Full-Length Article

The Chalice of Repose Project's Music-Thanatology History and Praxis

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Abstract

The palliative medical modality of music-thanatology as developed by the author and pioneered at the Chalice of Repose Project is an evidence-based practice-vocation-profession, and maintains a singular focus and orientation: the physical and spiritual care of the dying with prescriptive music. Music-thanatology palliative care is delivered in every psychosocial setting and serves every patient constituency, pediatric to geriatric. The music-thanatology delivery of prescriptive music occurs live, at the bedside; is responsive to the patient's unique, dynamic medical and interior conditions, and features quiet reception rather than clinician-patient interaction. This historical report provides a condensed overview of forty-four years of music-thanatology development, history and clinical practice. This includes a description of the historical and current curricula, excerpts from clinical field notes and an example of a spiritual practice that can sensitively orient musician-clinicians toward the existential patient experience. The bibliographical resources cited reflect the methodologies of a variety of scholarly disciplines in the biomedical and nursing arts and sciences and a full range of the humanities, all of which are integrated into music-thanatology education, formation and *praxis*. Recent population studies [1] report that there are currently over 46 million Americans aged 65 and older, and this number is expected to double by 2060. Life expectancy has generally increased and with it the need for excellent end-of-life palliative care programs. A full array of dedicated and competent practitioners skilled in a variety of end-of-life arts and sciences has never been so greatly needed in the USA. When interventional modalities have been exhausted, music-thanatology offers effective pain relief and meaningful, effective, cost-effective supportive care options during the final days and hours of life.

Keywords: ***Music-thanatology, palliative care, prescriptive music, narrative medicine, spirituality, transitus, monastic medicine, contemplative practice, letting go.***

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Preface

As the founder of the palliative medical field of music-thanatology, I have been invited to reflect on the history and practice of the clinical and pedagogical work pioneered by and through the Chalice of Repose Project. The perspective offered through 44 consecutive years of experience means that I have been present to history while also being an active participant, contributing to the making of history. I am clear that when one speaks in equal measure as both participant and observer, the narrative is textured. Nevertheless, however precious memory is, nothing quite surpasses the history of trial and error or success and failure as when it is fortified by the ability to refer back to the historical archive [2] of documents.

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The Ur-Vigil

The seminal experience that led to the work of music-thanatology arose unexpectedly during my work as an orderly 4-plus decades ago. In 1973, orderlies generally entered the work-force after having attended one or two introductory level in-services taught by nursing supervisors. Then they learned their craft "on the job" by following orders and caring for the needs of the patients or residents assigned to them. The time I am describing was a time in medical and nursing history that pre-dates what is now known as end-of-life palliative care or hospice medicine.

Although it may not be common knowledge amongst contemporary clinicians, in the 11th century, French Benedictine Cluniac spirituality established a subtle and holistic monastic infirmary practice [3] that pre-dates end-of-life palliative care practices by 800 years. The practice of monastic medicine occurred within the community infirmary, and offered a psychologically sophisticated, spiritually-culturally coherent and medically nuanced early version of what is today known as hospice care. Cluny itself was situated on a major pilgrim's route, the equivalent of a superhighway, and that particular monastic community disappeared

overnight with the suppression of the monasteries in Europe. With the dissolution of that community and the closure of the motherhouse, the European notion of hospice care seemed to disappear from view for several centuries during waves of medical epidemics and political upheavals. At times, viral, bacterial and parasitic contagion in plague, syphilis, cholera, influenza, smallpox, and other infectious disease vectors decimated large populations speedily. However much speed characterized these deaths, the nature of end-of-life illness and suffering would change radically in the post-industrial world.

By the early 1970's, cancer had become pandemic in many post-industrial and technologically developed countries. As the incidence of cancer increased exponentially, the biomedical, pharmaceutical, psychological and spiritual needs of the dying became increasingly complex and urgent, particularly with reference to the need for pain medications which adequately addressed malignancies, disfigurement, respiratory chaos and more. Unlike a plague or a flu epidemic from which individuals died quickly, the rise of cancer created entirely different qualities and elongated timelines of suffering [4]. These in turn presented doctors and nurses with increased pressures, and from this urgency, a re-birth of the medieval hospice movement emerged, only the skilled workers were no longer infirmarians working in monastic settings. They were walking the corridors of the great medical centers of the day.

By virtue of the pioneering work of Dame Cicely Saunders [5] who worked in oncology, the modern day European hospice movement emerged in 1967 with the founding of St. Christopher's Hospice in London. Seven years later, in 1974, Florence Wald of Yale University and two of her physician colleagues worked together as a team and founded Connecticut Hospice in Branford, Connecticut, the first [6] of its kind in the United States. A decade later, in 1984, JCAHO (Joint Commission on Accreditation of Health Care) initiated its first hospice accreditation service, and in1986 Congress permanently approved a hospice benefit for Medicare. The first board certifications [7] in end-of-life palliative care in the United States were pioneered by nurses in 1994, with physicians following suit in 1996. Thus we see a solid 30-year ferment tilling the field and making possible new levels and new kinds of patient care programs, from which new forms of pedagogy were also needed and developed.

It is in this same burgeoning and dynamic medical-nursing-cultural ferment that the history and development of music-thanatology is situated. Music-thanatology roots begin parallel to the founding of the Connecticut Hospice. When describing the relative austerity of the pharmaceutical adjuvants available (and administered) in 1973 as I am about to do, I am not implying any kind of intentional agency withholding process. A number of the goods, services, protocols, substances and cultural standards available today in end-of-life care had not yet been developed or implemented in the early 70's.

At the time in which I worked as an orderly, I was deeply struck by the disembodied institutionalization, corporatization and medicalization of death, wherein death's meaning [8], gifts and possibilities were frequently overlooked. Decades ago, corporate mortality statistics sometimes reflected more of the business (profit) model rather than an analysis of the quality [9] of care achieved that year. For me, the gulf between data and life generated more questions than answers. I was often uneasy and reticent with what I experienced or witnessed in the way that residents were dying and equally pensive about the way the bodies of the newly deceased elderly patients were sometimes handled. Despite the terrain, I did not know what to do with that inner rumbling other than discuss the situation with a trusted teacher. As a philosopher-theologian, he taught me how to grapple with ideas and to reason, and this was a boon.

For these multiple reasons I say that the *milieu* in which I found myself working as a part-time orderly in a semi-rural geriatric home was very different from the world in which health care professionals work today. I was a student finishing up a degree in music and worked only part-time. Orderlies were unranked members of the staff, and as a young musician, I related to people and to the world musically rather than clinically.

Most of the residents for whom we cared were Russian émigrés and many had been farmers. I was assigned to care for a man [10] who was actively dying of emphysema. The charge nurse active on that shift had explained that there were no longer any medical, nursing or pharmacological interventions that could change or improve his condition. His lungs were paper-thin: "a mere cough will take him". He wasn't the easiest resident on the ward to approach and was known to have thrown food and feces.

It was normal to encounter many different kinds of people and illnesses throughout a shift, but when I walked into "George's" room, a *great transitional social drama* was unfolding, only at the time, I had no intellectual notion of the staged rites of transition so helpfully identified by anthropology [11]. The descriptive phrase "death rattle" is another term learned immediately, though colloquial. It refers to the actual gurgling, thumping and rattling sound that can be produced by terminal respiratory secretions-which can accumulate in the throat and upper chest areas. "George's" rattling sounds clearly indicated struggle and imminency. Especially during the 1970's and 1980's, I can say that there were times when an unmedicated death rattle could be so loud and visceral that it did not and could not leave care-givers or staff members unaffected.

