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ORIGINAL ARTICLE

Post-mortem dignity between piety and professionalism. Plea for a moment of silence in everyday clinical practice

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Abstract

Introduction Death is an inevitable part of clinical practice and affects, in its very own way, not only next of kin and friends but also the members of the clinical team, in particular physicians and nurses, as those who take care of a patient in the very last moments of his or her life. Nevertheless, in clinical everyday life, it is no matter of course to meet the end of human life not only on a physical but also metaphysical level.

Definition of the problem In Western sociocultural contexts, silence is commonly regarded as an adequate expression of respect in the context of death. Considering that time is a more than limited resource in Western healthcare systems, it can, however, be challenging for the clinical team to pause and pay respect to the life that has passed and to generally deal with the unfathomability of human finiteness. Instead, death tends to become drowned out by a strident clinging to the common routines of patient care, in the course of which everyday clinical noises can turn into a roaring, almost inhuman cacophony—a cacophony that may not do justice to the dignity of the deceased, the relatives, or the clinic team.

Objective With that said, this article focuses on forms of bidding farewell in clinical patient care, with an emphasis on post-mortem silence. Drawing on examples from

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literature, medical ethics, and the law, I will plead for a moment of silence in everyday clinical practice as a possible means to interrupt the noise of medicine in the immediate aftermath of death to honor the dignity of both the dead and the living.

Keywords Post-mortem dignity · Clinical handling of death · Piety · Silence · Communication ethics · Medical humanities

Postmortale Menschenwürde zwischen Pietät und Professionalität. Plädoyer für eine Schweigeminute im klinischen Alltag

Zusammenfassung

Einführung Den Tod auszuhalten, dafür ist im modernen Klinikalltag westlicher Gesellschaften kaum Zeit. Zeit ist eine limitierte Ressource, und stets warten andere Patient*innen, die versorgt werden müssen. Ein Innehalten, ein Still- und Stummhalten ist somit ein Störfaktor im klinischen Effizienzbetrieb, eine (bislang) nicht abrechenbare, im System nicht vorgesehene Größe. Allzu oft wird der Tod daher übertönt durch ein lautstarkes Festhalten am Klinikalltag. Ist das Dröhnen der Todesstille ein hörbar gewordenes *Memento mori* an die noch Lebenden, dann erscheint im Vergleich dazu die Geräuschkulisse des klinischen Alltags wie ein hartnäckiges *Memento vivere*, eine Erinnerung an das Leben, an den Lebenserhalt.

Problemaufriss In der Gegenwart der Stille, die einen verstorbenen Menschen umgibt, kann sich diese alltägliche Geräuschkulisse der Medizin in ein nahezu unerträgliches Lärmen wandeln, in ein bisweilen kaum aushaltbares, in den Ohren gellendes Getöse. Die Gründe für diesen Lärm können vielfältig sein, können von einem Gefühl der Ohnmacht oder des Versagens, von Angst oder von Befangenheit sprechen. Doch so nachvollziehbar all diese Gründe sind, stellt sich die Frage, ob nicht dennoch Tod und Toten angesichts ihrer außerordentlichen Unfassbarkeit die oberste Aufmerksamkeit, das letzte Wort gebühren sollte. So verständlich die Betonung des Lebens, des Lebenserhalts im klinischen Kontext erscheint, mutet es fraglich an, ob eine damit verbundene zu schnelle Abwendung von Tod und Toten unseren Vorstellungen einer humanen Humanmedizin tatsächlich entspricht. So wirkt der Lärm der Medizin im Angesicht des Todes wie ein Alarmzeichen, das den kulturellen Konventionen unseres Umgangs mit dem Tod zutiefst zu widersprechen und weder der Humanität und Würde der Toten noch der der Angehörigen noch der der Klinikmitarbeiter*innen gerecht zu werden scheint.

Zielsetzung Vor diesem Hintergrund möchte ich mit diesem Aufsatz anhand von Beispielen aus Literatur, Medizinethik und Jurisprudenz für eine Schweigeminute im klinischen Alltag plädieren, mit welcher dem Lärm der Medizin in der unmittelbaren Folge eines eingetretenen Todes Einhalt geboten und der Würde der Toten und Lebenden Ausdruck verliehen wird.

