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Maslow's Hierarchy of Needs: A Framework for Achieving Human Potential in Hospice

ROBERT J. ZALENSKI, M.D., M.A.[1,2] and RICHARD RASPA, Ph.D.[2,3]

ABSTRACT

Although the widespread implementation of hospice in the United States has led to tremendous advances in the care of the dying, there has been no widely accepted psychological theory to drive needs assessment and intervention design for the patient and family. The humanistic psychology of Abraham Maslow, especially his theory of motivation and the hierarchy of needs, has been widely applied in business and social science, but only sparsely discussed in the palliative care literature. In this article we review Maslow's original hierarchy, adapt it to hospice and palliative care, apply the adaptation to a case example, and then discuss its implications for patient care, education, and research. The five levels of the hierarchy of needs as adapted to palliative care are: (1) distressing symptoms, such as pain or dyspnea; (2) fears for physical safety, of dying or abandonment; (3) affection, love and acceptance in the face of devastating illness; (4) esteem, respect, and appreciation for the person; (5) self-actualization and transcendence. Maslow's modified hierarchy of palliative care needs could be utilized to provide a comprehensive approach for the assessment of patients' needs and the design of interventions to achieve goals that start with comfort and potentially extend to the experience of transcendence.

INTRODUCTION

HOSPICE IS A SYSTEM AND PHILOSOPHY of care designed to support the goals of patients and families during the last phase of life. In the last century, necessary steps were taken toward providing an open comprehension of the burdens of mortal illness, through lessening the taboo against talking about dying,[1] and recognizing the dimensions—physical, social, emotional, and spiritual—of "total pain."[2] Expansions of the palliative care/hospice concept subsequent to these foundations have included interdisciplinary teamwork,[3] initiating care earlier in the disease trajectory,[4] and promoting opportunities for development at end of life.[5] All of these advances set the stage for reaching new possibilities, but there has been no widely accepted theory-driven practical schema to guide interdisciplinary teams toward realizing potential achievements of self-actualization and transcendence.

We believe that Maslow's hierarchy of needs can be adapted to hospice and palliative care to provide a theoretical and practical framework to achieve maximum human potential. Although we find Maslow's psychology to be compelling and robust in application to palliative care, we have found few citations in palliative care that describe this use of Maslow's hierarchy.[6,7] In this paper we review Maslow's work, summarizing and illustrating his hierarchy of needs; adapt the hierarchy to hospice and palliative care; apply the

[1]Department of Emergency Medicine, [2]Center to Advance Palliative-Care Excellence, [3]Department of Interdisciplinary Studies, Wayne State University, Detroit, Michigan.

adapted hierarchy to the care of a patient; and discuss its implications for patient care, education, and research.

MASLOW'S THEORY

Abraham Maslow is one of the foremost psychologists of the twentieth century. Though versed in Freud and Skinner, Maslow was repulsed by the negative implications of psychoanalysis and behaviorism for human potential, because of their focus on psychopathology.[8] Maslow responded by formulating a psychology that encompasses higher levels of human function. The result—his famous Third Force—is a humanistic approach to psychology. In *Motivation and Personality*, Maslow presents his theory of hierarchical needs and human development.[8]

Maslow postulates that the individual is an integrated and organic whole. A theory of motivation must include the study of ultimate human needs and goals appropriate to humanity's full range of being. Maslow asserts that the fundamental desires of human beings are similar despite the multitude of conscious desires. His psychology is premised on a shared humanity that crosses geographic, racial, gender, social, ethnic, and religious boundaries. This premise is rooted in a main philosophical tradition of Western thought, essentialism, that extends back to pre-Socratic philosophy and continues into the twenty-first century.[9] Maslow posits that human beings have a higher nature that can be understood and summoned in everyday experience.

Fundamental to Maslow's theory of motivation is that human needs are hierarchical—that unfulfilled lower needs dominate one's thinking, actions, and being until they are satisfied. Once a lower need is fulfilled, a next level surfaces to be addressed or expressed in everyday life. Once all of the basic or deficiency needs—so called because their absence is highly motivating—are satisfied, then human beings tend to pursue the higher needs of self-actualization. Indeed, the fulfillment of the basic needs is considered a prerequisite to such pursuit.

In discussions of the application and limitations of his hierarchy, Maslow took pains to emphasize that this theory is a schema. Needs can be partially fulfilled at lower and higher levels. Inversions or reordering of needs for particular individuals at particular turning points is also possible.[8] So, Maslow's theory is a framework for understanding and action rather than a rigid prescription governing all human activity.