"George's" anguish was palpable, and I was unprepared for the concrete and symbolic reversal that soon began to take place. His reputation for pushing staff away was no longer in effect, and he held on to my hand tightly. Because his lungs burst, "George" was essentially drowning in bed. I responded to him to the best of my ability, which was with immediacy,

something of presence of being, and song. I sang because although I am a harpist, singing was first nature to me; it was an embodied practice. I also responded to him from a position that is associated with childbirth, getting into bed and supporting his emaciated personhood and body from behind. I sang mostly unmetered music, very quietly, and as synchronization of breathing patterns occurred between patient and care-giver, the flailing and heaving began to lessen. He had very little time remaining and yet trusted and rested into me. For a brief period, we essentially worked together as a team. That is how it came to be that a young person was with "George" on the last day and in the final hours of his life.

I am describing a very human-centered and patient-centered responsivity, wholly unencumbered by formalities a young person could not have known at the time, though every reader understands that what happened then is not the way things are done now. In 1973, the reservoir of skills I had embodied largely revolved around courtesy and common sense (rather than anything resembling a clinical formation). My ways of being and living were musical. Only later did I grow to understand the clinical framework of timing, of bone conduction deliveries [12], of metered and unmetered music, of synchronization, of the spirituality of the human I – Thou encounter [13], or the mandatory split-second aspects of clinical decision making or what I now call *the spirituality of risk*. I had not set about to "do" something or to "found" anything when this first experience occurred. "George's" death had constellated a human attempt to respond with care to a person who couldn't breathe and was terrified.

I had grown up with the imagination *"As you do for the least of my brethren [14], so also you do for me,"* but in a flash, this picture matured internally as a kind of white lightning script [15]. "George" may have been Jewish or he may have been Christian. I say this because most of those residents were informally known to have had religious or faith identities but the admissions process at that time was not required to include specifics about spirituality. Encountering "George" *purely as he was* didn't express itself (in me) as anything resembling a dutiful burden or a religious legalism. It emerged instead as something more of a freely extended *"Yes"* which recognized the pure value of his irreplaceable personhood. He was a human being, not a task to be completed and not a problem to be solved. After the shift was over, I walked home aware of being filled with a life-changing, transformational experience, and spent the next decade learning how to better understand what had happened and how to integrate it back into the fullness of my own life. I knew something "big" had happened, and it was natural to ask myself about the historical precedence of uses of music at the end of life. From that day forward, although I did not remain an orderly for long, I tried to make myself available to others who called. That sums up the seminal event.

To date, the Chalice of Repose Project work of music-thanatology is comprised of three distinct stages or phases: 1973 to 1992; 1992 to 2002, and 2002 to the present. Each phase is characterized by an organic growth process which disclosed, through documented cycles of trial and error, an indescribable wealth of material, challenge and opportunity. The following sections describe the three historical phases from "George" to the present.

Phase One – 1973 – 1992

The first 19 years (1973 – 1992) of research and development took place in Denver, Colorado and its surrounding areas. This was a corridor of enormous archival scholarship coupled with dialogue with clinicians and scholars, and this content was brought into continual clinical opportunity. I made my Carnegie Hall debut as a harpist and singer in 1980 and worked as a performer, educator and conductor of chamber ensembles in the world referred to as "classical" music [16] although my own fields of musical performance gravitated toward medieval and 20th century music. Because the experience of the man with emphysema had been profound and transformational, it eventually became integral to my own thinking and interiority as well as the professional maturation process. I walked within two vocations and two careers simultaneously. While teaching and performing music, I never forgot "George," and so positioned myself to be able to receive a steady stream of clinical referrals in the care of the dying in Denver. In this way, without ever initially intending to "do" anything other than voluntarily respond to a constituency which was at the time underserved and marginalized, the growth of music-thanatology occurred naturally. It emerged authentically, and in dialogue with many friendly physicians and nurses whose quizzical scrutiny was influential, supportive and constructive. It is also worth mentioning that <u>*that*</u> quality of growth was relatively unfettered by the bonds of obligation and interest that routinely occur with institutional positions, formalities and initiatives.

The Denver years were generous, and allowed me to gradually become articulate about what I was seeing and doing, noting and questioning. I was very attentive towards and reflective about the choices of music I was playing (or not playing) when I was working harpistically with dying individuals. These were the years in which the specific what, why, when, where and how of the matter were developed through the combination of archival scholarship and direct patient care. Together, scholarship and documentation allowed me to contrast my own clinical observations and scholarly discoveries with more than two millennia of cultural history and medical research.

Contemporary writers Wilda C. Anderson [17] and Ken Thorp MD [18] each skillfully assert that an earlier time found science and medical science completely interwoven with one another and alongside the great linguistic, literary and

philosophical debates of the day. These authors remind readers that neither medicine nor science developed in isolation from philosophy or literature. That permeability can be overlooked or forgotten today, when we take specialization as a cultural norm.

The textual evidence that I studied and took seriously spanned a full cultural and attitudinal spectrum from antiquity to the twentieth century. The medical and musical resources documented both literary and visual histories of Greek [19] and Roman, medieval [20] and Renaissance [21] cultures and practices, philosophies and theologies as they related to the musical [22] and medical practices associated with living, birthing, health, illness and dying in those several time periods and cultures. Because of the diplomatic facsimile, many of these textual resources included photographic reproductions of the original manuscript, relevant illustrations, illuminations, reliquary carvings, as well as historical musical *incipits [23]*.

I owe worlds to the excellence of the combined Denver and Boulder university and seminary libraries without which the most pressing and nuanced of questions would have undoubtedly remained enigmatic. The historical archival resources on the history of medicine and the uses of music-in-medicine were richly complimented with contemporary reference works [24] on acoustics, hearing, tuning, scientific explanations on the mathematical origin of the scales, medical-scientific research on the human voice and larynx, and on the complexity of the musical environment. Other texts articulated the entire field of sensory perception [25], including neural and auditory processing. I mention these kinds of things because they are not typically taught as part of the core curriculum in graduate or undergraduate music performance degrees. To the acoustical and neural studies, Hans Jenny's contemporary work extended the acoustical research of Ernst Chladni (1756 – 1827) by articulating the theory and research of cymatics [26], a laboratory science evidencing sound as a visible organizing principle generating form and altering structure, even in a concrete physical medium.

Traditional medical [27] resources articulated a late 20th century biomedical imagination of anatomy and physiology, addressing the cardinal manifestations of disease, body-systems phenomenologies, and presenting exhaustive annotated pictorial methodologies on physical examination, patient history and case records, palpation and auscultation and more. Structurally, for me personally, the contemporary and medical study of febrile conditions, syncope and seizures, clotting disorders, respiratory, cardiovascular and neurological disorders were formative. I was able to read medical texts, musicology, philosophy and monastic medicine at the same time, and it was this simultaneous combination that opened up mutually fructifying worlds that helped me to develop my earliest ideas about the principles of prescriptive music.

Whereas the medical skills and procedures described in *Harrison's Principles of Internal Medicine* far exceeded the work of any musician-clinician, it also disclosed a host of invaluable biological clinical observations which aided me, as a non-physician, in learning how to see or recognize the subtle and dramatic bodily manifestations of serious illness that are routinely seen in end-of-life care settings. (During the course of any musical vigil in Denver, I might have observed suppurating deep tissue ulcers, bluish lips, abraded teeth, impaired balance and gait, incontinence, purple macules, clubbed fingernails, certain kinds of odors, jaundice, hypotonia, sensory ataxia, pronated forearms, flexed wrists or fingers, half-drooping mouth, etc. Seeing these signatures is one thing; understanding their origin is another, and yet making the connections toward thinking musically-clinically about them is a fruitful third).