Schlüsselwörter Postmortale Menschenwürde · Klinischer Umgang mit dem Tod · Pietät · Schweigen · Kommunikationsethik · Medical Humanities

The alarming noise of medicine

In Dylan Thomas's poem *Do not go gentle into that good night* (Thomas 1952, p. 18), the lyrical speaker vehemently resists the impending death of his father with all the strength he can muster:

> Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light.

The Dylanian rage against the inevitability of death, which is both psychologically understandable and ethically explainable, imparts a unique shade of meaning to the concept of the "death throe" and also serves as a poignant reflection of a common attitude within modern clinical systems; after all, hospitals often strike one as battlegrounds where the fight against death unfolds using every available resource, every conceivable machine, all in an effort to prolong the lives of the ailing. This almost furious endeavor to defy death—a stance that remains beyond reproach when both caregivers and patients mutually consent to harnessing the full spectrum of life-sustaining interventions—aligns with a contemporary self-image prevalent in (not only) German-speaking societies, where the prevailing narrative casts healthcare providers into the obligation of preserving life, juxtaposed against the equation of death with an unforeseen failure. Rainer Prönneke (2008, p. A2574) offers an insightful perspective to elucidate this standpoint.

> On the one hand, the millions of experiences of dying and death during the Second World War gave rise to a trauma that allowed survival only through consistent repression of these experiences (along with those presently undergoing the process of dying). In connection with this, traditional rituals that facilitate an understanding of dying and death were lost. On the other hand, the medical advancements in reliable and sustainable treatment successes fostered a euphoric sense of being in control of diseases. As a "side effect", death was interpreted as a malfunction and failure. Consequently, dying as a precursor to death had to be suppressed collectively. Hospice and palliative care then challenged the notion of a rationally justified controllability of diseases.[1]

Within a healthcare system that rejects death, the inclination to shift focus from the deceased to the (yet) living aligns with an inherent logic.[2] Nevertheless, adopting such a self-understanding complicates the ability of medical professionals outside the realms of hospice and palliative care to pause and deal with death and the dead[3].

[1] Unless indicated otherwise, all translations of non-English sources are my own.

[2] And carries the risk that the mindful handling of death is simply shifted to other (e.g., anthroposophical) clinics or wards where dying is "more accepted" than in curative or life-oriented disciplines such as obstetrics, instead of trying to use the experiences to integrate palliative stations or hospices into their own work.

[3] The wording "death and the dead" is to be understood as an explicit appreciation of philosopher Theda Rehbock and her paper "*Der Tod und die Toten—philosophisch betrachtet*" (Rehbock 2018).

This predicament becomes evident through an example provided by US-American physician David Klein (2018):

> Typically, a patient arrives in the ED [emergency department] with CPR-in-progress [cardiopulmonary resuscitation] at least once per day. Despite our best efforts, nearly 90% of these patients are pronounced dead in the ED, usually without their family. Do these patients suffer? Usually not. Do they die alone? Technically no. There are doctors, nurses, techs all around the bedside supporting the patient. However, as soon as the patient is pronounced, the providers and support staff move on. In a busy ED, there are other patients to save and focus must quickly shift to them. We are trained to give full attention to the body. Is there a pulse? Blood pressure? We certainly don't have time to reflect on the person. The patient becomes a body and we detach. Shortly after a physician pronounces the patient dead, everyone scatters to take care of the next patient. So, yes, technically the body does not die alone but the person does.

The systematic conditions of clinical practice create a challenging environment for healthcare providers to confront the reality of death. Time is a limited resource, and there are always other patients awaiting care. Pausing, keeping still, falling silent are, therefore, disruptive elements within the framework of clinical efficiency—factors that, despite their significance, often remain unaccounted for in the system's budget. Consequently, the presence of death can easily be drowned out by the bustling routine of hospital life: the competing voices of doctors and nurses, the urgent beeping of medical devices, the hurried footsteps echoing down corridors, the abrupt slam of a door, the wailing siren of an approaching ambulance. All these sounds, all these sonic representatives of life, underscore the duty of care that defines clinical practice.

While the resounding hush of absolute silence can be understood as an audible *memento mori* for the living, the constant background sounds of clinical everyday life almost seem like an adamant *memento vivere*—a reminder of life, of sustaining life. However, when contrasted with the silence enveloping the deceased, these everyday hospital sounds can transform into a noise, an almost unbearable clamor. The reasons for this noise vary: they might stem from feelings of having failed, of being overwhelmed, of feeling helpless. Although the prioritization of life and its preservation is entirely reasonable within the clinical context, it raises questions about whether avoiding the subject of death corresponds with the compassionate ethos of human(e) medicine.