THE HIERARCHY OF NEEDS

Briefly, the first level of needs is physiologic (e.g., the need for food, air, and water). The second level encompasses safety needs. These include security, stability, protection; freedom from fear, anxiety, and chaos. The third level of need is belonging and love. These needs involve the ". . . giving and receiving affection. When they are unsatisfied, a person will feel keenly the absence of friends, mate, or children."[8] The fourth level is the need for esteem, which is fulfilled by mastery of the environment and the prestige that comes from societal recognition. The fifth level, the need for self-actualization, entails maximizing one's unique potential in life. Living at this level can lead to peak experiences and even transcendence—the experience of deep connection with others, nature, or God, and the perception of beauty, truth, goodness, and the sacred in the world. Such experiences become highly motivating and lead to feelings of being enlivened and enlightened (Fig. 1).

Events from the twentieth century provide illustrations of the hierarchy. Media have provided

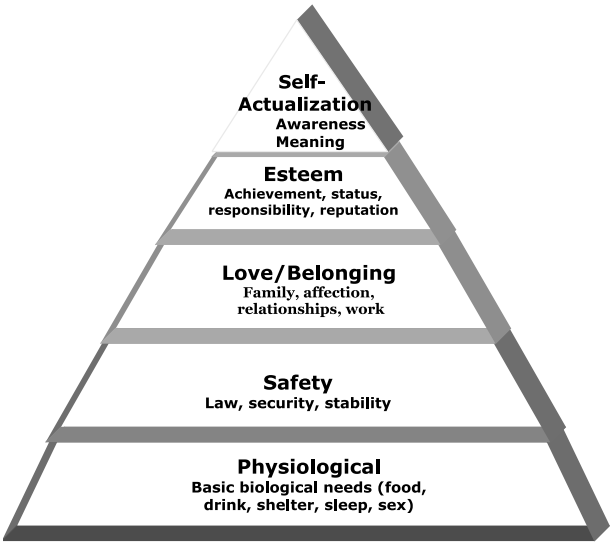

FIG. 1. Maslow's Hierarchy of Needs. The figure diagrams the dependence of higher on lower needs; the apex of the pyramid suggests that higher needs are less frequently realized.

stunning examples of the effect of deprivation at the first level in images of dying children in the deserts of Africa. They are exhibits of the desolation of hunger. Such wretchedness is a dramatic contrast to most children in the West whose complex lives, nurtured by sufficient food, are filled with opportunities for education, play, and dreams of prosperity. Examples of unmet needs at the second level have been revealed by research on human beings in extreme situations, such as hostage taking, concentration camps, prisons, and even prostitution rings. It reveals the brutality of life directed by a regimen of fear. Victor Frankl's work, in particular, on concentration camp inmates, demonstrates the unmaking of human beings in the face of intense fear for physical safety.[11] Fears about physical safety dominate life.

Lack of fulfillment at the third level has been dramatized by expressive culture showing the power wielded by yearning for belonging and love. The repertoire of Tennessee Williams' dramatic works, *Streetcar Named Desire, Glass Menagerie, Cat on a Hot Tin Roof*, and others reveal the suffering of love-deprived people struggling to make their way in life. American painter Edward Hooper illumines the isolation of people sitting in the glare of an all-night coffee shop as if trapped in silent glass bowls. Maslow, like American artists, sensed the *Weltanschauung*, or "time spirit," of midtwentieth century America that focused on the devastation of loneliness. Absence of fulfillment at the fourth level shows the necessity of the connection between the individual and community. Inclusion and respect from a group that shares values can lead to higher self-esteem. Artists, scientists, educators, and so on, work in a tradition with established norms of performance and rituals of inclusion and exclusion. We develop as human beings by successfully participating in communal traditions in every domain of life.

At the fifth level, self-actualized people have peak experiences. Cognitive psychologist M. Csikszentmihalyi offers interesting research on the characteristics of peak experience, including a merging of self and action, a dropping away of all concerns other than the activity in the here and now, and self-forgetfulness. When people are at their best, they are in the peak or, in Csikszentmihalyi's terms, the flow state.[12] The great Boston Celtics' basketball center of the 1960s, Bill Russell, calls these states of consciousness "magic moments." When they occurred, concentration was so intense that his play rose to new heights and he could almost predict where the next play would be.[13]

Recent scholarship in social science and humanities might question the usefulness of Maslow's hierarchy. For example, postmodern notions such as the politics of knowledge might suggest that there are more accurate representations of contemporary cultural forces and the dynamics of motivation. The discourse of how knowledge is legitimated, for whom, and for what purposes, might challenge Maslow's notion of a universally shared human nature.[10] Social constructivism, as well, would argue that such knowledge of needs is local, context specific, and culturally configured rather that total, universal, and natural. Other psychologists might consider Maslow's model to be superseded by newer theories.