In addition to the medical texts, traditional nursing [28] texts articulated a wide array of practical clinical perspectives, symptom control and pain management interventions and sensitive procedures for the care of the dying. The nursing texts were implemented through the conceptual lens and tenets of *holistic health care*. This nursing perspective certainly respected and hailed the advances of biomedicine, but quietly distanced itself from a purely mechanized view of the human body; holism returned human interiority back into the larger arc of health care. Plato, Aristotle and Hippocrates once used words such as *soul* and *spirit* and used them with precise technical specificity, but over the passage of time, these words had become almost exclusively associated with religion, and by the onset of the age of reason had been removed from the medical lexicon in favor of that which could be objectively weighed and measured. Holism enlarged the vistas and dimensions of the human being considerably and with it, I too found permission to consider and acknowledge more than the mechanized picture of the human body. Music-thanatology is indebted to medicine and nursing in equal measure.

Last but not least, a wide variety of texts from the humanities placed the medical, nursing and musicological texts in rich context. For example, the philosophers [29] and theologians [30] grappled deeply with the meaning of death and human mortality. Each using their own lexica, those voices advocated that awareness of death and human mortality constellate some of the most central and most transformative of the human-making experiences. In an age of pluralism, where one might serve people from 30 different faith traditions and positions East and West, (spanning believers, agnostics, non-believers and humanist realists), one needed to find a way to be competent and respectful with the complex terrain of human interiority, religious experience and religious identity. Indeed, it was gradually becoming permissible to integrate the diversity of expressions, meaning and values possible in human spirituality into the fundamentals of health care.

Meanwhile anthropologists [31] pioneered a methodology in which scholars read texts and field notes reflecting a depth and variety of human religious experience, institutional and non-institutional, communal and individual. Anthropologists researched many different time periods and cultures, and their contributions described the structural components of the transformative journey as it occurs at different stages of the human life cycle. The anthropologists did not feel obligated to function in doctrinal or confessional terms (even though many were indeed personally committed to a particular identity or position). The rites of transition which anthropology identified pinpointed the attending ephemeral yet transformative experience of growth through role reversal, *communitas*, liminality and the rites of re-incorporation. Because my research was not abstract, because it was grounded in years of growing experience with the people who were living their dying, it was easy (for me) to see that the liminal condition offered musicians particular entrée. The condition of liminality magnified the opportunity for musical permeability and effectivity. The liminal moments and corridors allow music to enhance the profundity of human experience rather than displace music as a secondary or tertiary social backdrop or sonic environment. However, if a scholar simply read anthropology in isolation, in abstraction, out of context, or without being able to "do" or apply field work of any kind, the connection between liminality and music could easily be overlooked.

In these layered ways incorporating humanities and sciences in equal measure, I paid particular attention to philosophical and theological commonalities and differences, and to musicological and medical *anomalies*, wherever and however they showed up. I studied each literature or methodology in its context and then cross-referenced the contents of each in my own notes. I did not read from within nostalgia for a by-gone past, or in order to replicate an historical practice (taken out of cultural context), or in unquestioned allegiance to past or contemporary cultural or religious paradigms. I read in order to learn and to discern in fresh ways of connectivity. In taking little for granted, one honors the time needed to stop and question personal, pre-critical, and/or over-reaching cultural assumptions. What role had authority played in the advancing of a now commonly accepted idea or a paradigm? Why and how had this or that discovery or idea become validated and or culturally dominant? What might be learned, adjusted and distilled into principle or valid application today? Questioning at this level always brings one back to epistemology, the field in which one grounds oneself by *thinking about thinking*. Here, one asks: How do we know what we know? Has the knowledge base been advanced through reason or through sense perception or a combination of both? As Plato [32] says: "*Appearances and Reality differ*."

Finally, for me, the theology-medicine interface [33] once pioneered at Duke University was also extraordinarily rich in meaning, potential and inter-religious [34] dialogue. Though the world has no surplus of physician-theologians, they bring exceptional finesse to the field of thanatology.

Regardless of the discipline being considered, as often as possible, I read bilingual translations of primary texts or manuscripts first and foremost (rather than reading survey anthologies or interpretive secondary commentaries). I did this in order to discover what could be learned directly from the ways pioneering individuals, groups, and cultures once perceived and lived their sciences and arts in their own periods of health and illness. How had they *lived* with illness and *spoken about* illness and bodily suffering and how had they given these realities *image*? Had the consciousness of human mortality affected daily life and preparation for the deathbed transition? If so, how? If not, why not? Many a commentator had risked a position statement on this already, but I found myself looking at literary and religious texts, including published liturgies and ethnographic works on home-based prayers, practices, sung and spoken ritual acts and blessings. I frequently marveled at the number that were actually thanatological in nature, even if un-noticed as such by scholarship.

The primary *spiritual* inspiration for music-thanatology is a Western form of monastic medicine. Benedictine monastic medicine is preserved in the written tradition. The monastic house at Cluny had situated itself along a primary pilgrim's route, was initiated in great good will, accepted death into the fullness of the human life cycle, and promoted a two-fold regimen of *care of the body* and *cure of the soul*. The monastic infirmarians had no impulse or desire to sentimentalize or "prettify" death; rather, while using their own surgeries and botanical medicines, they emphasized cultural continuity and the roles of loving care and devotion possible within supportive community. Their medical anthropology pre-dated Descartes [35] and their infirmary practices modeled a practical realism. The monastic customaries implicitly taught about the differences between healing and curing, indicating that although not all illnesses can be cured, and whether or not one has had an amputation or lost a mode of sense perception, it was possible to be inwardly whole and possible to die in a condition of completion and meaning rather than futility or tragedy. The quality of care facilitated by this model made ample room for the patient to focus on any inner work that needed to be done in order to die in peace. The Benedictines were psychologically astute about matters of forgiveness and gratitude. Each was perceived as a healing force, despite the fact that cure was not possible.

In contrast to monastic medicine, the contemporary *clinical basis* of music-thanatology is derived primarily from a dual study of oncology and internal medicine, both informed by the body systems fundamentals explicitly taught in anatomy and physiology [36]. (However, music-thanatology has not included gross anatomy as part of curriculum). To these it was logical to branch out into etiology,

phenomenology [37], the tenets of narrative medicine [38], qualitative and quantitative research design [39], and the vast topical biomedical and nursing literature published in professional journals.

By 1984, I had begun to wonder if death-bed practices and or liturgies differed between men and women, historically, or differed with the individual variations of self-awareness or realization, some of which is described today under the rubric of individuation [40]. I wondered what role gender [41] and biology may have played (separately and together) in the perceptions of health, illness and dying, and even possibly, in liturgies arising from different genders and communities. A worthily revered scholar once suggested to me that the question of gender was unimportant, but he had no experience in health care, so I persevered. I had noticed that the men and women whom I was seeing in the Denver hospitals were often experiencing, perceiving and speaking about their experiences, perceptions, bodily afflictions and or their suffering in different ways. I sought to listen deeply and understand how and why these differences were emergent, and this entailed that one not only reconsider the role of gender, but also that one think about sources of authority. How is authority conferred and inhabited? I marveled over the different ways that diagnosis and prognosis had been discerned and conveyed across different time periods and cultures. Though today we usually rely upon the specialist to tell us about a life-threatening diagnosis or prognosis, there was a recent time in which the dying individual had been closer to nature and to the seasons, and more keenly attuned to his or her own bodily health and interior condition. Even if the individual did not know the medical terms used by health care specialists, it was not unusual for a person to self-initiate the social drama. That is to say: one set it in motion, accurately announcing to others nearby the reality of his or her own upcoming death. It is understandable that in a technological delivery of medicine increasingly layered with specializations, we today generally rely upon the authority of larger-than-life diagnostic imaging technologies and sensitive tests, but the questions of biology, gender and self-knowledge remained vivid for me, so I held the questions and continued the search.

