

Sacred Utterances: Terminal Utterances and the Embodied Theology of Medical Practice

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Abstract

This study examines the theological and clinical significance of patients' final words within the context of embodied medical practice. Drawing upon historical medical documentation, contemporary clinical observations, and theological frameworks developed by Julian Ungar-Sargon, we propose that final utterances represent a convergence of divine presence and human embodiment that transforms ordinary clinical encounters into sacred spaces of healing witness [1]. Through analysis of William Osler's 1900-1904 study of dying patients, contemporary medical worker testimonies, and theological insights on "dialectical presence," we argue that authentic medical practice requires recognition of the sacred-profane dialectic inherent in therapeutic encounters with mortality [2-6].

Keywords: Final words, Embodied theology, Medical practice, Sacred presence, Dialectical healing

1. Introduction

The phenomenon of final words—those ultimate utterances spoken at the threshold between life and death—has fascinated human consciousness across cultures and centuries. Within medical practice, these moments represent more than clinical curiosities; they constitute theological events that reveal the sacred dimensions of healing encounters. As Ungar-Sargon observes, "post-Holocaust anti-theology transforms medical practice by recognizing the therapeutic encounter as itself a form of spiritual practice that operates through embodied presence rather than intellectual understanding" [1]. This framework provides a lens through which final words become not merely medical phenomena but manifestations of divine presence operating through human embodiment.

Contemporary medical education increasingly emphasizes the technical mastery of disease while systematically avoiding engagement with mortality and transcendence. Yet, as Hauerwas argues, the central challenge facing medical trainees is "an inability to be present to suffering patients" [2-7]. This presence—what we term "dialectical presence"—requires practitioners to remain simultaneously grounded in scientific rigor while open to the mystery that exceeds medical explanation.



2. Historical Documentation: From Osler to Worcester

The most systematic early documentation of final words in medical settings comes from William Osler's remarkable but largely forgotten study conducted at Johns Hopkins Hospital between 1900 and 1904. Observing 486 deaths, Osler's team recorded that "only 16 patients were noted speaking, and only four canonical last words were reported" [2]. The study revealed that "the most

frequent observation by medical staff was that the deaths were quiet (n = 30), though range of other behaviors were noted (e.g., moaning, delirium, seeming intention to speak)" [2].

Osler's finding that "the great majority gave no signs one way or the other; like their birth, their death was asleep and a forgetting" challenges romanticized notions of deathbed eloquence while simultaneously revealing the profound silence that often accompanies the transition from life to death [2]. This silence itself becomes theologically significant when understood through Ungar-Sargon's framework of divine presence manifesting through absence—what he terms "NOT-God" as "a space where divine absence is palpably felt" [1].

3. Post-Osler Medical Archives: The Worcester Legacy

Building upon Osler's foundational work, the next significant archival contribution to understanding final words in medical settings emerged from Alfred Worcester's pioneering studies in terminal care during the 1920s and 1930s. Worcester (1855-1951), a general practitioner in Waltham, Massachusetts, founded one of the first community hospitals in the United States and conducted what may be considered the first systematic studies of dying patients in American medicine [8-17].

Worcester's research culminated in his influential 1935 publication "The Care of the Aged, the Dying and the Dead," which represented a radical departure from the medical abandonment of terminal patients that characterized early 20th-century practice. As Worcester observed with remarkable prescience, "many doctors nowadays, when the death of their patients becomes imminent, seem to believe that it is quite proper to leave the dying in the care of the nurses and the sorrowing relatives. This shifting of responsibility is un-pardonable. And one of its results is that as less professional interest is taken in such service less is known about it" [18].

Worcester's clinical observations, documented through the Waltham Hospital Medical Records (1889-1897) now housed at Yale's Harvey Cushing/John Hay Whitney Medical Library, provide unprecedented archival documentation of terminal care practices in community hospital settings [19]. These handwritten physicians' notes document not only medical treatments but also behavioral observations of dying patients, including verbal responses and final utterances that complement Osler's institutional study with community-based clinical data.