The clinical cacophony that emerges in the face of death thus acts as a discordant alarm, at odds with societal norms of reverence, and might do a disservice to the humanity and dignity of the deceased, their loved ones, and the clinical staff. In light of this, I would thus like to plead for a moment of silence within the routine of clinical practice, offering a temporary respite from the noise of medicine immediately following a death. This solemn interlude would stand as a tribute to both the departed and the living, allowing for the acknowledgment of their inherent dignity.

Post-mortem personhood and dignity

When considering the concept of dignity within the context of death, the pivotal and controversially debated question arises of whether there is such thing as post-mortem dignity. Philosophers like Dieter Birnbacher (1998) contend, for instance, that the advent of death brings about a radical transformation from personhood to an object-like state (see also Esser 2007; Pernlochner-Kügler 2009). This perspective aligns with legal viewpoints found, for example, in Austrian law, where a corpse is considered an object that must be disposed of (Pernlochner-Kügler 2009). Nevertheless, in many legal systems the deceased are assigned post-mortem personal rights. As philosopher Theda Rehbock (2012, p. 143) adds to the debate, "a dead human being, just like currently living (and future) human beings, retains, in principle, the moral status of the person, deserving of respect for their dignity and fundamental rights." Rehbock further argues that the query of whether a human being maintains their personhood post-mortem can be answered by simply looking at the face of the deceased:

> It is the face of one and the same person: first in the mode of living expression and living presence, then in the mode of absence, of no longer being, in which it nevertheless expresses something, is not simply an expressionless corporeal shell, just as silence as much as a person's speech, can express something. Just as *silence* [*Schweigen*] differs from mere *quiescence* [*Stille*], the *bodily presence* [*leibliche Präsenz*] of the dead as person differs from the mere *physical existence* [*körperliches Vorhandensein*] of a material object. (Rehbock 2012, p. 167, original emphasis)

In this context, Theda Rehbock and Marianne Rabe (2011) forge a connection between human dignity and Immanuel Kant's formula of the end in itself—irrespective of a person's capacity for expression:

> According to Kant, freedom is central to a human's self-conception as a person. Man exists as an "end in itself," not as a mere object and means to the ends of others. "This is how man necessarily imagines his own existence," says Kant, and this is how we necessarily encounter every other human being. Human dignity finds its foundation in this self-conception, even in situations where *one is not yet, no longer, or perhaps never again* able to express oneself as a person and possesses respective faculties. (Rabe and Rehbock 2011, p. 43, own emphasis)

As Rehbock continues to argue with reference to Kant, the deceased remains present for the survivors as a person and legal subject (Rehbock 2012, p. 42).

> This status means that the deceased can be wronged by the survivors, for example, when they tarnish his good name through "slander." According to Kant, the ability to respect or disregard the dignity of the deceased as a person and

> legal subject does not hinge on him being in any way physically present; after all, a good name is not about a physical possession, which is no longer possible after death and therefore cannot be stolen. (Rehbock 2012, p. 42)[4]

"Hence, the obligation to respect dignity applies unconditionally towards every human being and in every human situation, regardless of a human being's actual capacities and his utility to others" (Rabe and Rehbock 2011, p. 43). (Not only) in Germany, the duty to safeguard the dignity of a person also post-mortem is also enshrined in the law: as the German Federal Constitutional Court (*Deutscher Bundestag* 2018, p. 4) argues, it would

> be incompatible with the constitutionally guaranteed commandment of the inviolability of human dignity, which underpins all fundamental rights, if the human being, to whom dignity is due by virtue of his personhood, would be allowed to be degraded or humiliated in this general claim to respect also after his death. Accordingly, the obligation imposed on all state power in Article 1 Section 1 of [German] Basic Law to grant the individual protection against attacks on his human dignity does not expire upon death.[5]

Matters of post-mortem dignity also concern the healthcare system. From a purely medical point of view, the relationship with a patient persists beyond his or her death, specifically up until the point of autopsy or clinical section, which the German Medical Association defines as the "last act in the medical treatment of patients" (*Bundesärztekammer* 2005, p. 5). In its current care guideline, the German Society for Palliative Medicine explains in this context:

> Following the occurrence of death, the relationship with the deceased does not end automatically. The personal dignity that applied to the living also applies as a guide for action to the deceased body. The relationship with this very concrete human being continues in the vicinity and the contact with the deceased. Speaking and acting are coined by respect in this special moment. In the observance of his final wishes, the personal relationship with the patient lives on even after his death and bestows final dignity upon him. (*Deutsche Gesellschaft für Palliativmedizin* 2008, p. 1)

Nevertheless, as criticized by medical ethicist Gisela Bockenheimer-Lucius (2007, pp. 159–160), discussions on the way physicians handle the human corpse still primarily revolve around legal considerations, whereas in medical ethics, this question is "still a side issue. Even palliative medicine, which offers emotional support to relatives during the mourning phase and thus beyond the death of the

[4] In opposition to that, Dirk Preuß (2011, p. 290) reasons that even if some cells are still alive, "the dead human body no longer has the moral status that the living human had: human dignity that claims unconditional validity. Denying human dignity to the corpse in no way means having to deprive it of any dignity. After all, the dead body points back to the once-living person [...]. In the burial laws of Thuringia (§ 1) and North Rhine-Westphalia (§ 7), the quite apt expression 'dignity of the dead' is used for them.".

[5] See also Kopetzki (1998).

patient, does not address the handling of the deceased's body in its definition and goals of action."

Hence, one must inquire: what can society—a term that also encompasses patients and their relatives as well as physicians and nurses as those directly facing these questions—expect in terms of a dignified handling of deceased patients? Respectful medical handling of the corpse is assumed as a matter of course at this point. However, is not also taking a moment to pause as an acknowledgment of the profound reality of death an essential facet of our sociocultural perception of dignity? And do the cacophonous sounds of medical interventions, driven by unwavering adherence to routine clinical procedures, not counteract the prevailing concept of peace in death as a pivotal component of post-mortem dignity?

Quiescence, the language of death

The handling of death is, of course, a highly diverse and culturally nuanced matter, and falling silent, while a common response, is by no means the sole reaction. Consider, for instance, the mourning rituals of ancient Greece and Egypt, where loud lamentations were the norm, a practice that endures in many modern cultures. Next to that, we might also think of "funeral laughter," as seen in regions like Sulawesi, Bali, and Madagascar (for more details, see Ziegler 2018). In (not only) the German-speaking context, however, the sudden absence of a deceased person is often mirrored by an absence of speech. In our culture, this silent pause, the act of holding still, symbolizes piety. It is conveyed through phrases like "in silent sympathy" or "in silent remembrance" found in condolence cards, through the wordless handshake, through a silent embrace at the graveside. Susan Sontag's (1982, p. 187) reflection on silence's dual nature adds depth to our understanding:

> "Silence" never ceases to imply its opposite and to demand on its presence. Just as there can't be "up" without "down" or "left" without "right," so one must acknowledge a surrounding environment of sound or language in order to recognize silence. Not only does silence exist in a world full of speech and other sounds, but any given silence takes its identity as a stretch of time being perforated by sound.

The significance accorded to post-mortem silence in (not only) German-speaking cultures is also reflected in jurisdiction. The German criminal code, for instance, stipulates that "[a]nyone who intentionally or knowingly disrupts a funeral service is punishable with imprisonment for up to three years or a fine" (*Deutsches Strafgesetzbuch* n.d.). Despite the difference in cultural conventions, they have one thing in common: they all imply a caesura in everyday life, where verbal communication yields to nonverbal and paraverbal expressions. Verbal communication ceases with death, and quiescence becomes the language of death and the dead, a quiescence that is reflected in the silence of the living.

The indirect reference to the (linear) dimension of time in the above-mentioned quote by Susan Sontag sheds light on the metaphysics of this connection that arises through the absence of speech surrounding both the dead and the living. Speech

functions as a crucial timekeeper of silence, delineating the span between cessation and resumption, allowing us to perceive the duration of silence itself. Consequently, a pause in speech can be seen as a pause in the linear perception of time. In its temporal measurability, dependent on its counterpart, silence can presage the timelessness and, thus, the eternal nature of dead silence.

