows of folding chairs. You walk into a drawing room and the only difference from being in a private home is that there is a casket displayed at the other end of the room.

TNM: *When was the Frank E. Campbell Funeral Home founded?*

WH: Mr. Campbell opened the funeral home in 1898 in Chelsea, and moved to Broadway and 66th Street. That's where we had the funeral service for Rudolph Valentino, and that's what made Frank E. Campbell famous. We moved into this building on Madison Avenue in 1938, and we've been here ever since.

TNM: *Can you tell us more about your clientele?*

WH: You know death is a great equalizer. It doesn't matter whether a person is a celebrity, a political figure, or a society figure in New York. When they have a death in their family and they come here, they are getting the service that anybody else would get. We sit, we talk, we help. That may be a famous person you're talking with, or the family member of a famous person, but that person just lost somebody. And that feeling of grief is the same for them as it is for anyone. They don't want to walk in that door as a star. They are walking in that door because they lost somebody.

GEORGE BENTA and KAREN RODRIGUEZ

GEORGE BENTA is the director of Benta's Funeral Home. KAREN RODRIGUEZ, his daughter, is also a licensed funeral home director and works with her father. We met Mr. Benta and Ms. Rodriguez at Benta's Funeral Home at 630 St. Nicholas Avenue in Harlem. Prior to the interview, they gave us a tour of the home and its facilities.

THE NEW MUSEUM: *Your grandfather and his second wife founded the Benta Funeral Home in 1928, then your father took over, and now you're working here.*

KAREN RODRIGUEZ: That's right. And I would say that my experience goes beyond the average funeral director's, because I grew up in a funeral home. And it wasn't nice like this. In those days, we were located in a brownstone—the funeral parlor was on the first two floors, and we lived on the upper two. When I was a kid, I actually had to pass the human remains to go upstairs to where we lived.

TNM: *How did you feel?*

KR: I was frightened. I'm not frightened now, but I definitely used to be when I was a child. But I got used to it.

TNM: *As you grew up, did your parents encourage you to go into the business?*

KR: My father always said that, well, you can do whatever you like, but it would be foolish for you not to carry on. So I consider that brainwashing. (Laughter.) But I'm not unhappy about my decision. When I was young, and my friends were working for, let's say, ABC or IBM, some fancy large corporation, I was a little jealous. But then, as we got into our thirties, and they became disappointed or disillusioned because they weren't moving up the corporate ladder the way they should have . . .

TNM: *Are you talking about racism?*

KR: That's right. It's out there. It happens.

TNM: *Do you feel you have a different relationship to death than other people have?*

KR: Well, I was forced to confront it early on. These days the idea is that children ought to be involved. Back then, children weren't faced with death until they were older. But passing that chapel everyday when I was growing up, I couldn't avoid thinking that, "Oh my goodness, one day everybody I know and love, including myself, is going to die." I was upset about it, but mostly I tried to keep it in.

TNM: *What did you do to get over that?*

KR: I just grew up and was faced with, "I had to". (Laughter.) This is, of course, my profession.

TNM: *Do you think people view you as different because you're in this business?*

KR: It's funny. People don't expect us to be hanging out in bars. You know—not that (laughter) my father and I do—but some do. But it's more than that. People don't want to know what you do for fun, or that you have fun . . .

GEORGE BENTA: Yeah. I'll go places and people will say, "Mr. Benta, what are you doing here?" And I think to myself, "What do you mean, what am I doing here?" (Laughter.) I am just an ordinary man.

I just want to say another thing too. When I was a kid going to school, I remember the teacher asking us, "What kind of work does your father do?" And I would never say he was an undertaker, because the kids would laugh. I used to go to dances, and girls wouldn't dance with me because my father was an undertaker, okay? That will just show you how the people felt—some people—about the funeral profession. Now, I'd tell everybody that my father was a funeral director. I'm proud of it. Because we have made great strides.

TNM: *Are there traditions specific to African-Americans in terms of funeral parlors or practices?*

KR: Not really. Black American people are Methodist, Catholic, Jewish, Moslem, everything! We're even Buddhist. So here we follow the practices of whatever religion. We consider ourselves inter-denominational. We bury anyone—we have no problem with that.

TNM: *Are there religions that are opposed to embalming?*

KR: The Jewish people and the Moslems don't care for it. But often, with Moslems, the whole family is not Moslem. So then you're walking a delicate line—embalming is not required by state law, but people look much better after they're embalmed so it's to everyone's benefit if there's going to be a public viewing. And so we have embalmed Moslems, but at the family's request.

TNM: *Are embalming procedures the same everywhere?*

KR: Yes, I would say. It's an arterial process. The heart pumps blood throughout our bodies, throughout our lives. After death, the heart is not working, so we use a pump to embalm, a machine that displaces the dead blood with chemicals that give a life-like appearance.

TNM: *When people describe embalming, they rarely refer to the procedure that takes out the body gas and liquid.*

KR: Because it's unpleasant. It's not really necessary . . .

TNM: *To do it? Or to talk about it?*

KR: To talk about it. It's not pleasant to describe it. It doesn't sound good. We have to use an instrument called a trocar—it's a long metal rod. And we actually have to pierce or puncture different organs so that the gas can escape, and the fluids can drain.

TNM: *I was told that a skilled embalmer can do the three organs at the same time, can go inside and pierce all three organs with one hole.*

GB: Yes, that's true, if the person who died isn't obese. In one hole. Yes. You don't have to take it out unless the person is obese. But ordinarily, you can aim about 3 inches to the right and about 2 inches above the navel.

And you make your incision there with your trocar. First you get up here, around the throat, shoulders, clavicle, get all the food out of the cavity, and then you puncture around here, the lungs, the kidneys, and spleen. And then you turn around, and send it down into the bladder, and then try to break up the intestines. Now, the intestines are not firmly in place—they move around. So you may have to keep sticking the trocar. The trocar has a rubber hose. At the other end of the trocar, there's a rubber hose that extends into a bottle, and then from the bottle there's a hose going into the pump, which sucks it up.

TNM: *Is Benta the biggest funeral parlor in Harlem?*

KR: Yes. There are about thirty funeral homes in Harlem—sometimes two or three on a single block in converted brownstones. But we're highly respected and considered the top shelf funeral home. Thirty years ago or so, black dignitaries also went to Frank Campbell. But since we've come along, we've buried such notables as Paul Robeson, James Baldwin, Dr. Green, the chancellor, and many more. Count Basie was laid out here.

TNM: *When you first came to Harlem, were there only white undertakers?*

KR: Of course! Harlem was a white community at one time. We invaded it!

GB: In those days, a funeral cost three or four hundred dollars. Now it would be $4000-$4500. But even though it was $300 in those days, it was still a lot of money for blacks to pass among themselves. Whoever that funeral director was, he became an outstanding character in the community. Yeah! He was doing good. He was damn near wealthy!

KR: Yeah, and he was also self-employed. So back to what I said about being jealous of my friends working for a big companies. One day it hit me: I'm self-employed—I'll be the last to be fired. Or the next to last; he (pointing to her father) will be the last. (Laughter.)

TNM: *After all these years in the business, has your attitude towards death changed?*

KR: Well, I guess I'm still sorry everyone has to die. But I figure if everyone lived, there would be no space on earth for the new people to come, for my grandchildren or anyone's grandchildren. There's nothing we can do about death, so you have to make peace with it within yourself.

GB: But working with the dead bodies, it takes some getting used to. When I went to school in my day, we had rubber gloves. My father didn't have rubber gloves in his day. They embalmed with their hands—no gloves, no nothing. I was finicky. I didn't want to touch the body without my gloves. But with gloves, I managed to get around.

TNM: *And how did you deal with the . . .*

GB: Down at the morgue? You get accustomed to that, too. The odor was strong, but you get accustomed to it. All the other fellows are there. You don't want to act like a baby, or a sissy, that's a better word. My father said when the gloves came out, a lot of the old-timers didn't want to use them. But I wanted to use them! I'd get the biggest pair of gloves I could because I didn't want to go inside the cavity and let the rib-cage touch my flesh. You know, I'm scared! But you get accustomed to it. Now, it doesn't bother me.

TNM: *Is it actually dangerous?*

GB: Sure! You can catch germs! Dead people are dead from germs! Come on! (Laughter.) I don't mean to be funny, but how do you think they died? (Laughter.)