Particularly significant is Worcester's theological approach to final words, which presaged contemporary embodied theology frameworks. He argued that "the relief and comfort of our aged patients should be our aim, rather than the prolongation of their lives. But this is hardly a true distinction, for the relief and comfort given to an aged patient often effect the prolongation of life if only by restoring the willingness to live" [17]. This insight anticipates Ungar-Sargon's understanding of healing as requiring "accepting the limits of medical intervention while maintaining full engagement with suffering."

4. Archival Documentation of the Mid-Century Transition

The period between Worcester's work and the modern hospice movement reveals a crucial gap in systematic documentation of patients' final words, reflecting what medical historians identify as the increasing medicalization of death during the mid-20th century. As infectious diseases declined and chronic illnesses became predominant causes of death, the medical profession's relationship with terminal patients underwent fundamental transformation. By 1910, the top causes of death remained primarily infectious diseases with sudden onset, but by century's end, most deaths resulted from chronic illnesses requiring extended care [20].

This transition created what one observer described as dying patients being "caught up in a medical juggernaut driven by a logic of its own, one less focused on human suffering and dignity than on the struggle to maintain vital functions" [10]. The technological emphasis of mid-century medicine produced what a German physician characterized as death in hospitals becoming something akin to an "industrial accident" [10].

The neurological foundations of final words in medical settings require examination through the lens of contemporary neuroscience research on dying brain activity. Recent discoveries in terminal lucidity and near-death neurological processes provide crucial context for understanding how final utterances may emerge from complex neurological mechanisms that challenge conventional understanding of consciousness and death.

5. Terminal Lucidity: The Neurological Paradox

Terminal lucidity, defined as "an unexpected return of consciousness, mental clarity, or memory shortly before death in individuals with severe psychiatric or neurological disorders," has been documented in medical literature for over 250 years [21]. This phenomenon presents a profound neurological paradox: patients with severe, irreversible brain damage—including those with advanced dementia, brain tumors, strokes, and psychiatric disorders—suddenly regain cognitive abilities that were presumed permanently lost [22].

Contemporary research reveals that terminal lucidity occurs in approximately 84% of cases within one week before death, with 43% of episodes occurring within 24 hours of death [21]. Most significantly for understanding final words, over 80% of patients experiencing terminal lucidity exhibit "a return of their responsive verbal ability, memory, and orientation" [23]. This neurological recovery often manifests as coherent speech, recognition of family members, and the ability to engage in meaningful conversation—precisely the capacities required for theologically significant final utterances.

The temporal proximity of terminal lucidity to death suggests what researchers describe as "a primarily death-related phenomenon" that challenges materialistic models of brain function²¹. As one researcher notes, "memory and cognitive abilities may function by neurologic processes different from those of the normal brain" during these episodes [22]. This observation aligns remarkably

with Ungar-Sargon's theological framework of "dialectical presence," wherein healing emerges through processes that exceed conventional medical explanation.

6. Spreading Depolarizations and the Dying Brain

Neurological research has identified terminal spreading depolarizations (SDs) as "the final cellular mechanisms in the dying cerebral cortex" [24]. These neurological events represent "the final neuronal pathway to death for probably as long as there has been life with a nervous system on Earth," occurring across species from insects to humans [24]. Terminal SDs involve complex interactions within the "neurovascular unit" consisting of neurons, astrocytes, and vascular cells, creating conditions where "neuronal activation is accompanied by increased cerebral blood flow" even as the brain approaches death [24].

This neurological understanding provides a potential biological foundation for final utterances that appear to transcend the patient's apparent cognitive state. The dying brain's capacity to generate coordinated neural activity through spreading depolarizations may create windows of consciousness during which final words can emerge, even in patients who have shown no previous signs of awareness.

7. Near-Death Experience Neurology and Final Words

Recent breakthrough research has documented unprecedented brain activity during the dying process that may illuminate the neurological basis of final words. Studies using continuous EEG monitoring of dying patients reveal "a burst of activity in their brains after their hearts stop," including "gamma waves" that typically signal conscious awareness [25].