Why, then, return to Maslow? Because we postulate that the theory of the hierarchy of needs can enable hospice teams to care more completely for patients at the end-of-life. Maslow's approach can encompass not only the relief of distressing symptoms, but can also make explicit the opportunities to address the psychological, social, and spiritual needs, taking one away from total pain and toward human fulfillment. Maslow's model can further open possibilities for transcendence at the end-of-life, perhaps a unique opportunity associated with this period.

Once modified for hospice and palliative care, Maslow's hierarchy of needs is highly suitable for assessing needs and reaching human potential of patients with mortal illness. The resulting framework could be used and tested for its utility in the assessment of need and the promotion of higher levels of self-actualization and transcendence.

ADAPTING MASLOW'S THEORY TO HOSPICE AND PALLIATIVE CARE

The etymology of "palliative" and "hospice" indicate their purpose in fulfilling the hierarchy of human needs. Palliative comes from the Latin *palliolum*, or cloak, a remedy for a condition that cannot be changed or avoided, like winter, but whose discomforting effect can be greatly lessened. Likewise, 'hospice" from the Latin *hospitalis* meaning host or guest, suggests a welcoming attitude in the provision of both physiological and

safety needs, conveying a sense of warmth and appreciation for the traveler.

In applying the pyramid to hospice and palliative care, we are not arguing that the hierarchy is universal (applying to all) or rigid where no higher level needs can be addressed until all of the lower ones are first satisfied. Our purpose is to provide an improved approach to structuring care to patients by using Maslow's schema. The hierarchy indicates the urgency of fulfilling more basic needs first, and helps suggest a logic for approaching a patient's problems and needs. For example, it is inappropriate to talk about meaning or transcendence to a person in pain, fear, or social dejection. At the same time, such conversations might be necessary before all physical pain could be relieved.

We propose that the relief of physical pain is a first-order need. The devastating and depriving effects of chronic fatal illness call for an application of a modified hierarchy of needs. Disseminated cancer, organ failure, or terminal frailty are conditions that threaten our most basic abilities—the expression of appetite and desire, the experience of pain and energy, the power to function as an embodied self in society. These threats can lead to a failure to meet basic biologic and safety needs. Untreated pain anywhere in the body can tyrannize consciousness and shatter any plan to extend the self into the world. Patients in severe pain often yearn for death as the great relief. In those moments, throwing themselves out the window or being run over by a truck may not seem undesirable.

The second order needs are for safety in a personal and social sense. When safety needs are not met, fears can dominate living, ranging from daytime worry to nighttime anxiety and insomnia. Fears might be about falling or physical safety. Fears can be about the way one might die, such as choking, suffocating, drowning, or they may concern the fear of death and the end of existence itself. At the extreme, fear can be completely isolating and paralyzing, rendering minute-to-minute existence unbearable. Maslow's hierarchy reminds us that until such fears are addressed and relieved, no progress can be made toward improved quality of life or ascending into the upper levels of the pyramid.

At the third level, devastating illness can test one's ability to give and receive affection, even if these needs were previously met, and, especially, if they were not. For example, after any disfiguring disease or therapy, like a mastectomy or amputation, people naturally wonder if they are still loved or even lovable. It is evident that special support systems, which can be mobilized by the hospice team, may be vital to address this worry.

The need for belonging is especially important at the end of life. Dying alone can be a brutal experience. Paradoxically, the end of life is the final space for intimacy. It is in this space that a person can feel secure revealing thoughts, feelings, and action that might otherwise be assessed as wrong or negative. Intimacy is the experience of being oneself, and of being recognized and appreciated for that self by others. Ideally, at the end of life the summoning of intimacy can become the space for healing.