Ultimately, I wondered how the peoples of pre-industrial ages lived with their dying as much as I wondered about contemporary experiences and people. I discovered many kinds of music arising from different periods – written tradition and oral tradition – indicating that people from every walk and station came to terms with the question of human mortality, directly and indirectly, through song, poetry, homemaking and agrarian customs frequently unrecognized as thanatological in nature. However, more than a few peoples and communities addressed consciousness of mortality outside of formal institutions, in their fields and at their firesides, not in infirmaries, universities or surgical theaters. The litany of anomalies being accumulated through interdisciplinary work indicated to me that not all death and dying experiences and practices were recorded as such, nor immediately recognized as such by cultural, musicological, liturgical and or medical historians, primarily because they were not looking for the expressions or the traditions in the places scholars expected to find them, secondarily because they had already been taught what to look for and the new evidence did not always fall into the proscribed categories, and third, because many experiences were not preserved in the written or literary tradition, but rather, passed down orally. There are differences between a remote island folk song about end-of-life leave-taking and the music notated in the monuments of Jewish or Christian liturgical sources that are formally sung and prayed at the end of life. The ethnographical resources include many details of "the ordinary experience" of dying at home, whereas the formal liturgical musical resources arise from within a more proscribed religious structure. Both present unique melodies of spiritual, cultural and intellectual significance.

In retrospect, I can see that I was entirely free to combine in equal measure the fruits of the artistic, the scholarly, the interior-spiritual and the clinical-scientific. In my experience, I needed all of these dimensions in order to meet the patient experience in real time rather than through an interpretive lens, from a theoretical distance, from abstraction, or from the perspective of a single imaginative religious tradition or symbolism. This harmony of ways and means facilitated the development of an interdisciplinary lexicon of terms, and nuanced theoretical frameworks and clinical protocols. If unified and cohesive, reflecting the strengths of multiple disciplines, music-thanatology communication could make sense to both clinician providers and scholars across a wide spectrum of the humanities.

Over time, I worked in every Denver metropolitan hospital and hospice and many long-term term care facilities, urban and semi-rural. Only after having garnered more than ten years of clinical experience, I began to present papers at conferences and also began to publish seminal ideas on the uses of music in the care of the dying. At the same time, in the world of classical music, I concertized widely and recorded successful solo albums and CDs for the major labels. This performing career is only important to mention here for a single reason. During the 19 years of this Denver development, I did not invoice dying individuals for my time nor invoice any hospital or hospice agency for the vigil work, but suggested instead the possibility of survivors making a contribution to an individual or an institution with whom they had experienced pain, difficulty or entanglement. (A precursor to the pay it forward ideal). The vigil work was freely offered because it was possible to do so. The livelihood being earned in performing and teaching classical music allowed me to fund and develop music-thanatology research and development without the kinds of allegiances that can otherwise tend to support yet hold back in equal measure. I

most certainly have found guidelines, standards and constraints to have enormously legitimate uses, but remain grateful for the almost two decade period in which the archival research and development were uninhibited by humanly made institutional or grant deadlines. After having delivered my first medical grand rounds at what was then called Rose Memorial Hospital, something called critical mass had become fully operational.

Following a number of demonstration trips back and forth from Denver to Missoula, Montana from 1990 to 1992, I received word that St. Patrick Hospital had voted to welcome music-thanatology as a palliative medical modality, and with that notice came the invitation to relocate. I had considered Colorado home, had never gone looking for anything different, yet knew that *that* moment was medical history. St. Patrick Hospital was founded by the Sisters of Providence and I was very appreciative of the practical and inspired ways in which women religious had served the history of medicine and served the needs of the public. I was equally impressed by the medical and university communities and by the visionary warmth of those in positions of administrative leadership in Missoula generally and St. Patrick particularly.

Phase II – 1992 – 2002

In July of 1992, in response to the invitation, I relocated myself, harps, library, and the Chalice of Repose Project clinical practice and the educational curriculum to Montana. Because of a significant multi-year "dowry" pledged from the John E. Fetzer Institute in Kalamazoo, Michigan prior to that 1992 relocation, (supporting staff and clinical work) we filed articles of incorporation that summer, and soon thereafter applied for non-profit status. With the exception of the absence of a burn unit (which Missoula did not have), the ten Montana years (1992 – 2002) presented the fullest possible spectrum of patient constituencies and every conceivable clinical opportunity and organizational threshold that might otherwise be encountered in a much larger metropolis or center of medical excellence. Over time, my own work and or the work of the Chalice of Repose Project was distinguished by awards, television documentaries [42], publications [43] and very generous philanthropic support from the Sisters of Providence, St. Patrick Hospital Foundation, the Charles Engelhard Foundation and the John E. Fetzer Institute among others.

The Chalice of Repose Project maintained the traditional physical classroom delivery system during this Phase II Montana decade, and accepted a new cohort of students in the School of Music-Thanatology every two years. The full time employee positions at Chalice combined teaching and clinical hours. By this, I mean that no full time 40-hour per week employee had a job description that entailed 40 patient contact clinical hours per week. Though we paid linguists for new translations of texts, we had no theorists on faculty. Each faculty specialist knew their field and worked in their field. Unlike university professors who might traditionally teach two semesters a year, my colleagues and I maintained clinical practice 365 days of the year and taught three semesters a year: fall, winter and summer. By 1994 we were serving the dying at three separate (unrelated) hospitals, multiple long-term care facilities and three hospices over many miles. From the first week of December in 1992 to September 30, 2002, the Chalice of Repose Project music-thanatology clinical practice received and served over 4200 patients. Every single one of those patients taught the practitioners precious things. Our teams delivered prescriptive music for men, women and children of every age group, ethnicity, religion, education, orientation and employment background as they were dying from cancers, degenerative diseases, pulmonary and respiratory disorders, organ failures, chronic and progressive conditions, cardiac and coronary conditions, infectious disease, trauma, failure to thrive and more. We worked locally in Missoula and yet we were also peripatetic, serving the dying as far away as Hamilton and Helena, a span of over 160 or more driving miles.

As cultures, institutions and economies change everywhere during the course of a decade, faculty questions about sustainability *and* awareness of the need for national outreach rose to the surface. By 1997, music-thanatology had become distinguished nationwide as a palliative medical profession through a variety of print publications and national television and radio broadcasts. But as a profession, music-thanatologists needed to serve the patient constituency wherever they were or are, rather than having the practitioners remaining clustered around a single city location or around a single medical institution. By 2000, that realization and the changed terrain required visionary growth and pointed to the need for an imaginative renewal. First, an organization has a life cycle not unlike a human being. In order to mature, it will develop self-sustaining programs rather than being or remaining reliant upon foundations or philanthropy for operational funding, or it will die. Second, individual practitioners need to take the initiative to develop clinical employment contracts in other cities, and all needed to cultivate contracts that supported healthy self-care while fostering continued clinical and artistic growth. Simultaneously, graduate level educational programs were going on-line nationwide, no longer requiring that students relocate to other cities to accomplish their continuing professional education goals. Fresh ideas about clinical privilege were emerging as hospitals and hospices closed and corporate acquisitions and hospital mergers reconfigured administrations and systems nationally. By 2002, the time for change and renewal had arrived.