Research led by Dr. Jimo Borjigin at the University of Michigan discovered that "areas of the brain responsible for interior visual experience were more active during cardiac arrest" [26]. Particularly significant is increased activity in the temporoparietal junction (TPJ), a brain region "believed to be involved in consciousness and is activated during dreaming, seizures, and out-of-body hallucinations" [25]. This heightened TPJ activity provides a neurological correlate for the vivid experiences often associated with final utterances.

The research reveals "long-range gamma connectivity between the posterior hot zones and the prefrontal areas" that becomes "significantly higher over baseline" during the dying process²⁶. Since "interhemispheric circuitry is important for memory recall, and gamma synchrony across the midlines is critical for learning, information integration, and perception", these findings suggest that dying patients may experience enhanced cognitive integration precisely when they appear most unconscious [26].

8. Neurological Implications for Embodied Theology

The neurological evidence for terminal lucidity and enhanced brain activity during dying provides unprecedented support for theological frameworks that recognize divine presence operating through embodied human experience. The discovery

that "cognitive abilities and memory may function differently during terminal lucidity in comparison to those of a typical brain" aligns with Ungar-Sargon's understanding that authentic healing often requires "accepting the limits of medical intervention while maintaining full engagement with suffering" [23].

The neurological paradox of terminal lucidity—wherein severely damaged brains suddenly recover complex cognitive functions—resonates with theological concepts of divine presence manifesting through absence. As Ungar-Sargon describes "NOT-God" as "a space where divine absence is palpably felt," the neurological evidence suggests that consciousness may operate through mechanisms that exceed current scientific understanding, creating space for what we might term "neurological mystery."

Furthermore, the documentation of enhanced brain connectivity during dying challenges reductionist approaches to consciousness that would dismiss final words as mere neurological artifacts. The complex patterns of gamma wave activity and increased interhemispheric communication during terminal states suggest that final utterances may emerge from heightened rather than diminished neurological integration.

9. Clinical Implications for Understanding Final Words

The neurological research on terminal lucidity and dying brain activity has profound implications for how medical practitioners understand and respond to patients' final words. Recognition that up to 90% of patients with severe dementia who exhibit terminal lucidity may die within seven days should alert clinicians to the theological significance of these moments rather than dismissing them as medical curiosities [23].

The discovery that terminal lucidity can occur "even in cases of severe, irreversible damage or degeneration to the brain" suggests that final words may emerge from neurological processes that operate independently of conventional brain function [21]. This understanding requires what Ungar-Sargon terms "shared vulnerability" rather than "medical omniscience"—a recognition that healing and consciousness may operate through mechanisms that exceed current scientific paradigms.

The neurological evidence also supports the theological understanding of final words as embodied events rather than purely spiritual phenomena. The documented increase in brain activity during dying demonstrates that divine presence operates through rather than despite neurological processes, creating what Ungar-Sargon describes as "sacred spaces where genuine healing can emerge" through the integration of scientific observation and theological interpretation.

10. Nazi Documentation and the Theology of Witness

The systematic documentation of the Holocaust presents a tragic counterpoint to Osler's clinical observations, revealing how final words acquire heightened theological significance under conditions of ultimate persecution. While there was no systematic Nazi program to preserve Jewish last words in the manner that

rabbinic literature preserves the final teachings of dying sages, scattered and chilling fragments survive in three primary sources. Perpetrator testimonies and reports occasionally record victim behavior before execution. Einsatzgruppen operational reports (Ereignismeldungen UdSSR) from Ukraine in 1941 note that before mass shootings, "some called upon their God" or "recited prayers," with victims specifically documented as "shouting Shema Yisrael or curses at the Germans." These clinical Nazi observations, focused primarily on maintaining "orderliness," inadvertently preserve testimony to what we might understand through Ungar-Sargon's framework as moments of "dialectical presence" where divine and human encounter each other at the extreme threshold of suffering.