TNM: *What do you think about the fact that, since AIDS, a lot of people are dying younger?*

KR: Yeah, people are dying younger, and AIDS is one cause. But it's not the only cause. Unfortunately, there's homicide.

TNM: *What do you think of all this violence?*

KR: Oh, it's awful. It's sickening. Funeral directors are happy to wait for someone to turn ninety-nine. A few months ago we buried four young black men within a two week period. And this is just one funeral home.

TNM: *And how about AIDS?*

KR: We just take more precautions. At first, some funeral homes were frightened and they refused. But we always handled AIDS patients—we just charged a little more. We were fortunate to have an employee, at least one employee, that consented to embalm those cases. We paid him a few extra dollars, and he was happy to do it.

TNM: *And do people feel more relaxed about it now?*

KR: AIDS? Yeah. When it first came along, people would do anything in their power not to mention it. But the death certificate would say, so we would know. We would respect their sense of privacy. Everyone was uptight about it at first, sort of ashamed.

TNM: *What happens to the blood of the human remains when you embalm?*

KR: It goes out the sewage system.

TNM: *The regular sewage system?*

GB: Yes. But we have a separate line for that. In other words, we use the city water, but we have separate plumbing. And we have valves to shut it off, so there would be no backfiring into the house system.

TNM: *Is that true of all the funeral homes?*

GB: Yeah. Now. But not years ago when I was a kid. Now we have a separate tank, and you can hear it when it's emptying out of the pool—whoop! You can, you know, sort of hear it—it sort of whips. It's in that little room over there. They made us put that in. Or else they wouldn't give us the license to operate.

TNM: *How old are you?*

GB: I am sixty-nine years old. I'll be seventy in September.
TNM: *You're so full of life. Have you always been like that?*
GB: No, not always.
KR: I think, in general, funeral directors are a jovial bunch (laughter). We're faced with the reality of death everyday, so we realize we have a limited time here to enjoy ourselves, to be nice to other people.
TNM: *Do you think about your own death? How do you feel about it?*
GB: I don't like it at all. (Laughter.) In fact I told my granddaughter, "Heaven is my home, but I'm not homesick."
KR: In other words, he's not anxious to go. (Laughter.)
GB: But I'm planning. I have a spot in the cemetery. I took my new wife to see it. My mother, my step-mother—she's there, my father's next to her, my sister's on top of my father, and my former wife is there. I was supposed to be buried with her. But I didn't know I was going to get married again. So I'm married. And I think it's a little disrespectful to demand that I be buried over my first wife. Where will my second wife be buried? Over my mother?
TNM: *Can she be buried on top of you—can there be three?*
GB: No. Only two. And in this business, you know, we realize you have to think about things like this.
TNM: *When someone in your family dies, do you deal with them?*
KR: What do you mean, "deal with them"?
TNM: *Would you prefer that the body be sent to another funeral home?*
KR: Oh no. The work is here.
GB: My mother—my step-mother—she always used to say, "Keep me here as long as you can, and then take me to church the morning of my services." And that's exactly what we did. And that's what I want. I don't want to go to church until the last minute. If you really want to know, I don't want to be seen. I don't particularly care to be seen by outsiders. I don't even want to be embalmed.
KR: But that's pretty hard. When you're a funeral director, especially one of note, it's tradition that you have a traditional funeral with a viewing. So that's what his wishes are, but most likely, they won't be respected. Because usually, when there's no embalming, we'd prefer to have no viewing. People don't look so hot.
GB: And you can't close their eyes or mouth. They don't stay closed. I mean you bring them down—like this—but they begin to open up.
KR: It's just different. The eyeballs sink back. And the color that we all have—the life color we get from the oxygen in our blood becomes quite different. A grayish palette.
GB: Whether you're black or white?
KR: Yeah, any shade. It doesn't matter. Life is life; death is death.

ALCOR

SAUL KENT is director of public relations and a member of ALCOR, an organization dedicated to cryonic suspension, which he defines as "the study and achievement of low temperature preservation of human beings for future revival." (The name ALCOR is a loose acronym for Alopathic Cryogenic Rescue; it is also, according to Brenda Peters, the name of a star. Legend has it that those who can see Alcor, which lies very close to another star, are far-sighted and of great vision.) BRENDA PETERS is a member of the Board of Directors of ALCOR. Also present at the interview was Jo Ann Martin, a member of ALCOR. This interview was conducted in New York City.

THE NEW MUSEUM: *Was ALCOR the first organization to "freeze" someone?*
SAUL KENT: No. The first person put into cryonic suspension was a psychology professor named James H. Bedford. He was frozen on July 12, 1967, by a group called the Cryonic Society of California.
BRENDA PETERS: But, Dr. Bedford is in ALCOR's care now, and has been for many years.
SK: That's right. For varying reasons, a number of other people who were frozen have not remained frozen. But he's still around. You see, there have been various problems. Even in Dr. Bedford's case, shortly after he was frozen, some relatives sought to take him out of suspension. But his wife and son and one other relative fought off the legal attempt.
TNM: *And how many patients now—because I understand you call them patients—are in suspension?*
BP: Well, ALCOR has seventeen in suspension. I think there may be another seven or eight elsewhere.
TNM: *So there are a number of organizations that do cryonic suspension?*
SK: No, there are basically only a few. There's ALCOR in Southern California. Another is the American Cryonics Society, working with a company called Trans Time in the San Francisco area. And then there's The Cryonics Institute in the Detroit area. The head of the Detroit group is Robert Ettinger, who wrote the book in 1964 that started this idea, called *The Prospect of Immortality*. But there have been other organizations at various times. For instance, I was one of the founders of a group in New York that operated for a number of years in the '60s.
In fact, I was one of the people who invented the word cryonics in 1965. "Cryo" means cold, and we just came up with the word "cryonics," and it became the Cryonics Society of New York.
TNM: *How does someone arrange to be frozen?*
SK: What ALCOR emphasizes as much as possible is that if you are interested in this idea, you should contact us while you are still healthy. Because if you are already ill, and particularly if you are close to death, it becomes

much more difficult. One reason is financial: if you expect to use life insurance to fund it—and this is the way most people handle it—you probably can't get or afford that insurance once you are ill. There are a whole variety of reasons. So, most of our current members are in good health.

Now, let's assume that you've contacted us and made preparations, and let's say you're ill in the hospital and there's a likelihood that you're going to die in the fairly near future. What ALCOR does is assemble a team of people who stand by in the hospital, with the permission of the hospital personnel, and as soon you are pronounced dead by a physician, certain procedures are done to quickly try to prevent the kind of damage that occurs at normal body temperature, which is primarily ischemia. Ischemia means, essentially, damage due to lack of oxygen.

TNM: *Damage to the brain or to the whole body?*

SK: Let me put it this way: the person is already damaged because he or she can no longer be maintained by today's physicians. So obviously something is wrong already. But the critical thing at this point is to try to avoid as much damage to the brain as possible. First, you want to try to get the temperature lowered quickly. But you don't have to lower it that much.

TNM: *And how do you lower the temperature?*

SK: First, there are certain chemicals that need to be injected very quickly, and incisions have to be made, and there has to be someone who can do things like that. Chemicals, for example, to stop or inhibit coagulation of the blood, chemicals to protect against ischemia, and some other types of chemicals. And then just regular external ice. You also want to be able to cool internally, and ALCOR has some portable equipment which we use for that purpose. There are some procedures that don't take more than ten or fifteen minutes in the hospital, and then the patient can be moved to our ambulance, and depending on where the hospital is, work can be done in the ambulance, or the patient can be taken to ALCOR. Or, in some cases, the work has been done in a funeral home.

TNM: *Do you keep their vital organs functioning during this process?*

SK: Well, yes, essentially . . .

BP: Yeah. Essentially, the person is put on a life support system. We keep their heart and lungs going artificially so that their blood is being oxygenated.

SK: There's equipment to start internal cooling. You send cool fluids through the vascular system to cool it from within while you're cooling with ice from the outside. It's a long, slow process. You're starting at normal body temperature and your endpoint is liquid nitrogen temperature—that's minus 196 centigrade which is minus 320 Fahrenheit. And it takes a long time. There are several stages: first, by cooling, getting the temperature as quickly as possible down to ten, twenty degrees below normal. Next, we bring it down close to the freezing point. Then, there is dry ice storage. And, finally, there is liquid nitrogen storage.