Phase III – 2002 to the Present

Following relocation to Oregon in October of 2002, and dual academic appointments at The Catholic University of America and Duke University, the need for a three-fold focus on education, clinical care and publishing became clear to me. The Chalice of Repose Project re-incorporated mid-year in 2003, re-opened the School in 2005 with the first cohort in Contemplative Musicianship, and has been self-sustaining for over a decade, rather than financially dependent upon philanthropic gifts for routine operations. National headquarters remain in Oregon, and yet we have retained the freedom to establish temporary satellite offices in other cities or locations if and whenever needed. New affiliation agreements are organically developed in locations nationwide as they are needed to support student internships and or as we develop new partnerships or different kinds of initiatives with other organizations. The intensive residencies required in contemplative musicianship and music-thanatology programs are delivered in Mount Angel, Oregon, yet music-thanatology students "do" their faculty mentored and faculty supervised field placements or clinical internships in their home towns.

Today, our educational programs serve a spiritually diverse student body, the majority of whom arrive in their middle or late 50's. Many individuals have decades of professional identity or employment history under their belts, but not all do. This variance means that each arrives with a history of success and failure, anxiety and confidence, knowledge and lack-of-knowledge, hunger and longing. Each moves toward new growth differently. For example, one might arrive as a self-taught lover of folk music and has a capacity for study. Another is very musical and professional yet can't imagine the agency formalities required of clinical privilege, and a third has great lyricism on harp but has never sung. Each moves in ways that reflect the variety of their pasts and very different skills and potentials. Most develop new musical capacities they never dreamed possible, and all discover that as they grow in depth, they necessarily re-encounter whatever personal biographical elements, patterns and communication dynamics that have shaped their adulthood up to that point. Applicants often apply to music-thanatology because they have garnered some very real experience with a loved one dying very well or very badly, and this experience became personally transformational. Inquiries and applicants come from the ranks of nursing, social work, medicine, music, psychology, education, religious life and business. They arrive wanting to see what they can do to make a difference, and as a result, most are re-thinking their ideas about profession and vocation.

The inter-disciplinary educational programs offered at the Chalice of Repose Project are available in an on-line and low-residency format. The programs are contemplative musicianship, music-thanatology, and archetypal and narrative thanatology. Students access program modules on-line, so they are able to live anywhere during their period of enrollment. Although a number in our ranks have already died, been incapacitated through illness, or retired, those who have completed their music-thanatology didactic and the clinical internship requirements through the Chalice of Repose Project have established work as contractors or employees in various locations. These include Colorado; New Mexico; Illinois; New York, Texas; Vermont; South Carolina; Hawaii; Wisconsin, Massachusetts; Washington; Utah; Oregon; Maine; California, New Jersey, Tennessee; Montana; Canada and the Netherlands. The majority of the students who have enrolled from 2005 to 2016 have maintained serious familial responsibilities while studying, and might be or have been care-givers for a dying sibling, a seriously ill adult child, a chronically ill spouse or an elderly parent who requires a series of hospitalizations. A demographic with this kind of profile needs and requires flexibility, so many need and receive extensions and or transfer cohorts to accommodate leaves of absence. The majority of our associates have also buried one or more loved ones, or had a serious illness or surgery of their own after completion of the program, and this too shapes the ways in which they later find a balance between work and life, even when they are inspired and working part-time in professional placements.

Upon completion of the program requirements, individual music-thanatologists combine their personal goals and decisions about professional placement and then cultivate the kind of position appropriate to their unique situation in their location. The combination of personal goals plus formal education plus previous employment history is germane to the story. Some associates have chosen to maintain dual careers, for instance, working part time in social work or in clinical psychology *and* part time in music-thanatology. Colleagues and professional associates may certainly work summative full time positions but a 40 hour week does not translate into 40 vigils a week. Each referral from start to finish requires considerably more than an hour, and each referral received is for an actively dying person, meaning that all of the patients with whom we work do indeed die. The nature and level of immersion and processing in end-of-life care is so intense that my colleagues and I cultivate job descriptions that combine their clinical and administrative hours and account for considerable driving time, clinical coordination, and organizational outreach activities.

For instance, it is the nature of my position that my job description is reconfigured and adjusted each year. I work a full time position, but my employment description is divided between clinical, pedagogical and administrative hours, in addition to publications and public outreach. At the Chalice of Repose Project organization, where the public mission is three-fold (education, clinical care, publishing) the numbers of clinical referrals ebb and flow in predictable cycles and do so for specific reasons. With those patterns in mind, and with the teaching and publishing load that has been carried here,

we have generally formalized organizational affiliations during any 12 month period in such a way that the referral flow would not exceed approximately 400 vigils annually. However, another corporation with only one focus (clinical care) might structure and language their employee and or contractor goals and commitments differently. To illustrate: Two skilled full-time clinical positions fulfilled and shared by a group of five part-time musician-clinicians, each of whom is peripatetic and driving 120 or more miles daily (to and from 3 different home or hospice locations) might be able accomplish good clinical coordination and advance communications with the agency, interdisciplinary team staff and the patient or the patient's family, and then deliver anywhere from 6 to 8 sixty-minute vigils daily, which includes the follow up completion of clinical charting and clinical notes or narratives. Differently presented, if they are well integrated into the agency system, the same team might be able to deliver fifteen hundred to eighteen hundred to two thousand 60-minute vigils annually (plus the required communications and medical record annotations). It is different and differently configured everywhere, whether urban or rural, and during any given week, several scheduled vigils might also be cancelled or need to be rescheduled, or a referral many be received too late, and the patient dies before the musician can arrive. In remote rural areas, the referral process can be very slow. In a large metropolis, the referrals can be so numerous that it can be overwhelming. It is only slowly, with time and experience, that one learns the amount of good work of which one is capable. My colleagues and I advocate that to exceed a certain amount of work in any one area that might result in a loss of quality in another area serves no good; it undermines credibility. Only with experience does one learn to make decisions that create realistic and sustainable possibilities as well as excellence in patient care. Last, I would be remiss if I failed to mention that more than a few amongst us also consider it an honor to be able to provide some amount of pro bono services as part of community service work.

As part of my commitment to music-thanatology education and outreach, I have taught music-thanatology and contemplative musicianship at Duke University and The Catholic University of America, and have delivered artist-in-residence, clinician-in-residence, or scholar-in-residence programs in contemplative musicianship and music-thanatology for graduate students in departments of music, theology, social work, nursing and medicine in many locations. I have accepted invitations to deliver plenaries, keynotes or residencies at over 65 American and European colleges, universities, seminaries, institutes and professional organizations. Because of those and a few fellowships and visiting professor appointments I have accepted over time, the Chalice of Repose Project has benefited from sustained dialogue with a wide variety of professional and academic conversation partners. Nothing we have ever "done" has been accomplished in isolation. The supportive assistance and expertise pouring in from professionals in the academic disciplines arising from medicine and the humanities cannot be under-estimated.

A Snapshot of the Clinical Practice

The music-thanatology practice I have taught and we have modeled entails several specific elements and formal criteria. Though some may live longer than others, every patient we receive is truly actively dying, and every referral requires the verification of a DNR or AND or similar status before one can proceed. The vigil model we teach is truly clinical-pastoral-medical-musical, and typically lasts about an hour unless something unexpected happens such as a burst of urinary or fecal incontinence, in which case, the need for patient dignity overrides and it is sensitive to reschedule. Unlike other allied professions and modalities such as chaplaincy and or psychology, music-thanatology is not a talk therapy. The music-thanatology delivery of prescriptive music is always delivered live, at the bedside of the dying individual, and occurs with voice and harp. (The choice of harp reflects the need for a portable and polyphonic instrument).