More substantive documentation emerges from survivor testimonies about others' final moments. At Ponary near Vilna, eyewitnesses recalled victims singing Hatikvah, Ani Ma'amin, or Shema Yisrael as they were led to execution pits. Survivors from Treblinka and Sobibor like Chil Rajchman and Thomas Blatt recount prisoners calling out to remember their names or to take revenge. In the Warsaw Ghetto, accounts by resistance fighters record comrades shouting both political slogans—"Long live the Bund!" or "Down with fascism!"—and religious invocations before death.

Perhaps most poignant are the clandestine writings where Jews literally wrote their final words minutes before death, burying them in the ground or hiding them in walls. The Ringelblum Archive collected in Warsaw includes last letters describing the moral choice to "die with dignity." These fragments reveal final utterances falling into three theological categories: religious invocations (Shema Yisrael, Ani Ma'amin, Psalms), political-ideological statements (Zionist or socialist slogans), and personal messages (names of loved ones, final pleas to remember).

The theological significance of these documented final words under Nazi persecution lies not merely in their content but in their embodied resistance to dehumanization. When victims recited the Shema—"Hear O Israel, the Lord our God, the Lord is One"—they enacted what Isaiah 53:7 describes as the "silence of the sheep before shearing," yet this silence paradoxically became the most powerful testimony. As documented throughout Jewish history, "Jews accepted martyrdom at the Inquisitor's stake and in the Nazi gas chambers" with the Shema on their lips, transforming final words into theological proclamations that transcend their historical circumstances.

12. The "Shema" as Embodied Theology

The documentation of Holocaust victims' final words reveals the Shema Yisrael as perhaps the most profound example of embodied theology under conditions of ultimate suffering. The prayer—"Hear O Israel, the Lord our God, the Lord is One"—functions not merely as religious recitation but as what Ungar-Sargon would recognize as "embodied ritual practice... as transformative response to suffering that neither resolves theological questions nor surrenders to nihilism"¹.

The theological significance of the Shema in extremis extends beyond individual testimony to encompass collective memory and divine presence. Rabbi Eliezer Silver's post-Holocaust use of the prayer to identify hidden Jewish children demonstrates how final words transcend their immediate context to become instruments of restoration. By calling out "Shema Yisrael" in Christian orphanages and observing which children began to cry, Silver revealed how the prayer had been embedded in embodied memory through mothers "putting them to bed each night and saying the Shema with them." This embodied transmission of final words across generations exemplifies what Ungar-Sargon describes as "therapeutic encounters as sacred spaces where genuine healing can emerge" [8].

Contemporary testimonies continue this theological pattern. Survivors of recent attacks report returning instinctively to the Shema in moments of mortal danger, "whispering or shouting or closing their eyes and moving their lips over and over again—"Shema Yisrael, Hashem Elokeinu, Hashem echad." One Holocaust survivor noted the theological distinction between those killed first and last: "those who stood on the right were only able to say, 'Shema Yisrael Hashem...' But those who stood on the left side reached the word 'Echad' and thus were able to proclaim G d's Oneness." This observation reveals how even the completeness of final utterances carries theological weight within the framework of divine witness.

13. Contemporary Medical Testimonies and the Continuity of Sacred Utterance

Modern healthcare workers continue to witness final utterances that range from the profound to the mundane, yet each carries theological significance when understood within the context of embodied practice. Recent collections of medical worker testimonies reveal patterns that echo both Osler's clinical findings and the deeper theological themes documented in Holocaust testimonies and martyrological literature.

Healthcare workers frequently report patients' final words that suggest recognition of transcendent presence. A nurse describes a patient with dementia who had "stopped talking completely" suddenly looking up and saying with genuine lucidity, "You look like an angel" [3]. Similarly, another patient told a caregiver, "You are going to beat this, you got away with murder, this is nothing"—words that haunted the practitioner years later⁴.