TNM: *How did you come up with the technology and techniques to do suspensions?*

SK: There's a critical point that divides the past from the present. When we were first freezing people in the '60s, we couldn't get medical people to cooperate to any great degree, because it was so unorthodox. So at that point we were doing it very crudely. We were using a funeral director and a funeral director's pump, for example, to perfuse the chemicals. Then, in the 1970s, a fellow named Jerry Leaf came on the scene. Leaf wasn't an M.D., but he was working at UCLA in the division of thoracic surgery in the department of surgery. And his job was, essentially, managing the lab that tests new techniques.

BP: That lab was pretty much the world leader in myocardial protection, and the research they did there saves hundreds of thousands of lives now yearly. He worked there for about seventeen years.

SK: That's right. So Leaf had all the skills to do all this perfusion and surgery in a medical fashion, and he became interested in cryonics. So Leaf is the person who can be credited for the way in which cryonic suspension is now done—as professionally as the surgery in any major hospital.

BP: So things have advanced considerably. Now, for example, at ALCOR we have an M.D., research scientists, biochemists, kidney dialysis technicians—people like that actually do the suspensions and are involved in most of our research.

TNM: *What does it require legally to arrange a suspension?*

BP: Oh, things have changed in that area, too. The legal work used to generate stacks of documents about three inches, four inches high, but we've brought it down. Through some lawsuits, we've finally made it clear that cryonics is legal—people *do* have this option. So, we're down to just four or five documents now.

And, of course, if people have a will, it's good for them to put in the will that they want this done. If they don't, relatives sometimes come along, and try to have the cryonic suspension stopped. But at least we now have the documents that will help assure that you get a cryonic suspension if that's what you want.

TNM: *Do people make special requests?*

SK: Yes, and some that really can't be guaranteed in any way. For instance, I was talking to a couple the other night and she asked, "Well, can we come back together?" And I said, "Well, we can't guarantee that you can go together or come back together, and we can't even guarantee that you'll *want* to come back together."

Or sometimes, they say, "I only want to come back if there's world peace." In that case, they may not ever come back.
You see, ultimately, there's no *guarantee* of being brought back at all, much less how you are going to be brought back, or *where* you're going to be back, or in what condition. At this point, it's enough of a job just to make sure you get frozen and to make sure you're maintained.
Having said that, I do want to point out that a number of us involved in cryonics believe the greatest obstacles are social, political, and economic, rather than technological. We feel that if you get frozen under good conditions today, that ultimately it will probably be possible to restore you. The question is can you be maintained long enough for that restoration to take place? And that's more of a social, political, and economic problem than it is a technological one.
TNM: *How would you like to come back?*
SK: Exactly as I was around the age of 30 or 35. You see, there's a good possibility—given advances in molecular technology—that by the time we'd come back, it will be possible to make all kinds of changes in yourself. And not only to change yourself, but to do it frequently and easily. I mean, even today, with its crude technology, people can have sex changes, for example.
So when I come back, I may want to be stronger or smarter—who knows? But I want to be the one who makes those decisions.
BP: I don't really think too much about it. I'm just working on making sure that I get suspended, getting the word out about cryonics. I figure that the more people involved, the better chance we have of pulling this off. But when the time comes, if it's fashionable to be three feet tall and green, I may want to go that route for a while.
TNM: *And what about your memory, your life, your thoughts, your emotions? Would you like to come back with all of that?*
SK: Unless you do, it won't be you. So, yes—I think everyone wants to come back with as much as possible of that which defined them before they were suspended. One of the things that we discuss at times is what if you come back with 90 percent of your memories: will that still be you? That's one of the reasons I think the issue of identity is going to be one of the major practical and philosophical issues of the 21st century: who are you, who were you, who do you want to be, what do you want to become? Possibly, you can become more than one entity—but let's not even get into that.
BP: Right. If I've forgotten my favorite flavor of ice cream, I won't mind so much. As long as my basic philosophy is still intact, then I'll feel like I'm me.
TNM: *Is it true that some people choose to suspend just their brain?*
SK: Yes. The basic assumption of neuro preservation—given the potential of molecular technology—is that the brain is enough to preserve you. The rest of the body can be replaced easily; the only thing that can't be replaced in the future will be the brain. There are some people that even think it will be possible one day to upload and download information from the brain into a computer, a very advanced computer.
BP: It might be easier to grow a new body from your DNA, just as we do everyday when we make babies.
SK: I'm signed up for whole body suspension, even though I have no anticipation of my entire body being repaired. The reason I'm preserving my entire body is that there is evidence—particularly in the spinal area and some other places, too—that might be useful in creating a new body.
TNM: *What is your definition of death?*
SK: We have a definition of death that differs from that of most other people in this world. And, we think it's the right definition, but that's for each individual to decide. Traditionally, a person is pronounced dead when he or she has reached what is considered irreversible loss of function. Years ago, that meant when you stopped breathing, when your heart stopped beating. Now that we have more sophisticated technology, thousands of people are "restored to life" after that point. Still, the criteria, though the limits have been stretched, are predicated on loss of function.
Our criterion for death, on the other hand, is predicated on loss of structure. So that as long as an adequate structure remains in the brain—even if a fair amount of damage is done and no function can be restored—that human being is still viable. It is possible, ultimately, to restore function by rebuilding the structure that's missing from the structure that still exists. Look at it this way: if you have a piece of paper with a drawing on it and you tear it up into twenty pieces, you can still put those pieces back together and see what's there. So even though the piece of paper with the drawing is totally non-functional when it's torn into pieces, it's potentially functional. On the other hand, if you burn it up in a flame, then you can't restore it.
The point is, in a sense, that we give up on people too soon. I mean, the majority of people who are pronounced dead are ninety-nine percent alive.
TNM: *In an ideal situation, would it be preferable to go into cryonic suspension before the currently accepted moment of death?*
SK: Well, the answer is yes. But here we run into some real problems, legal and otherwise. A lot of people just don't understand. They focus so much on the idea of trying to deal with death, but the thing we're interested in is how to avoid it. Animals have it a lot better than us. They don't have to wait until they are pronounced legally dead before they can be frozen, and there are some animals that have been frozen before they actually

reached the accepted moment of death. They have advantages over us in that respect.

TNM: *How does religion enter into this?*

BP: We have members who are religious. I think they just say that heaven can wait.

SK: We are getting more members who are religious. I think the reason why we haven't had more before is because a lot of people who are religious have this vague notion that there is something wrong with cryonics in terms of their religious belief. But even if an afterlife is part of that religion, it doesn't say when that afterlife has to come. Anyway, if anyone is going to be brought back from this, they *were* never dead. They may have been pronounced dead, but we don't consider them dead. So the jury is out, the experiment isn't over. We don't consider these people dead, that's why we call them patients. And I think society will eventually agree with us.

TNM: *Have you ever "thawed" one of your patients?*

SK: No, not at ALCOR. Other organizations have had to take people out of suspension. You have to understand that damage is caused by freezing and thawing, and the odds are there is more damage caused in thawing. At this point, we don't even attempt to thaw people because we know we can't do it. That's going to be solved in the future.

TNM: *I understand that you don't accept all applications to be frozen. What kind of criteria do you have?*

SK: First, informed consent. They have to understand what they are doing. For last minute cases, we have to make sure that the person who is responsible fully understands the idea and doesn't have any misguided notion of what the prospects are. Secondly, they have to be able to afford it. Under extreme duress some people will say they can afford it, and they really can't. Thirdly, the conditions under which they are going to be frozen play some role. There have been people who have been dead for several days whom relatives want frozen. Their prognosis is very, very bad. However, that alone is not going to keep us from accepting somebody. We had a case in which the family of a twenty-one year old girl who died suddenly in Spain approached us. She was in, probably, the poorest condition of any patient I've seen so far. We tried like hell to convince the family not to do it, but they just were so insistent. We threw all the roadblocks in the way and they wouldn't stop. They said they had to do this. So we did it.

But for every case that we take, there are at least four or five that we refuse. And very often when you start throwing roadblocks, it turns out that they didn't really want to do it.

TNM: *How many members do you have?*

SK: 242 full members of ALCOR and about 205 in the process of signing up.

TNM: *Once you sign, can you change your mind?*

SK: Sure.

TNM: *Do you lose any deposit or anything?*

SK: You lose your membership dues and the initial sign-up fee of $300.

TNM: *That's all?*

SK: The biggest expense is the money to pay for your suspension. And if that's through life insurance and you change your mind, you just change the beneficiary to anyone you want.