Our work is appreciated by staff, but when we are most effective, it is as if the work of music-thanatology becomes invisible. That invisibility serves a great purpose to the degree that the patient is maximally visible. If a musician-clinician is doing good work with a dying individual, the patient is both center and periphery. The skilled musician-clinician can work without drawing personal attention to oneself or without needing or seeking personal affirmation during the vigil. They derive their feedback in other ways. Unlike a concert performance setting, where a musician is elevated on stage, the focus of the music-thanatology vigil is entirely on the patient and centered in the patient experience.

In harpistic artistry, the sound of the activated string is always going to begin dissolving as soon as it emerges, and skilled musicians use the dissolve to clinical advantage. Following Martin Buber, we stress the primacy and sacredness of the human-to-human encounter through responsivity and music. This human-to-human encounter can often provide a spacious human intimacy that stands outside of time and in contrast to the high-tech mechanical apparatus that is prevalent in the intensive care, cardiac care or neonatal unit. We attempt to be present for those who are dying for the duration of the journey, be it a few months or a few days, *if that is their wish*. We want to be there when they are actually dying *if this is their wish*, and this availability is understood as a standard component of supportive end-of-life care in the hospitals or agencies supporting music-thanatology. We in turn support the physical and spiritual needs of the dying through two kinds of clinical referrals: *processing* and *imminency*. We differentiate between physiological pain and interior suffering and rely upon scales of 1 to 10 as pain assessment descriptors whenever appropriate.

At some level, for those who have a (terminal or life-threatening) diagnosis, dying can be described as an intensified living. We are aware that all contemporary evidence-based practices eventually render the details of health care, (our lives and our deaths) into impersonal data and do so in order to learn scientifically, cleanly, seeing and interpreting patterns, as well as noting anomalies and gaps. We understand and laud evidence-based practices and at the same time caution one another to remain connected to the patient experience and to work to keep health care patient-centered. One can unwittingly allow the scientific theory resulting from data analysis to eclipse awareness of the actual patient experience. The existential experiences of the dying do not always fit into the indications suggested by the data that creates a bell curve. Using the term *participant-observer* rather than only observer, music-thanatologists hope to remain sensitive to patient experience in a grounded and balanced manner. The music-thanatology practice I pioneered and taught has been evidence-based from inception. Even though our work has never been tied to or limited by the reimbursement issues so germane to the national discourse following the Affordable Care Act which became effective January 1, 2014, professional music-thanatologists who maintain excellence in documentation are well equipped to meet the analysis of evidence-based scrutiny that has become the mainstay of the electronic medical record.

Be that as it may, however much private details become impersonal data, each life, each vigil session, each dying person and each death is somehow spiritually and biologically unique and particular, never to be repeated. We can and do note commonalities and similarities in the patterns of our living and dying, and in all our human transitions, and yet our evidence suggests that each person lives his or her own dying uniquely. For music-thanatologists, among other things, this uniqueness means that no two deliveries of prescriptive music can ever be the same, even if the clinician is serving several patients today, each with a similar stage 4 cancer diagnosis. We teach a methodology rather than a reliance upon a static play list and we do not advocate on behalf of a rigid grid mechanical causality. The methodology requires that the musician really has to be present and functioning as a musician-clinician, able to make musical decisions based on observing and responding to the patient's condition, able to work through the principles of prescriptive music, rather than play background music from a pre-conceived repertoire list. Each delivery of prescriptive music requires something uniquely reflective of and responsive to the patient's own dynamic medical, biological and interior condition. One person may not experience a high degree of physical pain at all and yet may be suffering enormous sorrow, grief, anger, fear or shame over disfigurement or abandonment. Still another has adequate pain meds but is grieving in the knowledge that their imminent death means that their small children will not be raised by two parents and a spouse will be left alone instead of partnered. Another has very difficult physical pain because of the pressing tumors, but has achieved a peace and is gradually letting go. We do not arrive with preconceived ideas about any prognosis or condition, nor do we arrive with preconceived musical play lists. We have to be able to enter into the situation in a fresh manner, in order to observe and respond to the dynamism of the patient's condition in that hour.

Documentation

When we document, we advocate on behalf of a specificity [44] that reflects the measurable data of vital signs in addition to a wide variety of related observable physical phenomena. We also try to refrain from interpretive comments that leap into assumptions. For instance, we advocate that the "Ms. Smith was angry again" reportage is an assumption, whereas the much more phenomenological "Ms. Smith turned her face to the wall and sighed deeply" allows her body to have voice and become integral to the clinical narrative, even if Ms. Smith does not choose to use words. In this latter example, there is no judgment about Ms. Smith's "anger". Together, phenomenological observations, several quantifiable measurables and detailed musical indications demonstrate to staff peers and colleagues a level of clinical acuity, (observation and thinking), to which the musician must risk musical depth and musical artistry. Excellent documentation can paint an intelligible and useful picture for the colleagues with whom we work: physicians, nurses, chaplains, music therapists, social workers, respiratory therapists, hospital administrators, and clinical and administrative quality review readers accessing medical records through remote locations.

Here is an excerpt of a larger work offered to illustrate the what, where, why, when and how points documented following a vigil. Our colleagues attempt to be descriptive rather than explanatory. In the case excerpted below, the vigil referral was made to support a 73-year-old male who was single, had never married, and had led a fairly solitary life. The record indicated few visitors, and the staff providers had become his community support system. He had self-disclosed that he had gained little exposure to or interest in the arts or music during his life as an electrician, but he did express a desire for the musical vigil when the nurse suggested it.

> "Referral made by nurse SMcN following the discussion at the IDT meeting, because of R's demonstration of increasing mental confusion (attempting to place his shoe on his head; referring to his bed as the car; calling his sweater broccoli) exacerbated by anxiety or agitation (frequent tossing and turning in bed; mild sleep deprivation; tensed muscles; damp skin; shallow irregular breathing; repeated heaving, some yelps, loud sighing; wet eyes; mildly itching skin; etc). Beginning vigil at 16:40PM in silence in order to observe his breathing, the first 30

minutes of the hour long processing vigil emphasized the uses of melody and repetition. Choosing a theme unknown to the patient, so previous associations or memories could be avoided, the 1st part of the session emphasized a long, well-developed, instrumental, metered melody in ¾ in a concentrated minor mode characterized by 3 minor intervals. Repeated the theme a dozen times at the same or similar tempo (an adagio at about 56) but differently nuanced the music at each returning repetition. (used different harmonic structure; P5ths followed by m2nds; P4th alternating with m7ths; more and less texture, occasional ornaments; melodic variations; moving bass; occasional wordless humming on vowels; cadences that resolved fully; cadenced that remained open and did not return to a tonic). Synchronization was achieved shortly after 16:55pm. By 17:10pm, his breathing had gradually deepened and become more regular; his BP decreased from 122/84 to 110/78; the clammy perspiration on his forehead was no longer observed; his eyes were no longer wet or runny; muscles around eyes, nostrils, lips softened and relaxed; the tossing and agitation in bed and the pulling of the bed sheets ceased; he had began to watch the strings, listen intently, and appeared more focused and aware; he made frequent eye contact; smiled, called me by my name once, ("…Thank you…Thank you Tess…") and was resting quietly. After several moments of silence, I began the second half of the vigil in a new and contrasting direction, emphasizing a different theme, introducing a theme of unmetered music, in a brighter mode…… "

Music-Thanatology Curriculum

During the last decade, the music-thanatology curriculum has been offered as a low-residency, on-line program. (The curriculum has been revised no less than 17 times over 30 years and will continue to undergo revision typically annually). The curriculum during 2006 to 2016 has consisted of 24 individual, lengthy, structured, multidisciplinary and interdisciplinary modules, each module containing its own syllabus and bibliography. Each module has been sequential, building upon the content of the one previous to it, meaning that the modules need to be completed in order. During the previous decade, the week long intensive residencies have occurred twice per year. The 24 modules have traditionally been delivered over the course of about 28 months, meaning that there have been 2 brief scheduled breaks per year. Each student qualifies for the privilege of clinical internship by first successfully passing oral and written musical and public speaking exams, and most students sit for the orals more than once. Every music-thanatology student has a clinical internship requirement which is faculty mentored and supervised. Following successful completion of all 24 modules, all 4 residencies, and the internship requirements, the student completes a written paper that also serves as a comprehensive exam. After these steps have been completed, joyous participation in a pinning ceremony is well-deserved.