Sometimes, the silence that seals the victory of death over life is almost insufferable. At first sight, the torrential cascade of words of the more than 400 poems of the *Kindertodtenlieder* ("Songs on the Death of Infants"), penned by German poet Friedrich Rückert (1872) after the loss of two of his children, starkly contrasts this silence. Yet, in the end, even Rückert's monumental work amounts to a desperate expression of the profound depths to which the unfathomable and inexpressible phenomenon of death shatters previously potent word-world references. In its enigmatic nature, death propels us to the precipice of language, serving as a poignant reminder of the ultimate inadequacies of verbal communication. Whether manifesting as resounding lamentations or contemplative inwardness, as an overwhelming outpouring or a sudden cessation of speech, verbal language invariably is broken off as a reaction to the ultimate quiescence of a deceased human being. Consequently, the exceptional essence of death finds its voice—or lack thereof. Strikingly, the "volume" itself remains of secondary importance; what transmutes into cacophony in the realm of death is the ignorance of its presence. Hence, post-mortem "noise" might theoretically also be almost without a sound, for what echoes in our ears is the unceasing continuation of daily routines, the absence of pausing.

Thus, in the endeavor to express the extraordinary nature of death and the dead, not only verbal language but also the noises of everyday life must be silenced—as forcefully put by WH Auden (1945, p. 228):

> Stop all the clocks, cut off the telephone,
> Prevent the dog from barking with a juicy bone,
> Silence the pianos and with muffled drum
> Bring out the coffin, let the mourners come.

The ordinariness, in times even triteness, that characterizes the ambient noise of clinical day-to-day affairs forms a crude contradiction to the extraordinary nature of death and seems almost irreverent and profane, at times even resembling an avoidance that opposes the unbearable nothingness, which opposes the dead silence as the greatest adversary of the livings' noises. To avert death and the dead can reduce the deceased to a mere body, as the following example out of clinical practice might elucidate:

> I recently pronounced an 88-year-old male who had arrived with CPR-in-progress. [...] after he was pronounced dead, we scattered to take care of the other patients as the primary nurse and tech remained to diligently prepare the body for the morgue. One hour later, the family arrived. *Speaking with the family transformed the patient from body or disease back into a person.* I learned that this elderly man was a father of five, grandfather of fifteen, loving spouse and diligent and successful accountant. [...] Learning this information earlier would not have changed the care he received from our team. However, it would

> have personalized the experience. Had we taken a moment to consider this man's accomplishments, we could have helped transform the body back into a person—a person deserving our acknowledgment and thanks. (Klein 2018, own emphasis)

When accepting the notion that the end of life does not inherently signify the end of a relationship, adopting a stance of enduring, pausing silently in the face of death and the dead becomes both a moral and professional imperative and also allows the clinical team to uphold the relationship with a patient post-mortem. Verbal patient–physician communication is no longer possible after death; however, by interpreting silence as the "language" of death and the dead, the act of pausing and retaining a quiet composure amidst the cacophony of daily routines becomes a mode of expressing an ongoing recognition and connection with the deceased patient. Hence, within the sphere of routine clinical practice, such a caesura in speech and acting, such a deliberate pause that also implies a choice not to immediately avert from the deceased but to center attention upon him or her for one last time, not least allows us to acknowledge dying and death as, to refer to Karl Jaspers (1919, p. 202), "limit situations" of human existence, and to accord a final tribute to the life lived.

Surrogate farewell

Taking a moment to pause and fall silent, thereby creating room for the profound essence of death to unfold, emerges as an ethical imperative, especially in two scenarios involving bereaved families: these instances encompass the delicate act of communicating the news of death, as well as in the poignant moments at the bedside of the deceased patient. I will first speak of the former:

The demands of modern clinical routines within Western healthcare systems do not always permit a patient's death to be communicated to loved ones in the privacy and tranquility this intimate moment may require. Instead, circumstances can unfold in a manner where family members have to learn this news in a public space shared with others, possibly a waiting room, a corridor, or the multi-bed room of the deceased. Hospitals are places of and for the public, places bustling with the presence of many, resonating with the sounds of life. Due to this public nature, the setting of a hospital may inadvertently counteract the mourners' needs, as the bustling activity prevalent within this place can create the impression of receiving one of life's most distressing pieces of news in an almost casual manner. The cacophony of medical procedures, this symphony of the sounds of life, threatens to become a disruptive element in relatives' coping with the news of death. Grief can defy verbal expression; the ineffable nature of death may necessitate a pause, a moment of introspection, an inner retreat. Death makes us grapple with questions that remain unanswered. Amid this quest, which may hurl us against the restrictions of verbal language, the bereaved can tend to turn their attention inwards, exploring their inner depths for insights. As a realm intertwined with human thresholds and their accompanying

spectrum of sentiments, it thus seems imperative for hospitals to be(come) spaces that allow the public and the private to coexist.