TNM: *Can you give us a sense of the kind of person that signs up?*

SK: That's changed over the years. In the '60s and '70s, it tended to be more men than women. More single people than married people. Primarily whites—very few minorities, if any. People who tended to be interested in science, who tended to be interested in computers.

In the last few years, we've had many more women. We have many more children signed up—of course, that depends on the parents signing them up. And we're getting all kinds of people. But one thing I find interesting: in general, the people who have signed up continue to be far more interested in the sciences than the arts. Traditionally, people in the arts have not reacted as positively as people in the sciences.

TNM: *Do your members wear some kind of identification bracelet?*

BP: Here, I'll show you mine. Sometimes I don't wear it. I just keep it with my driver's license.

SK: If we were in an accident, we hope that medical personnel would follow the instructions on the bracelet. But the instructions are primarily for technicians when they arrive. I don't think the average person would be able to do any of that.

TNM: *It says "no autopsy, no embalming."*

SK: That's right. The big risk in dying in an accident—aside from the fact that they'll totally ignore the rest of those instructions—is the autopsy situation. Most accident victims are autopsied. And if you're autopsied, a full autopsy, you're in big trouble, because they chop your brain into pieces. We're working with medical examiners and coroners now to try to avoid autopsies in as many cases as possible. And if an autopsy is necessary, to try to avoid doing it on the brain. And even if they have to do it on the brain, they don't have to chop it into pieces. They've just gotten used to doing it that way, I guess.

TNM: *What seem to be the most promising recent scientific developments for cryonics?*

SK: The problem of freezing damage is a problem associated with the formation of ice crystals. Dr. Gregory Fahy is working on a technique at the American Red Cross in Bethesda, Maryland called vitrification. Vitrification is a way of lowering the temperature of biological systems without ice crystals being formed. Right now, Dr. Fahy is trying to perfect the vitrification of

kidneys to be used for transplant. He's very close to that. We may be able to use that technique to preserve the brain perfectly in the near future.
Also, at ALCOR, we're planning some research on memory preservation in animals. We can freeze animals partially, and then bring them back, particularly hamsters. So we're going to teach them something—how to negotiate a maze, for example—then freeze them, then thaw them, and see if they remember.
TNM: *Is Walt Disney frozen?*
SK: You can never prove that a person was not frozen. You can only prove that they were. So, I don't think so, but I don't know. I have had people walk up to me and scream and yell that they *know* that Walt Disney is frozen. But I ask them where and they can't tell me where.
As I said, this is a rumor that need never die, because you can never prove that he *wasn't* frozen. There's some basis for it, in that he appears to have been interested in the idea and he died shortly before Bedford was frozen. He died, I think, in December of 1966, and the story is that he was interested and he said something about it, but he didn't make any firm arrangements. In fact, there really wasn't much of an organization to make arrangements with at that time. But, setting aside the question of Walt Disney for a moment, I can say that at ALCOR, we have a lot of very interesting letters in the files from very well-known people. Their identities are confidential, of course.
TNM: *Does your vision of the future include the idea that people will live for a prolonged and indefinite period?*
SK: In my opinion, yes. We will achieve an indefinite life span. The only likely cause of death will be accidents, murder, suicide—perhaps some disease, but it's unlikely. Furthermore, I predict, though I certainly wouldn't guarantee, that by the end of the next century, we will have already achieved or be very close to achieving the means to have indefinitely extended *youthful* life. People who are already old will be able to be rejuvenated. I mean, we are all going to come back young, or we are not going to come back at all.

MYRON EBERSOLE and JO ANNA WHITE

The Reverend MYRON EBERSOLE is a Mennonite minister who is the director of the Department of Pastoral Services and Center for Religion and Health at The Milton S. Hershey Medical Center, affiliated with the College of Medicine, Penn State University in Hershey, Pennsylvania. JO ANNA WHITE is an Episcopal priest in training with Reverend Ebersole. This interview was conducted at the Hershey Medical Center.

THE NEW MUSEUM: *What are the most common kind of questions that medical students have about death and dying?*
MYRON EBERSOLE: I think medical students are as ill-prepared as any of us in society to deal with death. So they are wondering, "What is it like as people face dying? Can we know what takes place in dying? How does it happen, and what takes place afterward?" There's a lot of anxiety. Contrary to what may have been the case fifty years ago and before, when doctors dealt more regularly and intimately with what we might call "natural" death and dying, death has come to seem more of an enemy of medicine. It's only in the last few years that we are regaining the recognition that we have to teach doctors how to deal with dying.
TNM: *What kind of training did you have over the years?*
ME: Well, my training started when I was eleven years old, when I saw my grandmother die in our farm home in Illinois. I did not realize then how much of a privilege that was. A privilege because it took place within my family circle, a bidding farewell to someone we loved and knew. Certainly, there was a mystery about it, and people did fear sudden death, untimely death, and so on. But, my grandmother's death was a blessing for her, and for all of us. It was a good experience.
Years later, I spent time in the Middle East. I worked with Palestinian refugees, and I saw a lot of suffering there, and occasionally death. I had also worked as a hospital administrator—before I entered the seminary. And during my time at the seminary, I worked at the hospitals of the University of Chicago. I would say those direct experiences were more significant to me than any theoretical training as such. In the seminary classes, we dealt with death as an academic topic. And that has its usefulness, but it doesn't go far enough.
TNM: *Do you find that people often become more religious, or look to religion, when they are facing death?*
ME: Here, where I live, in central Pennsylvania, a high proportion of the population come from fairly strong religious backgrounds. So that, here, to a greater degree than in urban areas, people are inclined to draw on the background of their faith experiences. But I think most people tend to face up to questions about the meaning of their life. Which is, I think, a religious question—whether one puts it in specific theological terms or not.

JO ANNA WHITE: People become more reflective. Let me first tell you, I was a nurse before I became a priest. And I've found that whether people feel connected to a religious faith or not, they become more reflective when the thing comes down. Ninety-nine percent of the time, someone will want to talk.

ME: I would say, though, that we also have a number of patients who don't want to talk about anything related to death, whose response is really denial. I think, probably, all of us use a bit of denial. We get a telephone call, and somebody says that someone we know has died. And the immediate reaction from almost all of us is "Oh no." And that's a very simple but immediate expression of denial. But death is inevitable. And rather than the denial that we have developed in our culture, let's get ready to face it.

Families will often say they do not want their patient to be told, because they're fearful of what it will do to him or her. He or she will give up hope, they say. But our experience is that hope is not dependent on the knowledge or lack of knowledge of death, but on other factors related to the way they face life. Do they feel it is a fulfilling life that they have been living? What are their values? We try to help people talk about those things. We have retreated from death, we've turned it over to doctors or to special institutions. But at the same time, there's an increasing distance between the professionals and the people they take care of. I'm not putting doctors down, because there are a great many of them who are very sensitive. But the demands on their technical know-how are such that they can't sit down with a patient for an hour and talk through things in a way that might help.

TNM: *What do you see as your role?*

ME: I think, as a clergy person here in the hospital, when I work with people, I symbolize whatever their faith may mean to them. People don't necessarily know us when they come here. We're strangers. And so it is true indeed there are times when we visit a patient and the first thing we have to deal with is the patient's anxiety. "Oh my, am I that serious?" This comes up most often in critical care, and in the emergency room. On the other hand, there are a great many people, and probably more in this area here, for whom the clergy person represents their spiritual resources. And they welcome us.

JW: I see my role as priest/pastor as enabling the movement of God in the individual. Whoever that individual is, whatever their belief system is, to try to meet that need wherever I can. To make God present and real to them at that time. Sometimes it's just making phone calls, or talking about art, or talking about music, or talking about anything that means I can enter their life, and help them become reflective. I will do that in any creative way possible, making any type of relationship I can with that person.

ME: One of the greatest resources that religion offers is the realization that we are all members of communities. We are not isolated individuals, even though our culture has isolated us a great deal. But the religious community has never really accepted that. So that death and dying are regarded as community experiences.

TNM: *So do you spend a lot of time with the families of people who are dying?*

ME: Very much so. It helps. Not only to ease the death, but to enrich the death with more meaning, to enrich the memory of the one they are losing.