At the fourth level, the inability to accompany family or friends in usual activities can lead to doubts about one's ability to enjoy life with others. Disability and resulting unemployment can devastate the person's sense of self-esteem and worth. Such dislocations can lead to intense suffering.[14] The hospice and palliative care team can make special efforts to appreciate the patient for all that his or her life is and has been. Inviting the patient and family to share with the team the previous activities, accomplishments, and values can markedly affect the attitudes of caregivers and patients alike. Recognizing the patient's contributions to a profession as a craftsman, technician, lawyer, as well as to a friend or family as son, daughter, father, mother, relative, or friend, may restore a sense of value and esteem.

According to Maslow, fulfilling the first four levels of the pyramid gives patients the best chance to achieve the fifth level—self-actualization and transcendence. Maslow's definition of self-actualization is, "the tendency to actualize one's potency, to become more and more what one idiosyncratically is."[8] This fits well with Cicely Saunder's description of the goal of a patient's "being himself" at end of life.[15] Transcendence is connection to others, the universe, or divinity leading to an intensification of life, a feeling of limitless possibilities, and a sense of wonder and awe.[8]

Maslow's hierarchy suggests that addressing the first four needs—symptom control, safety, belongingness, and esteem—is valuable in itself as well as for the potential to achieve self-actualization and transcendence. As the illness progresses,

lower needs, such as hunger, might literally be transcended. The patient may no longer be able to eat, and, thus, nonmaterial needs might be the only domains that can still be satisfied.

Measurements of quality at end of life, such as the McGill Quality of Life Questionnaire scale[16] focuses on emotional and spiritual concerns and confirms that intimacy, esteem, and actualization are indeed the prized domains in the final phase of life. Moreover, each step up the hierarchy, such as freedom from pain, is itself a kind of transcendence, a leap that releases energy for future tasks of development. Figure 2 outlines specific elements of the patient's experience within the hierarchy.

APPLICATION TO PATIENT CARE

We will use the adapted hierarchy to analyze the care given to Frank, a patient seen by the palliative care consult team at Veterans Hospital. His first name and his story are used with written permission of his family. Frank was diagnosed with an abdominal mesothelioma in 2003, and his inpatient doctors gave him 2 months to live. However, he then went on to live for 1 full year in hospice care. His major health care problem prior to cancer was a severe affliction with posttraumatic stress disorder (PTSD). Episodes of flashbacks and bouts of depression were disabling for him ever since his return from Vietnam. His family recalled twice-yearly hospitalizations around painful trigger times, such as Memorial Day, when they would have to literally drag him to the hospital. Prior to his diagnosis of cancer, Frank's quality of life was severely jeopardized by these episodes.

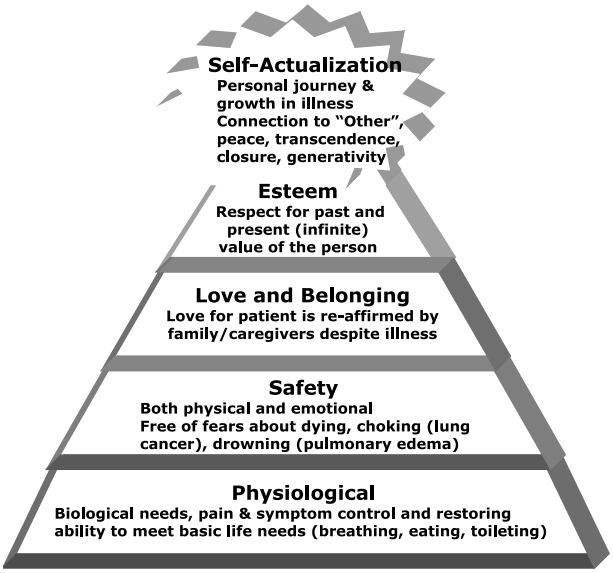

FIG. 2. Maslow's hierarchy adapted to hospice and palliative care. The figure diagrams the dependence on lower needs; the apex of the pyramid suggests that higher needs are less frequently realized.

Maslow's hierarchy of needs enables us to conceptualize and elucidate the care he was given. The palliative care team treated each type of need as it was discovered. When Frank was initially referred to palliative care, he had several first-level deficiency needs. On the physiologic level, he was experiencing nausea, pain, and a high degree of discomfort from a malignant peritoneal effusion, which recurred despite serial abdominal taps. Intermittent opiates, reglan, and an indwelling "pigtail" abdominal catheter were successful in nearly completely relieving these symptoms.