"Only she who knows relation and knows about the presence of the Thou is capable of decision. She who decides is free, for she [45] has approached the Face."

Martin Buber

A Snapshot of a Contemplative Dimension as an Applied Spirituality

From the beginning, I imagined that vocation and profession could be unashamedly unified in the *praxis* of music-thanatology. I have seen first hand that this can be accomplished in a manner that speaks authentically to practitioners representing spiritual diversity (Jewish, Christian, Buddhist, etc). It is a practice that emphasizes personal freedom, refrains from the tendency to religious syncretism, and allows individuals to maintain fidelity to the particularity of their faith or spiritual traditions.

In observing many professionals in health care settings, one can see that some are distracted and pre-occupied, and others are more present and responsive, however, both usually have in common that they tend to be over-worked. The difference between morale and skill level and the ability to work with presence of being occurs as a result of a variety of reasons. It seems clear that something beyond procedural *technique* or *technical skill* is required if one is to offer excellence to the patient and avoid burn out. This is true not only for the nurse and the physician, but also for any integral musician-clinician. We are trying to articulate something about bridging the arts and sciences. We ask ourselves how clinical acuity and musical artistry can function and breathe together in coherence for every musician working in a health care setting. We do our best to point out to students that if one is playing an instrument without paying attention to the breathing patterns of the patient, or if one is playing an instrument as if the quality of the music does not ultimately matter, one can hear a kind of distracted, ineffective, predictable, pre-occupied, relentless click-track delivery, a sort of background music, regardless of the instrument being played. If this occurs, the disconnect means that the quality of patient care suffers. It is also where the difference between appearances and reality can become painful if deep attentive listening is not an integral part of the delivery and work. Whenever things are not what they seem to be, it is time to step back, correct and adjust.

The mission statement at the Chalice of Repose Project takes that into heart and mind, structure and commitment. It risks an atypical organizational leap when it affirms the primacy of the contemplative dimension in all aspects of our work. We say that we will *lovingly care for the physical and spiritual needs of the dying with prescriptive music; make patient-care services available to individuals and loved ones*

during the weeks, days and hours leading up to the moments of transitus; educate clinicians, care-givers and the general public about contemplative musicianship, music-thanatology, monastic medicine, and the possibilities of a blessed, peaceful or conscious death; model and integrate these contemplative values into daily life, work environments, patient care programs, curricula, and all work-related initiatives.

It is more difficult to model and integrate the contemplative dimension into daily life and work than it seems. People forget this, but in my experience, the accountability factor of the contemplative dimension is in some ways more challenging than learning how to play an instrument beautifully. The contemplative reflective capacity can't be memorized. It must be practiced, lived, and eventually becomes embodied. The personal responsibility and accountability required to choose to *walk one's talk* is the heart of the matter. Briefly, when we refer to the contemplative dimension, we are including (among other things) the inter and intrapersonal capacities for truthful reflection and growth.

In this light, each of us has seen or witnessed a capable or dedicated person at a hospital or hospice who suffers from fragmentation. Fragmentation is a modern day malaise, and some would say it is epidemic or pandemic. What professional or adult isn't overworked, over-extended, and pulled in too many directions simultaneously? In the contemplative orientation, it is safe to say: if one is truthful and mature, who can look within and fail to find fragmentation in greater or lesser degrees in <u>our own</u> daily life? Fragmentation shows up in myriad inter and intrapersonal communication expressions, choices, attitudes and postures, as does its remedy: *presence of being*. By taking the time and care to see obstacles and shortcomings within oneself before seeing them anywhere else, I lay down a burden and embrace an opportunity. In this way, it is possible to lay down defenses, see personal patterns and self-correct with good will and gratitude. It is not only possible to avoid the temptation to unjustly defame another or blame the colleague for the outcomes of personal choices or shortcomings; it is a characteristic of the individuation process. An era of *post-truth [46]* group speak does indeed magnify fear and distraction, but if one has the maturity, integrity and professionalism to want to inhabit a lived commitment, to walk the talk, one can also engage in the reflexive spirituality that supports growth, and allows one to adjust and self-correct rather than blame or project. How often though is this ideal gracefully accomplished in the corporate setting? In personal life? In professional life?

When addressing the malaise of fragmentation, Thomas Merton [47] went to the heart of the matter and repeatedly advised people to *try to recover their fundamental unity*. In a mutually extended presence of being, something truly collaborative gestates and emerges. We extend reciprocal commitments to one another equally rather than reserve them for ourselves and demand them unilaterally from another. In addition to starting to become capable of seeing ourselves unvarnished, as we truly are, and recovering that fundamental interior unity Merton describes, we begin to be able to take a second step, that of developing the ability to learn from everything and everyone. This includes a courageous reflective return to the tuning, fine-tuning, and attunement possibilities wherein both success and failure can be clearly seen and lovingly and compassionately integrated. However much the healthy person winces upon discovery of personal folly and/or personal shortcoming or inflation, gratitude for the opportunity to apologize, correct and demonstrate improvement results in something unmistakably spacious and radiant. A third area that gradually begins to become more integrated in this milieu is the awareness of human mortality. Morbid fascination or curiosity or intrigue: *no*; a sensitive awareness: *yes*. With these three staged elements, we approach a fourth and crowning example of a spiritual practice that contemplatives of multiple faith identities and formations can share while maintaining fidelity to one's personal religious tradition or philosophical position. This praxis is one that allows a professional music-thanatologist to deepen and expand while drawing near to the patient experience of death and dying, even if at a level differently from the biological one in which the patient resides. The practice is called "letting go."

Letting Go

Dying entails a kind of unbinding process. The biologically dying person learns the process of *letting go* in his or her own time rather than in clock time, corporate time or community time. No two time-lines are the same and the learning curve cannot be forced. In end-of-life biological dying, during the journey from the onset of illness to the point of diagnosis to the eventual death, the dying individual gradually *lets go of* many layers of former identity, the layers that were once vibrantly "ours" in previous times of health and well-being. One way or another, one learns to *let go* by choice, by necessity and by default. I may have been a partner at the law firm or a fine cellist in the orchestra before I was diagnosed with this lung cancer. I may have been a loving parent who adored her children and spouse, even if I now have trouble expressing myself because I am depleted or aphasic after a series of strokes. I may have earned a wonderful livelihood before, and even been attractive, with a gorgeous head of hair or graceful movements. But now, things are different and changing. I can no longer work on those legal depositions or earn that impressive paycheck or provide for my family. I can no longer see or hold my children, or make love with my spouse. I am dependant upon others even for elimination. My hair has fallen out, others wash my face and moisten my lips, and I will never again play a *legato* on that cello.