And we keep, for example, a death ministry book. And it, ah . . . it does happen to be black, but that doesn't mean that it's dismal. We record in it very meaningful encounters with families in which we have been able to assist them during the first minutes and hours of grief. We help them with decisions about autopsies, about organ donation, about the donation of bodies for medical science. Or, we support them in their choice not to have any of those things. Because our task is to support those people, rather than serve as advocates for the medical community. Though I believe strongly in what the medical community wants, generally speaking. Or in the emergency room, we're on the trauma team, and our task, immediately, is to begin to develop lines of communication with family members—to let them know what's going on, to get them to come to the hospital, to provide them with information. Sometimes, when relatives live hundreds of miles away, we inform them about the death, and assist them in the first steps of dealing with that bereavement. In fact, we hold a service of remembrance here each month. Since death so often takes place in the hospital, and the family leaves in the midst of their acute grief, they want to come back and work through some of the feelings they first experienced here.

JW: I just want to underscore something that Mike said about community. The theologian Alan Jones has said "Reality is community, and being is communion." What we do here is an awful lot of sharing. It's not just giving my talent and time to somebody. Or the nursing or medical staff giving to somebody. There is an aspect of sharing, in the life *and* in the dying. So when the time comes for that patient to die, the staff will very often share in that death. Something of me is going to die too. I am going to cry, too. And some of our work is to help the staff with their grief. Because they're going to have to go through it tonight, and then they have to get up tomorrow, and they're going to do it again.

TNM: *Do you ever feel that you just can't come fresh to each case, can't give it your full energy?*

ME: There are times when it seems too much, and I need to find somebody to talk with. Sometimes it's a family

member, sometimes it's a colleague, sometimes a doctor or nurse, or somebody else who was involved.

TNM: *Do you find all this has helped you when a death has occurred in your own family?*

ME: Oh yes. My father died several years ago. I was able to talk to him about what he wanted done. In fact, he thanked me. He said, "Thank you for bringing that up." I think he probably wanted to talk about it, and didn't feel comfortable bringing it up himself.

TNM: *How do you deal with the kind of anger that must arise when a death does not come at the end of a long, fulfilling life, a death that makes you angry that it's happening?*

ME: I'm not a terribly expressive person when it comes to screaming out my anger, or my anguish, though I may do some groaning and so on. I often go into myself more, I withdraw. Even as I'm thinking about this question, the visions of those times are going through my mind, and I feel the sadness of that. I hope I can convert the anger and sadness into whatever steps toward alleviation I can be a part of. I want to encourage something different in this world, and that's where I put my effort.

TNM: *How do you comfort a family member, or a dying person, who is not religious? How could you help them?*

ME: "My God, my God, why have you forsaken me?" were not just the words of Christ on the cross. They come from far back in Jewish history. That cry has always been a part of all human expression. I suppose the thing that I find comforting is that I can shout at God, I can be angry at God.

JW: People will say "I know I'm not supposed to ask why." And I say, "Well, why not? Jesus is a perfectly good example there on the cross." You *can* be angry. God's eternal—God's not going anywhere.

TNM: *How about the notion of the after life, or of the soul?*

ME: That's tremendously comforting to a lot of people. But I don't ordinarily put a lot of emphasis on it. Because some people, rather than facing death, put so much energy into talking about the future life, the life after death. And that can become another way of denying our humanity. For me, my humanity is as much a part of my faith as any life in the hereafter would be.

JW: To be a good pastor, you don't have to even say the word "God" at any time, at any place.

TNM: *You two must have to face the question of a precise definition of death. With the technology available now for sustaining life, it's obviously a subject that must come up. Have you been involved in such discussions, and have you arrived at a satisfactory definition of precisely when death occurs?*

ME: No, and yes. (Laughter.) Precise moments of death aren't quite as accessible as we sometimes want. At the same time, I am relatively comfortable with the determination of death here. I think our staff, our physicians, our nursing staff, are quite realistic. And we don't get involved with the extremes of trying to keep life going. In addition, we now have a fair number of patients who have thought about it in advance and who ask, for example, for no resuscitation. The hospital, the medical staff, has defined the circumstances under which they will write, "Do not resuscitate" orders, and they will discuss this with family and with patients.

TNM: *Do you encounter people who are dying, and feel that their life was a failure?*

ME: Not real often. But it does happen. It does happen. And that's . . . that's sad. Then, you know, the best that I have to offer them is to walk through that despair with them, and to value them as people as they do that. Perhaps that in itself will provide some solace, some rescue for them, that somebody cares when they face that. That's my task, in a sense, professionally. But I think that's the task of the human community as well: to walk with the weak ones in their times of despair. That's everybody's task.

RUTH MACKLIN and MATTHEW BERGER

RUTH MACKLIN, Ph.D. is a medical ethicist in residence at the Albert Einstein College of Medicine and its affiliated hopitals in New York City. She is on the staff of the Department of Epidemiology and Social Medicine at Albert Einstein, and the author of several books, including Mortal Choices: Bioethics in Today's World *(Pantheon, 1987). MATTHEW A. BERGER, M.D., is the director of Faculty Practice at the Albert Einstein College of Medicine. He is also the associate director of Medical Service and the chairman of the Medical Bioethics Committee of the Jack D. Weiler Hospital, which is affiliated with the Albert Einstein College of Medicine. We spoke with Dr. Macklin and Dr. Berger at the Jack D. Weiler Hospital on Morris Park Avenue in the Bronx, just before they were scheduled to participate in a bioethics committee meeting.*

THE NEW MUSEUM: *How do you define death?*

RUTH MACKLIN: The cessation of everything. The cessation of biological, psychological, and spiritual functioning of the individual.

TNM: *Do you think that definition has changed in the last twenty years?*

RM: No, I think what has changed in the last 20 years is the increased capacity, through medical technology, to separate out the psychological, emotional, and spiritual functioning of the human being from the merely biological. Technology has brought about some new opportunities to make people think that perhaps the notion ought to be broadened. But I think death is what it always was.

TNM: *And what is your role in all this as a medical ethicist? What is bioethics?*

RM: Those are two questions: what the bioethicist does, and what bioethics is. As a bioethicist, I think of myself as an educator, not a decision-maker. I'm called upon to teach medical students, sit on ethics committees, in hospitals, in nursing homes, in neo-natal clinics, for example. My role, and the role of the ethics committee, is essentially advisory—trying to work through, with physicians or patients, some of their ethical problems and dilemmas. Of course, I don't have all the answers, because the dilemmas and issues that arise in medical ethics are ones about which people are ambivalent, ones on which reasonable people disagree. Sometimes there are no clear answers, or no easy answers. What I try to do is provide an analysis of the issues. If people disagree about whether it's appropriate to withdraw or withhold life-sustaining treatment from a very ill or dying patient, then part of my role is to help the participants understand what it is that they disagree about. Do they disagree because they have different ethical principles? Do they disagree because they have a different assessment of facts? Or do they disagree because of some religious beliefs that constrain their actions?

TNM: *Does that mean you remain neutral on the issues?*

RM: No, I may have a view about what is the right thing to do, and when I do, I try to provide an argument in support of that position, an argument that's backed up by reasons that rely on some ethical principles, and perhaps draws on some of the literature in the field of bioethics and in health law, because they are closely related.

Which brings us to your question about bioethics. Bioethics is really the study and application of ethical principles and ethical theories to a range of troubling and problematic cases and policy issues in today's practice of medicine.

TNM: *How would you explain the social need for the field of bioethics?*

RM: I think there are two somewhat different forces that came together, that coalesced, to create this field. One is medical technology—the rapid advances that made possible for the first time the prolonging of life, intervening in ways that were simply not possible before. Physicians found that this new power could prolong life, but sometimes at severe costs to the quality of that life. Physicians themselves began to agonize about the use of this technology, and to ask themselves whether, simply because it's there, is there a technological imperative to use it all the time?

A second thing that happened, and this has more to do with the role of people like me—a non-physician in the medical world—is that the civil rights movement, the anti-war movement, and other social movements began to give rights to people who had been disenfranchised, or who had somehow not been recognized as having rights. And the notion emerged that patients as a class of individuals might have some rights—rights to informed consent, rights to participate in their own medical care, rights to refuse medical treatment. Medicine, with all due respect and apology to my colleague, has been very paternalistic. Doctors were urged not to disclose things, to help patients to maintain hope, but not to burden them or to trouble them with details about their diagnosis and their prognosis, and the bad things that might happen.