Once these were addressed, we were able to explore the level of safety needs: Frank was afraid of dying a slow painful death and of lingering in agony. This concern was specifically addressed by his palliative physician as often as was needed by reassuring him, that if such symptoms developed, he would be given the opiates and other medication needed to relieve his symptoms. As he strongly desired, such pain would be relieved even if it was accompanied by the side effect of sedation. The team assured him that medications effective in treating such pain would not be spared. When Frank was fearful of further nausea and vomiting, the hospice team explained which drugs and interventions would address these symptoms. This commitment to pain and symptom relief settled his fears.

On the third level—belonging and affection—Frank was fortunate to still have living and loving parents, as well as a brother and sister who were very committed and active caregivers. He had lost his wife to cancer 10 years prior. Frank was pleased to have a hospice nurse whom he found quite physically attractive, as he considered himself still an eligible bachelor. He had coworkers, former businessmen, and friends. In particular, he had a Marine Corps friend—his best friend from high school—who stayed with him through the end of his life. In addition, hospice staff liked Frank, with whom they laughed and joked, even when performing the most routine tasks and procedures. His health care team, including his doctors, celebrated his birthday, and even remembered him with long-distance calls

when they were away on trips. The team physician brought a small wooden carving of a dragon from a trip to China, which helped persuade Frank that he was cared for even when the doctor could not be with him. Frank and his family treasured these calls and tokens of affection.

On the fourth level, the VA hospice staff respected Frank for his service to his country. They listened to his stories about war in the jungle, the young men he left behind, the Marine base that he ran, and the way he cared for those under his command. He recounted how he floated for days in the South China Sea but escaped capture. The team also listened to his narratives of his work life, tales of his life as a builder of fabulous homes worth millions of dollars in Orlando, Florida. The palliative care team knew that such interested listening was a generative act that could lead to healing.

Did Frank reach the fifth level of self-actualization on Maslow's hierarchy? The authors believe that by meeting these deficiency-needs, Frank reached toward Maslow's highest level. This achievement occurred in stages, and not in clear, unbroken movements. What follows is a chart of his progress that maps the geography of his healing.

Frank comprehended his prognosis. He knew he was dying, yet that awareness somehow provided a deep, existential relief. The pain of his PTSD, from which he suffered for more than 30 years, was ending. His severe PTSD, requiring at least two hospitalizations per year, vanished when he was given the terminal diagnosis. He seemed to be able to shed the guilt of having survived the deaths of younger men in Vietnam for whom he had felt a total responsibility.

Another instance of Frank's movement toward self-actualization came from doing things he mistakenly believed he could no longer do. The palliative care team encouraged Frank to say how he would like to spend his final months. The team gave him permission to dream. Frank responded. He spoke of a longing to go to Florida, to rewalk the steps of his first date in St. Augustine with his late wife. He wanted to feel the salt spray on his face and the sand between his toes, and revisit the mansions and his former business partners who now owned them.

These plans may also have served to meet a higher need as well as address a fear. One of his spiritual fears was that after death, he might lose the treasured memories of his wife and friends. His father had inadvertently suggested that possibility, perhaps hoping to provide a release. Frank wanted explicit reassurance from the hospice doctor and asked, "That cannot be true, can it?" While no one could guarantee an afterlife, strengthening his connection to his past was a concrete way of avoiding his father's prediction. His doctor suggested he could deepen his memories by traveling to Florida. Revisiting the significant people and places would simultaneously be a leap into the future and a journey into the past. Frank could reach for new adventures and, at the same time, complete his fond memories of the past.

His "pilgrimages" to Florida were a way of strengthening those memories. As soon as his indwelling abdominal catheter was placed and draining, Frank purchased airline tickets to Florida, and asked his palliative care doctor for permission to go. After assuring adequate support, provided by his best friend, his doctor gave him "permission"—a resounding yes. So successful was the trip that Frank repeated the journey two more times. By embracing connections to the memory of his beloved wife and his past, he was achieving closure.

In his final months, Frank's focus turned toward his family. Being with them was the most important part of his life. He sold his house and moved in with his parents. His family, particularly his brother and sister, cared for him. His parents spent precious time with him. Frank and his father, a World War II veteran, exchanged war stories that they had never previously shared. At each stage of his illness, Frank began to express gratitude for the life and time that he had, in contrast to so many that he knew. His swollen abdomen, he said, was small burden in comparison to those who had lost limbs, or were in the ground at age 18.

Frank's extended family felt that 30 years after Vietnam, they had mysteriously gotten the old "Frankie" back. Frank was cheerful, kind, and even a comic with his nephews. The usual fears of his "going off" at Christmas parties, a troubling prior pattern, were assuaged. This was clearly a different year. During a palliative care visit in January 2004, Frank declared that he had had the "best Christmas ever."