The gradual stripping away process is indeed difficult, but does not necessarily constellate a nightmare arithmetic in

which the human being becomes a zero sum. Often, the *letting go* process can constellate something resembling addition rather than subtraction. In one of the most mysterious and sacred paradoxes of human existence, it is sometimes possible that voluntary self-emptying and voluntarily becoming "less" can result in the arrival of the new, the previously unknown, from which we look and suddenly discover that we ourselves or the care-givers nearby have gradually become "more" and at times, even a radiant more. Maybe until the onset of this cancer, the nurturing aspect of someone nearby has remained unavailable and underground. The sibling, the spouse, the children, neighbors or colleagues have remained in their original roles and perceptions, but now the cancer ushers in a series of changes and role reversals. Mom or Dad or that capable department chair had always provided! Now they can't. As the illness begins to progress and the previous role or identity of that ever-dependable parent or colleague falls away, others discover new strengths and capacities within themselves that had not come to light before. They recognize the opportunity and step up to the plate. Each becomes more and new proportionate to the heartfelt awakening and responsivity that is possible when we love and care.

Chalice of Repose Project music-thanatologists represent individuals of spiritual diversity (Jewish, Christian, Buddhist, etc). They share a contemplative practice without suffering a loss of personal freedom. We too can choose to learn the ancient philosophical, religious and indigenous meditative practice of "letting go [48]," or *dying to* something small *daily*. Each time we voluntarily choose to "die to" and/or "let go" of something *unfruitful* in ourselves, we let go of some of the dead wood of our lives. We "let go of" the brambles accumulating in our thoughts and feelings, habits, patterns, perceptions and stories. In "letting go," we are clearing. We are creating interior space and preparing for service. Each time we voluntarily choose to "let go of" an *unfruitful* attachment, a bias, a fear, an unquestioned assumption, a resentment, a blame orientation, a petty attitude, or especially the hubris of a self-serving deception, we are practicing as contemplatives and we are "letting go". Through this posture and attitude, it is possible for individual professionals to more fully approach and appreciate something of the unbinding process and the letting go process lived by the patient. The dying person in that hospital bed is changing and accomplishing their unbinding, their "letting go" process at several levels: biological, psychological, spiritual, cultural, linguistic, and more. One can become stuck in unfruitful ways and means, but fruitful change is characterized by movement: graceful, lyrical interior movement.

In the medical records at the Chalice of Repose Project, we say: *Ms. Smith's transitus occurred at 19:00 on Tuesday, September 13, 2016.* Use of this evocative term *transitus* is a way of bringing the awareness of human mortality as a rite of passage into a more cohesive and more nuanced whole, and one that signifies movement rather than futile stasis. In acknowledging and naming transitions, and in acknowledging the growth possible in end-of-life rites of transition, we are in fact bringing death back into the fullness of the human life cycle. In so doing, something about coherence is elevated. Each reader will one day experience their own personal end-of-life biological death. The contemplative dimension serves the present and the future, the patient and the practitioner, the agency and the administration. It helps practitioners to become more sensitive to the needs of the dying. Every dying individual who is respected and supported through their intensely lived and meaningful dying process contributes something essential to the larger human-making curriculum and to culture. What the dying are in fact giving is legacy, and they are accomplishing it in a layered and textured terrain. The contemplative dimension is also inwardly personally restorative and helps prevent professional burnout. At the same time, the practice of "letting go" teaches individuals in small incremental ways how to prepare for their own final moments, which may come tomorrow, next year, or ten years from now.

The Chalice of Repose Project is a small organization, but each professional practitioner has the potential to make a cumulative positive difference. The advances of modern medicine may wipe out the incidence of certain kinds of diseases in the future, yet the dying will continue to be with us. The quality of care being described in the best palliative care programs affects a wide range of people, not only the single person who has just died. Wherever professional music-thanatologists work in hospitals and hospices, there is this to say about a shared spiritual praxis that is fundamental to the clinical work. Voluntary contemplative practices like *letting go in small daily ways* helps each individual meet and transform the hardening tendency that sooner or later comes to every professional. *Letting go*, voluntary self-emptying, and making room for that which is truly new constitutes a clearing. This can contribute to a radiant sustainability, and I understand that this vision speaks deeply to many, not only students and associates. Ultimately, this is only one of a dozen other contemplative practices [49] that seasoned professionals share and that are described in another publication. That being said, I come back full circle to *letting go* and ask individuals and groups in sincerity and practicality: In what medical, musical, academic, corporate, religious, governmental or community setting could such a contemplative *praxis* as *letting go* fail to bear new fruit and thus serve a great good?

Currently: 2017

Regardless of the many changes and advances accomplished over the several decades, the work of music-thanatology remains intimate. We speak of the importance of beauty, intimacy and reverence in our attitudes and in our work and work ethic. We have addressed Buber's intimate I-Thou

encounter in this article. Artistic beauty in the delivery of prescriptive music is a fundamental requisite, and when synchronized with the patient's respiratory cycle, the music can facilitate an encounter of wordless intimacy. The word "reverence" refers to wholehearted regard for the individual who is dying and for the sacredness of the unique process that is taking place. End-of-life leave-taking can be truly holy while nevertheless remaining evidence-based and data driven.

Music-thanatologists continue to work in every psycho-social setting in which the dying are actively living their dying. The practice my colleagues and I model has made a quiet contribution to of end-of-life care programs and to end-of-life clinical thinking, lexica and praxis. The musical artistry of professional music-thanatology clinical work has made a qualitative difference in the way individuals die. By extension, the musical work of the vigil has made a significant difference in the way in which the dying person's loved ones and survivors have been able to integrate loss and death back into the fullness of the human life cycle. There is no question that survivors suffer the loss of their beloved spouses, children, parents, siblings and friends, and there is no question that physicians, nurses and administrators continue to offer remarkable end-of-life programs nationwide as they too repeatedly see many of their own patients die. Even though survivors and care givers grieve and mourn, process and integrate, we receive oral and written feedback expressing enormous gratitude and the feedback arrives at the most unexpected moments. When loved ones remember that their spouse, sibling, child or best friend died within intimacy and respect, acceptance of the loss becomes more possible, and survivors are grateful to the hospital, hospice, the providers, care givers and administrators. The work of music-thanatology has been able to offer something of spiritual, human, cultural and clinical significance when interventional medicine has ceased being effective or possible, and it is only one way of many.

I am unable to count the number of times a person or an organization has written to ask how we did what did, and *how did you mainstream?* They usually imagine that music-thanatology was the result of a brief research grant or a dissertation. In describing the time taken, I hope to provide realism. My second hope is that readers intuit from this overview something implicit and precious about ordinary life. If or when we actually see, hear and respond to the most ordinary events and activities that emerge in daily life, including noticing the stranger in the street or the clerk at the market, an almost miraculous road can appear. One doesn't go looking for it. That road comes to you and leads you everywhere, even beyond the farthest dreams.

Profound gratitude is extended to individuals and organizations for decades of invaluable contributions. Without them, the clinical, musical, pedagogical, publishing and contemplative dimensions of this work would be poor. It is an honor to lovingly dedicate this work to Lawrence L White. His radiant vision and servant leadership model have changed the lives and deaths of many. Most of all, we thank the many thousands of patients with whom we have walked for the worlds they have taught and continue to teach about *life* itself.

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Biographical Statements

Harpist and singer Therese Schroeder-Sheker founded the palliative medical modality of music-thanatology and is the Academic Dean of the School of Music-Thanatology at the Chalice of Repose Project in Mount Angel, Oregon.