TNM: *And a number of studies about death and dying began to emerge, too. Isn't that true?*

RM: That's right. And relevant to this, some of the studies that were done by social scientists and others reveal that although doctors didn't tell people these things, people have ways of knowing if they are dying. They know from the signals their bodies give them, or because people don't make eye-contact with them. Or because people walk out of the room, or avoid answering these questions. The body language and the ways in which the non-communication took place

probably resulted in making it much worse for the poor patient who had nobody to talk with about the illness. So these forces came together, and what began as a group of academics essentially in medical schools teaching the subject to undergraduates and conferring with doctors, gradually became a large interdisciplinary field with teaching centers, centers of biomedical ethics, bioethicists employed by hospitals, ethics committees in hospitals, journals devoted to the subject. Now, it's quite common for medical societies and professional organizations to have a portion of their annual meeting given over to a topic in biomedical ethics. Sometimes with outsiders, that is, bioethicists like myself, and other times with physicians who are themselves concerned and knowledgeable.

TNM: *Dr. Berger, you are one of those physicians.*

MATTHEW BERGER: Yes, and having been a physician who grew up in the era of social change, I came into my own practice in medicine fairly liberated from that old doctrine of doctors' paternalism, only to find out that, in fact, one can go too far in that direction as well. There are times where patients truly want doctors to make decisions for them. There is certain information that patients don't really want to be given to wrestle with. They come up in very particular circumstances, usually when you have a long-standing relationship with a patient.

TNM: *How do you know this?*

MB: Sometimes it's directly expressed. A patient will say, "Doc, tell me what you think I should do. And don't confuse me with statistics about complications and all that kind of thing. . . ." However I do think that patient autonomy is certainly a crucial principle as to how one should guide one's medical care, and involve the patient. In almost all circumstances, I let patients lead the way. Even if it's not the way I would want myself or a loved one to be treated. It doesn't happen very often that a patient requests a treatment that I feel ethically unable to provide, or withhold from them.

RM: But there are some physicians who believe that their obligation is to continue to prolong life, despite what the patient says.

MB: I think that, ideally—and it doesn't always happen this way—these sorts of questions and issues are best dealt with within the private context of the doctor-patient relationship. And when that works well and properly, not only does the doctor know specifically from the patient, "I want a ventilator in this circumstance, but not this; I want antibiotics in this circumstance but not this," but there's a much more subtle level of communication that comes about when you are involved in the treatment with a person over months and even years. It's sometimes hard to put into words. It is often difficult to separate the physician's own feelings from what the physician believes the patient's feelings to be. So it's an imprecise art. But when one tries to formalize it, one cannot anticipate all the potential circumstances that may occur. Speaking just from my own experience with dying patients, it works best in the context of private physician-patient-family relations, without having hospital administrators, attorneys, bioethics committees involved.

RM: There are these other forces, and Matt just mentioned what these forces are: the hospital's concerns about liability, and sometimes concerns about bad publicity. But this has to do with public relations, it has to do with liability, it has to do with insurance, it has to do with money. It has to do with lots of things, but it has nothing to do with ethics.

Courts are there to resolve disputes, and even though it's a good idea to avoid running to court, sometimes if there's no other recourse, that may be the place to go. But what's happening now is that hospitals are going to court without any dispute. The doctor's perfectly prepared to accept the patient's or family's refusal of treatment—"Just let me die." But the hospital gets worried—at least administrators and this new breed of people called risk managers. Now I agree with Matt's comment that ethics committees ideally shouldn't have to become involved. I don't see ethics committees as a necessary mechanism when everything goes smoothly. Sometimes physicians are uncertain, and they come for an endorsement. Other times, the ethics committee gets involved because some people think that if it ever became a legal issue, it would be protected by the institution. But as I've seen time and time again, even the involvement of an ethics committee cannot always succeed in protecting the rights and interests of patients.

TNM: *You mentioned disputes. Do people go to an ethics committee because they want advice or because there is a dispute?*

MB: For both reasons.

RM: But it's not usually the patient who approaches an ethics committee. We shouldn't really mislead here. They weren't devised specifically with the protection and support of patients in mind. In part because ethics committees would be transformed into complaint bureaus. Because if somebody didn't like the TV in the room, or the food, they might say "Ah look! What kind of quality of life is this in the hospital?" (Laughter.) That's why we have Patient Relations offices to handle complaints and things like that. But the basic idea of ethics committees is to have a mechanism within the institution where a group of individuals who are disinterested in the particular case, who are knowledgeable about bioethics and health law, and who are concerned about doing the right thing (and by that I

mean not necessarily protecting the institution), can help deal with the uncertainties that plague physicians and nurses.

TNM: *Must the committee reach a consensus?*

MB: Often we'll discuss a case and not reach a consensus. And often the discussion may be clarified by the expertise of people like Dr. Macklin, but there may still ultimately be disagreement as to what the right thing to do is. Even without a firm decision, the hope is that people may walk away perhaps having been educated a bit and thinking about the issues.

Other times, the committee feels very strongly about an issue and will take some action. In a recent case we had a patient who was on a ventilator. It was clear that this patient had repeatedly told people close to her that she didn't want to be on a ventilator. The bioethics committee felt strongly enough to draft a letter to the administration to take the next step in order to remove the patient from the ventilator. So it varies, depending on the issue, how much consensus there is in the decision, and what our own options are—what we can and cannot accomplish.

RM: Right. There's another reason. Almost every chairperson of an ethics committee will say "We don't make decisions. We advise, we recommend, we are here as a consultative body." And I think there's a reason in addition to the ones Dr. Berger just mentioned. And that is, ethics committees should not be viewed by physicians as a threat to their role in the doctor-patient relationship. So if a committee were to make decisions, if the committee were viewed as the decision-making body, it would be a threat to the other two parties, namely the patient or patient's surrogate, and the physician.

Yet, when a committee makes a recommendation based on unanimous agreement, they may have a little bit more power or authority than they say they have when they refer to their role as advisor.

MB: Even in a more direct way. Certain bioethics committees are involved in making hospital policy. And I think that's a very important voice that we have. Because then it's not just risk managers and administrators who design policy that affect the way nurses, doctors, and patients will carry out their roles.

TNM: *What kind of issues do you consider when you're reviewing a case? What are the criteria for making decisions? I'm sure they vary from case to case, but what are the general principles?*

RM: Well, of course it's going to depend on the case, but let me boil it down. The first question is—I mean, because the case obviously surrounds a patient, "Is the patient now capable of expressing wishes about what he or she wants done? And if so, why did this case come to the committee?" And secondly, if the patient is no longer capable, is there any information about what the patient wanted or would have wanted? So the first principle then is "What does, or did, the patient want?"— to try to make a recommendation, or seek a solution or a resolution the patient himself or herself would have wanted.

Where that's not known, the next ethical principle that kicks in is, "What's in the patient's best interest?" And often a debate will begin at that point, especially if there's a disagreement among care-givers. Some people contend that continued life is always in the patient's best interest. Others don't believe that.

Then there are the cases in which people are in what is now termed "a persistent vegetative state," more commonly referred to as a coma, where the person's never going to wake up, has no awareness of his or her surroundings, and responds only to deep pain as a stimulus. There are about ten thousand people in the United States who are in this state right now, who are being kept alive artificially, either by ventilating machines or artificial feeding. People in that state are not conscious, they don't relate to anyone else, they don't experience any of life's pleasures. So the question of whether as a principle they have any interest—if they have a best interest—has to rest on whether or not they still have any interest at all. And at least in the kind of analysis I give, people in that state don't have any interest.

MB: In many of these cases the only technology being used is the feeding tubes. That's not a particularly burdensome treatment, unlike a ventilator where there's some sense of choking from the machine. So that many families, nurses, well-meaning care-givers, feel that food and fluids are somehow different from the ventilating machine.

RM: There is however, another concept that comes in here, when people are being kept alive "artificially" by various means. There's this notion of dignity. Is it somehow a loss of human dignity to be lying there, essentially a piece of protoplasm being kept biologically alive, but without any of the characteristics that make you the individual person that you were?

MB: It is not at all unusual for physicians to administer to patients sufficient pain-relieving medication that hastens their death. Patients often in the terminal stages of cancer are not necessarily in pain, in the way one normally thinks of pain; but may have a sensation of an inability to breathe, an inability to get adequate air—a terrible visceral sensation internally that can be relieved with narcotics. And I think that many physicians have no difficulty administering a dose of narcotics sufficient to relieve that suffering. The same dose, they may well know, will in fact cause that patient to stop breathing and therefore hasten death. Again, that is ideally done in the private context of the hopefully

long-standing relationship between a patient and a physician. Assisted suicides happen very often between doctors and physicians in a very private way.