Three members of the palliative team visited Frank the day before he died. A new spiritual distress became apparent. When asked why he appeared fearful, Frank explained that he was not sure that he had lived a good enough life. Having been raised in the Catholic faith but having given it up, he felt that it was too late to ask for forgive-

ness, and too hypocritical to turn to God, in the last days of his life. Reassurances and offers to have a sympathetic chaplain visit appeared only mildly to allay these fears. About 30 hours after these conversations, Frank died in his brother's arms with his family at the bedside, the community hospice nurse present to alleviate symptoms and to provide guidance to his family of caregivers.

Frank's dying in hospice was a journey of healing toward self-actualization. He lived his last year of life with exuberance, and his family's memories of that time are an enduring gift. His funeral was a celebration, and the hospice team members who attended were treated as the family members they had somehow become.

IMPLICATIONS OF MASLOW'S HIERARCHY

This case example shows an application of Maslow's hierarchy. It illustrates how the deliberate addressing of the more basic deficiency needs stabilized the patient and allowed him to actualize his important end of life dreams. Earlier attention to spiritual care may have led to addressing forgiveness and spiritual worth that arose at the very end of life. Such work might have left Frank more prepared to face his final days.

Maslow's framework provides a comprehensive approach not only for achieving comfort at end of life—through the relief of symptoms and addressing of fears and safety issues—but for a self-actualization that can be achieved in the last parts of the journey. We believe that Frank reached the final hierarchical level by fulfilling attachment and esteem needs in his community of family and caregivers.

Healing and coping with suffering

In the third edition of *Motivation and Personality*, Maslow himself suggests a way of conceptualizing healing in the face of serious illness. A person who is able to meet the range of human needs described in the pyramid could be considered healed despite the absence of a cure for terminal illness. This distinction between healing and curing is a key to growth and, even, renewal in the face of chronic fatal illness. Experiencing loss and then restoration at differing levels of the hierarchy can move a patient to express gratefulness for those things which have been taken for granted. Frank communicated appreciation for the feelings of comfort, rest, and the presence of people who provided love and esteem despite the difficulties of terrible illness. Gratitude is an amazing sign of the highest level of self-actualization.

Maslow's hierarchy also has the power to inform caregivers about the suffering of those who have never had the basic needs of safety, love, or esteem fulfilled. For those who are already suffering from "deficiency" needs, one effect of fatal chronic illness may be to reopen the original wounds and produce additional suffering. When the wounds are reopened, there also may be a possibility of healing these wounds in a deeper way.

The conscious implementation of Maslow's approach may increase motivation and enhance success for patient and caregiving team. The value of applying Maslow's hierarchy to chronic illness is beginning to be recognized.[6,7,17,18] Extending that application in the domain of palliative care can deepen the understanding that Maslow's work fosters, namely that unmet needs prevent further progress in caring and healing for the terminally ill. The use of Maslow's hierarchy is compatible with other interventions, such as Victor Frankl's logotherapy.[19] We believe that Maslow's emphasis on an experience of life complements Frankl's emphasis on an experience of meaning.[11]

SUMMARY AND FUTURE PLANS

The explicit use of Maslow's hierarchy in the care of hospice patients can be the difference between tragedy and transcendence at the end of life.[18] Addressing symptom control and the relief of fears are not only important in themselves, but also the basis for further development in the domains of love, esteem, and actualization during life's final phase. As the case of Frank illustrates, the sensitive attention the hospice team gives to the patient in providing pain relief, alleviating fears, delighting in stories and verbal exchanges, eliciting and encouraging dreams—these acts can inspire patients to transcend the disease. Thus, in the face of death patients can experience an intensification of life and a profound connection to the people and the world around them. Maslow's approach could serve as the theoretical framework for the design of interventions that might help many develop greater potential at end of life. We intend to develop and test these interventions

that are derived from this adaptation of Maslow's hierarchy of needs to palliative care. The most important benefit, in our view, that the hierarchy may provide is its comprehensive reach. Symptom control, relief of fear, expression of love and esteem can have the power to inspire a patient and family to experience self-actualization and transcendence.

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Address reprint requests to:
Robert J. Zalenski, M.D.
Department of Emergency Medicine
Wayne State University
4201 Saint Antoine
6G UHC
Detroit, MI 48201

E-mail: rzalensk@med.wayne.edu