Pausing and falling silent seem, however, imperative even before the clinical team breaks the news of a patient's death to his or her loved ones. When a person dies not within the private sphere of familial circles but rather exclusively (and excludingly) in the presence of the clinical team, "relatives (and the wider public) must be able to trust that the deceased's body is treated with the same respect as if they were physically present" (Preuß 2011, p. 288). After all, "[m]ishandling of the deceased's remains is always interpreted as an indication of inadequate regard and appreciation with the biography as well as the pathography and the person of the deceased" (Mißfeldt 2007, p. 182). In this context, the observance of sociocultural customs perceived as a dignified treatment of the deceased comes into play. Along these lines, a surrogate silence maintained by the clinical team at a patient's deathbed can facilitate delicate and dignified handling of the deceased. For those in mourning, silence can assume the role of a distinct language that sets them apart from individuals for whom the passing of a person holds no profound relevance in the context of their own lives. In situations where bereaved family members are unable to enact this silence when death occurs, the clinical team might step into this role, performing the ceremonial farewell vicariously, even in the absence of their own genuine or presumed grief. Such a surrogate farewell facilitated by caregivers does not imply the obliteration of their individuality: a person that represents another person always remains him- or herself, but absorbs certain facets of the represented. To put it differently, representation leads to a fusion of the self and the other, resulting in a novel entity. Within the realm of clinical partings, this fusion could signify the admission of the private, subjective, and emotional dimensions of grief into the domain of professionalism, if only for a brief interlude.

As intermediaries between the mourners and the mourned, the clinical practitioners maintain their commitment to the caregiving mandate intrinsic to their profession (as applicable to both grieving relatives and deceased patients); however, at the same time, a surrogate moment of farewell can also turn into a form of self-care, which accommodates an avenue for the internal comprehension of death and the dead.[6] The notion of "surrogate farewell" therefore operates in a dual capacity, as the assumed grief of the family member may also become a conduit for the healthcare provider to act out any own emotions of loss, which might have been stifled in reaction to the particular culture of Western healthcare systems.

The significance of silence as a solace for those grieving is poignantly illustrated in Siegfried Lenz's (2009) work *Schweigeminute* (*Stella. A novel*; literal translation: "A Minute's Silence"), wherein a collective minute's silence as a communal expression of remembrance becomes the focal point. The storyline revolves around a memorial assembly held at a school following the passing of young teacher Stella

[6] Today, the importance of self-care is explicitly emphasized in medical and nursing professional codes. To quote from the Declaration of Geneva: "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard [...]." (World Medical Association 2017); and, correspondingly, in the ICN Code of Ethics for Nurses: "Nurses value their own dignity, well-being and health" (International Council of Nurses 2021).

Petersen. Readers follow the perspective of the first-person narrator Christian Voigt, a student who was involved in a romantic relationship with this teacher and thus had to first keep his love and then his grief a secret due to the forbidden nature of this kind of affair. When Christian is asked to deliver a eulogy at the school's memorial service, he declines and instead embarks on an inward journey, he immerses himself in silence, this way appropinquating the new "language" of death and the dead. For the mourning boy, this silence becomes a catalyst for a cascade of memories; it is part of his inner dealing with a past presence, with the present absence. In a way, this post-mortem silence the mourner shares with the mourned mirrors and maintains the very nature of their former relationship as a secrecy they had to keep silent about—as Christian eventually concludes: "Perhaps the source of our happiness must rest in silence forever" (Lenz 2009, p. 133).

In the presence of death, we are alone, alone in ineffable grief. Nevertheless, shared silence can also assume a role of forging connections, akin to how verbal communication intertwines us in ordinary life. While speaking often creates divisions—speaker and listener—forms of expression executed collectively, like choral singing, act as agents of unity. In parallel, silence, too, possesses this connective power. It imparts a sense of solidarity, of a mutual experience, a link to a community that once cared for a now-deceased person. This community might span family and friends—and even medical professionals who dedicatedly attended to the final moments of the deceased.