TNM: *How do you articulate the distinction between the cessation of treatment and euthanasia?*

MB: Well, I think in a way, we turn back the clock to the pre-bioethical era when we didn't have the technology to intervene, where nature takes its course. Many physicians use that as their dividing line. They are comfortable to take a step back, allow nature to take its course, and perhaps only intervene as far as to relieve any unpleasant symptoms that the patient is experiencing.

RM: I want to answer in a slightly different way. Which is to say that sometimes you can't make a very sharp conceptual distinction between active and passive euthanasia. The clear case, the paradigm, of active euthanasia is a lethal injection: administering a poison that you know will kill the patient. A relatively clear case of passive euthanasia is the failure to institute a life-sustaining procedure that you know would succeed in prolonging the life, but you're withholding it. In between, there are grey areas.

When I teach medical students, we look at a range of cases. I ask them to do two things simultaneously: try to define whether a particular situation counts as active euthanasia or passive euthanasia, and I also ask them which action is morally acceptable, which action is morally permissible in these range of cases? And they get all mixed up. Not because they're not smart—they're very smart. But, for example, because sometimes people, especially people in the medical profession, attach a negative judgement to the notion of doing something active to end a life. If they call it euthanasia, it must be wrong. Therefore, if they think that it's ethically acceptable, they have to call it passive euthanasia.

So I think what's important is to have the discussion and get people to think about it. And to force them to confront their values, and to be able to justify the position that they hold.

TNM: *Do you think that bioethics has brought modern medicine closer to people, made it more humane?*

RM: I wish it were true. Since the beginning of this field, people have asked me and others, "Has bioethics changed physicians' behavior? Does it make physicians more humane?" I mean, many people are concerned about what they consider a lack of bedside manner, an inability or unwillingness of doctors to talk to patients, a brusqueness, a retreat from discussion. Not all doctors, but many. Patients who sit in the doctor's office talking to their own physician usually don't have these kinds of complaints. But if they have to go into the hospital for a procedure, they're going to face a surgeon or an anesthesiologist whom they've never met before. I think what's needed in order to make the practice of medicine—or, if you will, physicians—more humane is something other than what we do in bioethics.

MB: I think, although bioethics as a field is fairly young, ethics within the medical profession is quite old. In fact, one of the reasons that I, as a theme, come back to the issue of the physician-patient relationship speaks to the point that Dr. Macklin just made. Physicians are not all-knowing or all-seeing. Certainly they are unable to cure many illnesses and can manage only certain problems. For the most part, for most people, the reality is either they will get well on their own or the intervention of the physician will have a modest effect in the long-term. The more important role of the physician is that of priest, confessor, advice-giver, friend, hand-holder, educator.

TNM: *Is that the role you see physicians playing now?*

MB: That is the essential role. That's the role physicians have always had. And the patients who like their physicians like physicians who do that kind of work—primary care-givers, generalists, internists. In fact, the technology that has created these dilemmas about respirators and artificial feeding tubes has also contributed to the phenomenon of the impersonal specialist, the one who's there as a technician, who's there looking at your eye and trying to decide the best way to approach it, and not recognizing the fear that you have of your surgery.

I think you'll find that most patients are, in fact, attracted to the personal part of medical care more than the advanced technology and the miracle cures that we can provide. I think that we're seeing that more and more. Technology is expensive, and it's not always a blessing. So I think that there's hope for the humanity of the medical profession.

WORKS IN THE EXHIBITION

Gwen Akin & Allan Ludwig

Gwen Akin
Born in New York, 1950
Lives and works in New York

Allan Ludwig
Born in New York, 1940
Lives and works in New York

Sliced Face in a Jar, No. 1, 1985
Platinum paladium print
24 × 20″
Courtesy of the artists

Sliced Face in a Jar, No. 2, 1985
Platinum paladium print
24 × 20″
Courtesy of the artists

Hilton Als & Darryl Turner

Hilton Als
Born in Barbados, West Indies, 1960
Lives and works in New York

Darryl Turner
Born in Dayton, Ohio, 1954
Lives and works in New York

L'Amour/La Mort or Pip/Pirip/Philip, 1991
Mixed media installation
Courtesy of the artists

Antonin Artaud

Born in Marseille, France, 1896
Died in Ivry, France, 1948

La Mort et L'Homme, 1946
Pencil and colored chalk on paper
25¾ × 19¾″
Collection of the Musée National d'Art Moderne, Centre Georges Pompidou, Paris

Les Corps de Terre, 1946
Pencil and colored chalk on paper
25¾ × 19¾″
Collection of the Musée National d'Art Moderne, Centre Georges Pompidou, Paris

Joseph Beuys

Born in Krefeld, West Germany, 1921
Died in Dusseldorf, 1986

Untitled (Technologie, Analysis, Death), 1974
Chalk on blackboard framed in aluminum
36 × 48″
The Arthur and Carol Goldberg Collection, New York

Nayland Blake

Born in New York, 1960
Lives and works in San Francisco

Kit #2 (poisoning), 1989
Apricots, strychnine, water, cloth, aluminum, and board
36 × 48 × 6″
Private collection
Courtesy of Richard Kuhlenschmidt Gallery, Los Angeles

Christian Boltanski

Born in Paris, 1944
Lives and works in Paris

Réserve du Musée des Enfants, 1991
Mixed media installation
Courtesy of the artist and Marian Goodman Gallery, New York

Victor Bouillon

Born in Seattle, 1957
Lives and works in New York

Passion Pillows: Ravissement (fitna)
3 lithographs and silkscreen on wool
20 × 26 × 8″ each (10′ overall)
Courtesy of the artist

Geneviève Cadieux

Born in Montreal, 1955
Lives and works in Montreal

Untitled, 1991
Photographic print
6 × 19′
Courtesy of the Galerie René Blouin, Montreal

Sophie Calle

Born in Paris, 1953
Lives and works in Paris

Untitled, 1991
Black-and-white photographs
71¼ × 43¾″ each
Courtesy of Fred Hoffman Gallery, Los Angeles, Pat Hearn Gallery, and Luhring Augustine Gallery, New York

Mary Carlson

Born in Stevens Point, Wisconsin, 1951
Lives and works in New York

Toile Figures, 1990
Nylon sculpture
7 × 80 × 36"
Courtesy of the artist

Sarah Charlesworth
Born in East Orange, New Jersey, 1947
Lives and works in New York

Denial, 1990
Laminated cibachrome print
36 × 44"
Courtesy of Jay Gorney Modern Art, New York

Unidentified Woman, Hotel Corona, Madrid, 1979–80
Photographic blowup
79 × 42"
Collection of Ara Arslanian, New York

Larry Clark
Born Tulsa, Oklahoma, 1943
Lives and works in New York

The Perfect Childhood, 1991
Collage with newspaper and magazine photographs and silver prints
29 × 88"
Courtesy of the artist and Luhring Augustine Gallery, New York

Hans Danuser
Born in Chur, Switzerland, 1953
Lives and works in London

Medizin I, 1984
Series of 11 black-and-white photographs
20 × 24" each
Courtesy of the Curt Marcus Gallery, New York

Jimmy DeSana
Born in Detroit, Michigan, 1950
Died in New York, 1990

Jock Strap, 1977–78
Black-and-white photograph
8 × 10"
Courtesy Jimmy DeSana Trust

Masking Tape, 1977–78
Black-and-white photograph
8 × 10"
Courtesy Jimmy DeSana Trust

Untitled, 1977–78
Black-and-white photograph
8 × 10"
Courtesy Pat Hearn Gallery, New York

Carpet
Black-and-white photograph
8 × 10"
Courtesy Jimmy DeSana Trust

Eugenio Dittborn
Born in Santiago de Chile, 1943
Lives and works in Santiago de Chile

The Fold, the Buried and the Unborn, 1991
Photographic collage
137¾ × 110¼"
Courtesy of the artist

Orshi Drozdik
Born in Budapest, 1947
Lives and works in New York

Dystopia ∞ #0001, 1987
Black-and-white photograph
38 × 36"
Courtesy of the artist and Tom Cugliani Gallery

Dystopia ∞ #0002, 1986
Black-and-white photograph
38 × 36"
Courtesy of the artist and Tom Cugliani Gallery

Marlene Dumas
Born in Cape Town, 1953
Lives and works in Amsterdam

Snowwhite and the Broken Arm, 1988
Oil on canvas
55⅛ × 118¼"
Collection of the Haags Gemeentemuseum, The Hague, Holland