These testimonies reveal what Ungar-Sargon describes as the physician-patient relationship becoming "a space of 'dialectical presence' where healer and patient encounter mystery together, abandoning the illusion of medical omniscience in favor of shared vulnerability" [1]. The parallels between contemporary medical testimonies and documented Holocaust final words suggest a continuity of embodied theological experience that transcends historical circumstances while maintaining the sacred dimension of ultimate witness.

Particularly striking are cases where patients seem to possess

knowledge of their impending death that transcends medical prognosis. One patient told a nurse, "The next time you wash me I will be dead," and died shortly thereafter [4]. Another asked a medical worker, "Ever seen a man die? Well, you're gonna see one tonight," dying within a week despite the worker's reassurances [6].

These instances suggest what we might call "embodied revelation"—moments where divine knowledge manifests through corporeal intuition rather than rational analysis. As Ungar-Sargon argues, authentic healing requires "accepting the limits of medical intervention while maintaining full engagement with suffering—a medical practice that can hold both scientific rigor and spiritual humility without requiring their intellectual reconciliation" [1].

14. Sacred-Profane Dialectic

Our theological framework provides crucial insights for understanding final words within medical contexts. His concept of "archetypal and embodied approaches to medical practice" challenges "the mechanistic reductionism of modern medicine while proposing alternative frameworks for understanding illness, healing, and the therapeutic relationship" [8].

The therapeutic encounter becomes a locus of divine-human interaction where, as he writes, "authentic healing emerges from recognizing the sacred-profane dialectic inherent in therapeutic encounters" that "transforms ordinary clinical settings into healing environments" [8].

Modern palliative care theory recognizes that suffering is fundamentally "holistic, so one cannot tease out aspects of suffering into physical or existential domains" [9]. This understanding aligns with what Saunders termed "total pain"—a recognition "of the interdependency of mental and physical distress" that creates "a more embodied notion of suffering, thus constituting a profound challenge to the body-mind dualism on which so much medical practice... was predicated" [10].

We extend this framework theologically, arguing that medical practitioners must learn to "remain present to suffering that exceeds explanation while maintaining commitment to healing that does not depend on understanding ultimate causes" [1]. This approach transforms clinical encounters into what he terms "sacred spaces where genuine healing can emerge" [8].

15. Toward Embodied Medical Practice

Contemporary medical education increasingly produces practitioners who are, as one observer noted, "caught up in a medical juggernaut driven by a logic of its own, one less focused on human suffering and dignity than on the struggle to maintain vital functions" [10]. This approach reduces death to what one German physician described as something akin to an "industrial accident" [10].

However, final words reveal dimensions of human experience

that transcend technical medical intervention. When a patient says simply, "I am OK" before peacefully dying⁵, or when another declares, "Oh... It's beautiful" while looking upward⁵, these utterances point toward realities that medical technology cannot measure but which practitioners must learn to recognize and honor. The concept of "dialectical presence" offers a practical framework for healthcare workers encountering final words. This approach first requires what might be termed interpretive engagement, recognizing that "authentic healing emerges from... hermeneutic approaches to medical practice that emphasize interpretation over mere technical application" [8]. Such engagement moves beyond the mechanical application of protocols to embrace the art of understanding what emerges in the therapeutic encounter.

Equally important is the integration of sacred and profane dimensions within clinical settings, understanding these spaces as locations where transcendent and immanent realities interpenetrate. This requires practitioners to remain open to dimensions of experience that exceed medical measurement while maintaining rigorous attention to scientific observation and intervention. The practitioner learns to hold both realms simultaneously without requiring their intellectual reconciliation.

Central to this practice is the acceptance of embodied vulnerability rather than the maintenance of what Ungar-Sargon calls the "illusion of medical omniscience" [1]. This vulnerability is not weakness but rather the recognition that healing often emerges from shared presence with mystery rather than mastery over it. Finally, this framework calls for movement beyond contractual models of care toward what Ungar-Sargon describes as "a theological framework for physician-patient relationships grounded in covenantal rather than contractual models"[8], where the therapeutic relationship becomes a sacred trust that transcends mere service provision.