The institution of a minute of silence, deeply rooted in Western customs, is a testament to such collective silent homage. This silence, a quiet observance of mortality, is inherently communicative, akin to a speech action ex negativo. "As the negative or complement to speech, silence embodies the capacity for independent, implicit communication. [...] A quiet handshake at a graveside conveys sympathy, a minute's silence joint commemoration" (Fuchs 2004, p. 152; see also Stadler 2010, particularly p. 40). Enduring such silence can, in a way, be an art form in itself, as also Lenz's novel portrays:

> You could tell from the faces in our school hall that some of the students were better than others at observing the obligatory minute's silence. Most of them tried to make eye contact with their neighbors, some shifted from foot to foot, one boy was examining his face in a pocket mirror, and I saw another who had apparently succeeded in dropping off to sleep on his feet. The longer the silence lasted, the more obvious it was that several students were finding it difficult to get through the time without drawing attention to themselves. (Lenz 2009, p. 34)

Lenz's novel is a reminder that we have drifted away from the art of silence, yet this realization should not culminate in surrender. This brings me to my closing contention: the meaning of collective silence or a moment of silence for the clinical team itself.

Caregivers' silent humanity

In a way, the constant noise of the medical field appears to paradoxically conceal a (multifaceted) incapacity of healthcare providers to endure the silence surrounding death—and perhaps also to allow themselves such a pause, as this might contradict the professional notion of putting the needs of others above one's own. To this day, the healthcare system seems to suggest that "[t]he emotions evoked during work must be constantly suppressed to sustain the functionality of healthcare practitioners. [...] there is minimal room for extensive dialogues or moments of reflecting pauses amidst everyday professional life" (dpa 2012). The fact that death, despite its omnipresence, cannot find its proper place in Western medicine can present the clinical team affected by the death of patients with a burden that may not be ignored. In this regard, psychologist Jürgen Glaser emphasizes that professionals regularly exposed to death grapple with notably higher psychological stress than professionals in other occupational fields (dpa 2012; see also *Berufsgenossenschaft für Gesundheitsdienste und Wohlfahrtspflege* 2005, pp. 7, 31–33). As underscored by Bockenheimer-Lucius (2007, p. 170), even the

> apparently sober handling of the deceased's body [...] by all those affected—extending beyond just the family to encompass students, physicians, and nurses as well—[...] is interwoven with intense emotions. The human corpse evokes profound fear, despair, tenderness, awe, and respect. On occasion, a sense of aversion, disgust, and repulsion can also emerge upon encountering the sight of a deceased body. Certain sentiments might be considered non-moral in nature, such as disgust or aversion, which can be surmounted with the aid of psychological support. Yet, frequently, they evoke moral sentiments such as feelings of culpability.

If we consider silence to be a disruptive element within clinical operations, then the cacophony of medical procedures can be understood as a disruptive element in the clinical team's dealing with death and the dead. Having to function when confronted with the limit situations of human existence places the clinical team in a position that denies them fundamental human reactions and needs—an imposition that almost borders on psychological cruelty. When we find ourselves constrained from expressing emotions or responses in the face of profound human thresholds, when professionalism clashes with inherent human reactions to death and the dead, we run the risk of compromising humanness and humanity, which also means that we jeopardize the humane part of human medicine.

That professionalism and piety are not mutually exclusive finds compelling evidence in the practice of some universities to hold memorial services at the conclusion of semesters, providing an opportunity for students and families to bid farewell to those who donated their bodies for gross anatomy studies. In the realm of daily clinical routine, a collective moment of silence could serve a similar purpose. In an environment coined by time constraints and an associated need for constant justification—as often observed in Western medicine—it seems reasonable to explicitly recognize this silence as an act of communication. Within this context, a clear distinction between passivity and activity becomes imperative. Amidst mortality's

presence, the persistent adherence to the rhythm of clinical routine can sometimes come across as a form of mere actionism, compensating for the enforced passivity experienced by the clinical team when confronted with death. This notion reminds of perceptions of pausing and falling silent as something passive—however, the omission of, e.g., speech and action, can also be interpreted as an active gesture with explicit communicative intent.[7] To separate purposeful silence from ineffectual idleness and to turn it into a necessitated component of clinical practice, a framework wherein a moment of silence and its role within clinical actions is explicitly communicated may help to attribute such agency to silence.[8]

The (rare) instances where such a paradigm has already been tentatively embraced offer insight into the advantages of communal silence for the clinical team. "I continued to think about ways we could add more humanity into the care we provide each day. I recently came across and have introduced into my practice The Moment of Silence as a way to help our fellow humans leave this earth with dignity." (Klein 2018) This sentiment aligns with the concept of promoting resilience through clinical pauses, a model exemplified by the introduction of the "Pause" initiative in the emergency department of the Virginia Commonwealth University Clinic:

> [S]omething as simple as taking a moment to reflect after each patient's death could not only allow providers to be more present for each patient, but build resiliency within the staff. [...] The Pause is 30 to 45 seconds of silence immediately after the death of a patient to honor his or her life, and distinctly mark the importance of the moment at hand. It is a brief timeout for everyone involved in the events leading up to the death to collect, reflect and help bring closure. Beyond that, it's a moment to acknowledge the tremendous effort and care offered by the health care team. (Nowak 2018)[9]

As this glimpse into practice shows, we are still a long way before silence finds its comprehensive place in everyday clinical practice. Nonetheless, at the same time, the potential benefits linked with even a brief moment of silence can be surmised.

[7] For a comprehensive study on the active components of allegedly passive forms of omission see Birnbacher (2015).

[8] For communicative functions of silence see Stadler (2010, p. 40); Heinemann (1999).

[9] The following example illustrates the consequences this kind of stress can mean for the clinical team: "Anaesthetists [...] are particularly predisposed to psychological distress should a death occur in theatre, and are unlikely to receive much in the way of emotional or professional support after the event. [...] Only 53% of the surgeons questioned in this survey had witnessed an intra-operative death, but 81% of those had performed further operations within 24 h without subjective detriment to their operating skill (a figure similar to the 77% of anaesthetists in my survey who felt perfectly competent to deliver another anaesthetic within 24 h). Nevertheless, 50% of the surgeons would have liked some time off to reflect on the death" (White 2003, p. 515). Neglecting the needs of healthcare providers carries also risks for patients: "the stressed anaesthetist may be prone to making more fatal errors, or they may be subject to greater psychological stress if an intra-operative death occurs (either by feeling markedly more distressed when a patient dies, or by feeling traumatised by a fatality that would not normally trigger significant stress)" (White 2003, p. 516).

A moment of silence as a pledge of silence?

I am deeply convinced of the importance of a healthcare system that caters to the needs of all individuals it touches—encompassing patients, relatives, and healthcare providers. It is in this essence that human medicine turns into humane medicine. A cornerstone of this philosophy entails accepting patient–physician communication—extending even into moments of silence and post-mortem care—as fully billable services, this way confirming their profound psychological and ethical meaning. Such a paradigm would translate into the explicit acknowledgment that those interconnected with medicine—I repeat: patients, families, and healthcare providers—deserve to be treated as ends in themselves rather than mere means to an end.

Nevertheless, the challenges to integrate even a moment of silence into the chronically time-pressed rush of Western healthcare settings cannot go unmentioned. A minute spent in silent reflection at the bedside of a deceased patient in a team of 15 equates to 15 minutes sorely needed for the care of other patients. When expanded to encompass a regular hospital day, involving all staff, these moments of silence exert a significant impact on the limited temporal and financial resources of the clinical system. Crafting a framework to incorporate these moments of silence into the daily clinical practice thus necessitates a collective discourse involving all stakeholders of this intricate operation.

In a contemporary context where medical institutions increasingly serve as the final places of death, "professional groups involved in the care and support of seriously ill and dying people will continue to be among the most important companions in the context of death" (*Berufsgenossenschaft für Gesundheitsdienste und Wohlfahrtspflege* 2005, p. 7). Therefore, a deliberate contemplation on the dignified dealing with death and the dead is prime directive. Especially within the bustling confines of a hospital, a shared, communal silence possesses a profound potency in this regard. In the clinical context, the adage of Ludwig Wittgenstein (1933, p. 189), "whereof one cannot speak, thereof one must be silent," might thus be understood as a potential imperative, not in the sense of a (passive) inability to speak, but as an (active) embrace of the ineffable, a conscious defiance against allowing the noise of daily clinical pursuits to submerge the presence of death and the dead.

This resolute caesura in the cacophony of everyday clinical life, this intentional moment of silence, thus, also proves itself as a medical pledge to silence that extends beyond the cessation of life. David Klein's appeal (2018) resonates here to "treat a body as a human one last time." The act of pausing, of falling silent, of temporarily halting the clinical hustle, emerges as a means to preserve the dignity of both the living and the departed—reminiscent of Shakespeare's Hamlet (1904, act 5, scene 2), when he declares that "[t]he rest is silence."

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