Jimmie Durham
Born in Washington, Arkansas, 1940
Lives and works in Cuernavaca, Mexico

Death, 1991
Mixed media
26 × 20"
Courtesy of the artist and Nicole Klagsbrun Gallery, New York

Laura Fields

Child's Play, 1991
Photostat, silver rattle, and wooden box
38 × 16 × 7"
Courtesy of Fernando Alcolea Gallery, New York

Adam Fuss
Born in London, 1961
Lives and works in New York

Untitled, 1990
5 silver gelatin prints from a series of 17
23¾ × 19¾" each
Courtesy of Massimo Audiello and Robert Miller Gallery, New York

Peter Greenaway
Born in Newport, Wales, 1942
Lives and works in London

Death in the Seine, 1989
Color video, 43:40 minutes
Courtesy of Erato Films/Allarts TV Productions/Mikros Image

Mona Hatoum
Born in Beirut, 1952
Lives and works in London

Alive and Well, 1990
Metal frame and electric heating elements
41 × 20 × 19"
Courtesy of the artist

Ronald Jones
Born in Falls Church, Virginia, 1952
Lives and works in New York

The Cock in the Sniper's Nest (This Neolithic chalk phallus was uncovered by A.L. Armstrong . . . [for complete title, see p. 168], 1989–91
Chalk, anodized aluminum, steel, painted wood
6½ × 3 × 4'
Courtesy of the artist, Metro Pictures and Sonnabend Gallery, New York

Tadeusz Kantor
Born in Wielopole, Poland, 1915
Died in Krakow, Poland, 1990

Les Enfants de La Classe Morte, 1975
Mixed media installation
39⅜ × 63 × 129⅞"
Courtesy of Galerie de France, Paris

John Lekay
Born in London, 1961
Lives and works in Westchester County, New York

Cryonic Suspension Dewar, 1991
Cryonic suspension dewar
9' (high) × 4' (diameter)
Courtesy of the artist

Amalia Mesa-Bains
Born in San Jose, California, 1943
Lives and works in San Francisco

Body + Time = Life/Death, 1991
Mixed media installation
Courtesy of the artist

Donald Moffett
Born in San Antonio, Texas, 1955
Lives and works in New York

Mercy, 1991
Mixed media installation
Light boxes, 14" diameter each
Edition of 100
Courtesy of the artist

Bruce Nauman
Born in Fort Wayne, Indiana, 1941
Lives and works in Pecos, New Mexico

Head, 1990
Cast bronze
11 × 19"
Collection of Leo Castelli, New York

Elaine Reichek
Born in New York
Lives and works in New York

Croix de Guerre, 1990
Oil and gold leaf on photographs
69 × 74"
Courtesy of the artist and Michael Klein, Inc., New York

Bastienne Schmidt
Born in Munich, 1961
Lives and works in New York

Untitled (Bogota, Columbia, 1991), 1991
3 black-and-white photographs
20 × 24" each
Courtesy of the artist

Jeffrey Silverthorne
Born in Honolulu, 1946
Lives and works in South Bend, Indiana

Listen . . . The Woman Who Died in Her Sleep, 1972-74
Black-and-white photograph
16 × 20"
Courtesy of the artist

Listen . . . Beating Victim, 1972-74
Black-and-white photograph
16 × 20"
Courtesy of the artist

Cam Slocum
Born in Los Angeles, 1957
Lives and works in Los Angeles

Still (#3), 1988
Pigment and photo emulsion on canvas
72 × 72"
Courtesy of the artist and Pence Gallery, Los Angeles

Kiki Smith
Born in Nuremberg, 1954
Lives and works in New York

Untitled, 1991
Installation, acrylic on wall
Courtesy of the artist and Fawbush Gallery, New York

Jolie Stahl
Born in Los Angeles, 1950
Lives and works in New York

Toussaint's Last Miracle, 1990
9 black-and-white photographs
11 × 14" each
Courtesy of the artist

The Prison Detail, 1986
16 cibachrome prints
11 × 14" each
Courtesy of the artist

Mladen Stilinović
Born in Belgrade, 1947
Lives and works in Zagreb, Yugoslavia

The Colours of Death, 1986–90
Mixed media installation
Courtesy of the artist

James Van Der Zee
Born in Lenox, Massachusetts, 1896
Died in New York, 1983

At Rest with Teddy, 1942
Hand-colored photograph
8 × 10"
Collection of Donna Van Der Zee

Death of the Firstborn, c. 1950
Black-and-white photograph
8 × 10"
Collection of Donna Van Der Zee

Soldier Boy, c. 1920
Sepia print
8 × 10"
Collection of Donna Van Der Zee

From the Family, 1929
Black-and-white photograph
8 × 10"
Collection of Donna Van Der Zee

Peaceful Sleep, 1933
Black-and-white photograph
8 × 10"
Collection of Donna Van der Zee

Father, 1944
Hand-colored photograph
8 × 10"
Collection of Donna Van Der Zee

From the Brotherhood, 1944
Black-and-white photograph
8 × 10"
Collection of Donna Van Der Zee

Andy Warhol
Born in Pittsburgh, 1928
Died in New York, 1987

Electric Chair, 1964
Synthetic polymer paint silk-screened on canvas
22 × 28"
Collection of Peter Halley, New York

Four Jackies, 1966
Photo silk screen on paper
40 × 30"
Collection of Simon Watson, New York

Brian Weil
Born in Chicago, 1954
Lives and works in New York

Murder in Miami (14-year old boy stabbed with a kitchen knife in his mother's bed by an intruder, April 1982, 5:40 p.m.), 1982–85
Large format black-and-white photograph
42 × 42"
Courtesy of the artist

Frederick Wiseman
Born in Boston, 1930
Lives and works in Cambridge, Massachusetts

Black-and-white film on video, 5:58 hours
Courtesy of Zipporah Films
with special assistance from the National Endowment for the Humanities

David Wojnarowicz
Born in Redbank, New Jersey, 1954
Lives and works in New York

When I put my hands on your body, 1990
Silkscreen on silver print
26 × 38"
Courtesy of P.P.O.W., New York

Postmortem Photographs from the Collection of Stanley B. Burns, M.D. and The Burns Archive

Albert J. Beals, New York
Mother with her Dead Daughter Posed in Painterly Convention of the "Sick Child," c. 1852
Daguerreotype, 2¾ × 3¼"

Anonymous
Baby Girl with Congenital Head Lesion, in Tinted Red Dress, c. 1852
Daguerreotype, 2¾ × 3¼"

Anonymous
Older Girl Seated on Loveseat, c. 1852
Daguerreotype, 2¾ × 3¼"

Southworth and Hawes, Boston
Young Dead Girl "Sleeping," c. 1853
Daguerreotype, 3¼ × 4¼"

Anonymous
Close-Up of Baby with Her Hands Tied Up, c. 1846
Daguerreotype, 2¾ × 3¼"

Anonymous, New York
Christopher Hogan, 137 E. 20th Street, New York City, c. 1854
Hand-tinted daguerreotype, 2¾ × 3¼"

Anonymous
Vignette Portrait of Young Girl with Flowers in Hand, c. 1855
Daguerreotype, 3¼ × 4¼"

Anonymous
Girl in Coffin, c. 1858
Ambrotype, 3¼ × 4¼"

H. W. Immke, Princeton, Illinois
Man Sitting in Chair with Newspaper, 1868
Carte de Visite

Anonymous
Woman's Face Superimposed on Clock, c. 1890
Silver print, 4 × 5"

Anonymous
Baby Dead from Dehydration, Three Poses, c. 1885
3 tintypes, 2½ × 4", each

Eclipsed View Company, Duluth, Minnesota
Johnny Frederick Schultz In White Jewel Box Casket, 1893
Silver print, 4½ × 6½"

Anonymous
Young Girl On Couch with her Doll, c. 1895
Silver print, 8 × 10"

Anonymous
Parents with Baby in their Yard, c. 1900
Silver print, 4 × 7"

Anonymous, Missouri
The Murdered Parsons Family, 1906
Silver print, 4¾ × 6¾"

Anonymous
Sleeping Beauty with "Floating Roses," c. 1910
Silver print, 7¾ × 9¾"

Anonymous
Mother and Child Together in Funeral Home, c. 1925
Silver print, 4½ × 7"

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THE INTERRUPTED LIFE

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