16. Case Study: The Embodied Theology of Final Utterances

Consider the testimony of a pediatric hospice nurse who witnessed a 10-year-old boy emerge from a 12-hour coma, sit up, sing "Twinkle, twinkle little star. How I wonder who you are," look around the room smiling at everyone, then lie back and take his final breath. The nurse concluded: "We were all speechless. It was quite beautiful" [11].

Through a theological lens, this moment exemplifies how "divine love manifests through ultimate human witness" while revealing the "sacred dimensions of medical practice." The child's final words—a simple children's song about wonder—become a theological statement about the mystery that exceeds medical understanding while affirming the beauty that can emerge even in dying.

17. The Silence and the Sacred

Returning to Osler's finding that most deaths occur in silence, we must ask whether this absence of final words diminishes their theological significance. Ungar-Sargon's framework suggests the opposite: divine presence often manifests through absence,

creating spaces where "mystery together" is encountered rather than explained.

As healthcare workers report, many of their most profound encounters with dying patients involve not dramatic final statements but moments of quiet presence. One nurse described staying with a patient who simply "pleasantly adjusted his own pillow, laid his head down, and then his eyes went blank. This man just made himself comfortable before laying down to die" [4].

This embodied preparation for death—the simple act of adjusting one's pillow—becomes a form of prayer, a final gesture of human dignity maintained in the face of mortality. Such moments reveal what Ungar-Sargon describes as "embodied ritual practices... as transformative responses to suffering that neither resolve theological questions nor surrender to nihilism" [1].

18. Implications for Medical Education

Medical education must recover what Hauerwas calls the physician's role as "one offering presence in the midst of pain" [7]. This requires training that goes beyond technical competency to include what we might call "theological sensitivity"—the ability to recognize and honor the sacred dimensions of therapeutic encounters. Ungar-Sargon's framework suggests that this involves developing "therapeutic orthodoxy"—a methodological approach that operates deliberately at the boundaries between orthodoxy and heresy through practical application of religious concepts to healing practice" [1].

Such curriculum integration might encompass narrative medicine that trains practitioners to attend to the stories embedded in final words and last gestures, understanding these utterances as texts requiring interpretive engagement rather than clinical data to be recorded and dismissed. Equally important would be the development of presence practices, contemplative disciplines that enable sustained presence with suffering without the compulsive need to fix or explain. This could include theological reflection that integrates perspectives on suffering, presence, and healing into clinical training, helping practitioners understand their work within larger frameworks of meaning. Finally, interdisciplinary dialogue between medical professionals and theologians, chaplains, and spiritual care providers could create spaces where the sacred dimensions of medical practice receive serious intellectual and practical attention.

19. Conclusion: The Embodied Word

Final words in medical settings represent more than individual expression; they constitute theological events that reveal the sacred dimensions of healing practice. Through Ungar-Sargon's framework of embodied theology and dialectical presence, we see how authentic medical practice requires recognition of the sacred-profane dialectic inherent in therapeutic encounters with mortality. Whether patients speak eloquently of transcendent vision, utter simple expressions of acceptance, or die in the profound silence that Osler documented, each encounter represents what Ungar-Sargon

describes as "authentic healing often requiring accepting the limits of medical intervention while maintaining full engagement with suffering"¹.

The embodied theology of medical practice calls practitioners to become witnesses not only to disease and cure but to the mystery of divine presence operating through human embodiment. In this framework, final words—or their absence—become sacramental moments where the ordinary clinical encounter is transfigured into sacred space.

As healthcare continues to evolve toward increasingly technical approaches, the wisdom embedded in patients' final utterances calls us back to the fundamental vocation of healing: not merely to treat disease but to accompany fellow human beings in their encounter with the mystery that exceeds medical explanation while affirming the dignity and transcendence that emerges even—or especially—at the threshold of death.

This embodied approach to medical practice, grounded in theological reflection and clinical presence, offers a path toward healing that honors both scientific rigor and spiritual depth, creating space for the sacred to emerge within the profane realities of illness, suffering, and mortality.

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