International Journal of Ageing and Later Life, *Advance access*, 2026 © The Author
doi: 10.3384/ijal.1652-8670.5682

Mortality matters: providing a universal ground for care

*By Albert Banerjee**

Abstract

Can centering mortality contribute to a caring society? My argument in this paper is that while analyzing the intersections of oppression matters, highlighting the universal need for care also matters. This common ground has been hidden. Drawing on critical theories of medicine and technology, I suggest that health discourses have fragmented vulnerability and death into pathological processes in the hopes of control. Against this backdrop, I use the concept of mortality to support an intersectional analysis that weaves together different forms of ailments – disability, aging, disease, accidents, etc. – to reveal the fundamental vulnerability lying beneath. Centering mortality highlights aspects of life that are essential to care (e.g. finitude, vulnerability, meaning, and our connection to nature). I conclude by exploring the links between the fear of death and the neglect of care, suggesting that learning to engage skillfully with mortality may prove a significant contribution to a caring society.

Keywords: care, death, health, mortality, technology; intersectionality

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Introduction

> Prioritising and working towards a sense of universal care – and making this common sense – is necessary for the cultivation of a caring politics, fulfilling lives, and a sustainable world. (The Care Collective 2020: 19)

Can centering mortality contribute to a caring society? My argument in this paper is that there is important work to be done to foster solidarity around the universality of vulnerability and a shared need for care. This common ground has been hidden. I suggest that health discourses are partially responsible for this, having fragmented vulnerability into pathological processes in the hopes of control. Against this tendency, I want to turn to the wisdom of death to highlight our shared need for care. Death has often been understood as one of the few things that "we" all share, something that binds us together in a common humanity despite whatever may divide us (Sallnow et al. 2022). The rich and poor both die. Though the lives they lead and the deaths they die may be very different, they are both joined in a shared mortality.

Inspired by intersectional research, I suggest using the concept of mortality to bring these various strands together. I have often thought of intersectional research as a form of weaving, bringing together different analytic lenses – gender, race, class, age, sexuality, disability – to illuminate human experience. A similar conceptual weaving is what I undertake in this paper. By starting from death, I use our shared mortality to move beyond the "conceptual limitations of…single-issue analysis" (Crenshaw 1989: 149), weaving together different forms of ailments – disability, aging, chronic illness, etc. – to highlight our shared vulnerability and provide a common ground for care. This then is a contribution to a caring society, one that starts from the wisdom of death.

In what follows, I review some analytic strategies that have been deployed to imagine a caring society and then turn to death as a possible source of solidarity. One might expect that in the health care field the backdrop of death would lead to greater wisdom and compassion. Unfortunately, it does not. Instead, what prevails is a technological rationality that fragments death into an array of risks, such that we can barely recognize any common ground. Against this rationalized death, I suggest that the concept of mortality can act as a frame that highlights elements of our

existence relevant to care (e.g. our shared vulnerability, the significance of finitude and meaning, as well as our connection to nature). Moreover, mortality brings these elements to the fore – not at the end of life – but in the present moment: immediately. Paying attention to mortality may help weave strands of existence that are often kept separate, while encouraging us to find the courage to care.

However, the fear of death, as I shall argue, is powerful and is one of the existential reasons for care's neglect. A caring society requires a recognition of shared vulnerability, and that is scary stuff. It is much more comfortable to pretend that care is only needed by some people, and perhaps only because they have failed in some way. I therefore conclude by suggesting that one contribution to building a more caring society might involve developing the knowledges and skills to engage with mortality in ways that do not close down into fear but open up into care, compassion and love. This will need to be both an individual and a collective project. It will also need to be a multidisciplinary project. Moving beyond technical approaches to mortality involves turning to the arts, the humanities, spiritual, and non-Western traditions. The writing of this paper reflects my own scholarly exploration of these diverse fields, nomadic at times, but always guided by interest in learning from those perspectives that engage with mortality in both practical and life affirming ways. This is one of the reasons I find thinking about care so compelling.

Contributions to a Caring Society

> What, we now ask, would happen if we were to begin instead to put care and the very centre of life? (The Care Collective 2020: 2)

There are many strategies that can be used to foster a more caring society. As someone who has worked to understand the limits of technological rationality – and the individualizing, reductionist, materialist worldview it engenders – I have been particularly drawn to those scholars who have recognized that care offers an alternate vision: a different way of seeing and being in the world. This approach is reflected in the research on the logic and ethics of care as well as in feminist epistemologies more broadly which seek to outline a more caring metaphysics (Code 2006; Gilligan 1982;

Mol et al. 2010; Ruddick 1995). These perspectives emphasize that care requires distinct ways of being, knowing, and doing to paraphrase Watson (2005: 305). Supporting care, therefore, involves studying, understanding, and articulating its unique characteristics, effectively giving care its own language. This enables us not only to better understand what is needed for care to be done well but also to discuss and share good care practices. Mol et al. (2010) describe the strategy nicely:

> [W]e seek to give words to things (events, habits, frictions) that have previously been unspoken. Such articulation work may help to make the specificities of care practices travel. Perhaps when articulated, when put in so many words, care will be easier to defend in the public spaces where it is currently at risk of being squeezed. Perhaps care practices can be strengthened if we find the right terms of talking about them. (p. 11)

This approach to fostering a caring society seeks to learn from care itself and develop an appropriate language for representing it. This strategy addresses the common challenge, as noted by Mol et al. (2010), that solutions to carelessness are often imported from unrelated fields. This is particularly evident in the context of nursing homes, where I have worked. Solutions to insufficient care are often borrowed from the financial sector – such as privatization, new public management, and auditing – and have frequently caused harm (Banerjee 2023b). This strategy for creating a caring society then begins from a point so obvious it tends to be ignored: To protect care, we need to understand what care is and what caring requires.

Another strategy has been to centre care in our thinking about society. In Canada, using the federal election as a springboard, a coalition of feminist political economists and activists (Armstrong et al. 2021) came together to elaborate what they called a "care economy." In their *Care Economy Statement*, they offer a vision of care as a fundamental component of basic societal infrastructure that enables both economic growth as well as personal wellbeing. Their statement puts care at the heart of economic thinking. Centering care in this way transforms what the economy is about. From economic growth for its own sake, thinking about the economy becomes about whether and to what degree Canadians are able to receive and give care. Care, in this vision, no longer occurs as an afterthought or an unnecessary cost as it so often does in conventional economic talk. Rather, the statement reveals that care is not only central to

the economy but foundational for societal wellbeing. "A well-functioning care economy," the authors (2020: n.p.) observe, "is key to the functioning of all the other parts of the economy."

We find a similar strategy in Tronto's (2013) work on democracy, where care serves as an orienting principle. Indeed, Tronto invites us to reimagine the very purpose of democracy as a means of negotiating caring responsibilities. Care is thus put at the heart of democracy. Again, the world occurs very differently when we do this. What if, Tronto asks, we understood democratic politics as being about caring for citizens and also caring for the needs of democracy? Not least, she suggests centering care in this way would orient politics around the day-to-day struggles that so many working- and middle-class people face. This would make democratic politics clearly relevant. She proposes this approach as a challenge to those who believe the electorate are disinterested. They may be, but this is largely because political conversations do not touch their daily lives. Centering care in democratic discourse, Tronto (2013: xii) suggests, would shift conversations from an "abstract set of concerns about 'the economy' to a way of coping with real people's lives that is much closer to the way that people actually live." In a prescient observation, Tronto not only argues that giving and receiving care should be central to democracy, but she also emphasizes the importance of caring for the democratic process itself – if democracy is to serve as a viable foundation for equitable social organization.

The above strategies center care as a means of advocating for a caring society. To some degree, they presume a commitment to care – requiring a preunderstanding that care matters and ought to be centered. Another less direct approach, but possibly more compelling for those who are not working in the realm of care scholarship, is an approach that centers the *need* for care. Rather than start from the assumption that care is a good, these strategies aim to persuade by showing a universal requirement for care and thereby build commitment. This is the strategy I am taking in thinking about the significance of death and mortality, but it is worth recognizing that these are not the only entry points.

Others have made similar moves. For instance, the Finnish Viva Collective (Vaivakollektiivi) has introduced the concept of "ailment" as a contribution to a caring society (Zechner et al. 2022). The term refers to the litany of specific troubles that plague us. This includes death as well as

the existential "bothering awareness of the fragility and limits of life" (p. 2). More broadly, the concept of ailment draws attention to an "endless diversity" of troubles that plague human beings. Ailment is not specific. Indeed, the concept is intended to be used in the "abstract." In this abstract sense – and like mortality as I shall show – ailment highlights "*generalised care needs*" (p. 3). Seen in this way, the Viva Collective argues that ailment may become a source of connection and community. Of course, the Viva Collective recognizes the fact that connection is not the only response to ailment. Responses may vary. Some care needs are more visible than others. The "ailments of more marginalized bodies remain invisible, unrecognized and barely responded to by other ways than neglect" (p. 4). Thus, from these different responses, there emerges what they term a "politics of ailment." While the authors grapple with various political and organizational responses in their text, their attention to difference is always held against the universal backdrop of a generalized ailing human. "The ailing nature of humans," Zechner et al. (2022) write, "is understood as a permanent and all-encompassing feature that generates action and creates webs of connection in societies" (p. 5).

Just as ailment reminds us of our shared vulnerability and need for care, in what follows, I turn to death and mortality, for they have long been understood to be sources of wisdom, compassion, and solidarity.

The Wisdom of Death

> Death is not waiting for us at the end of a long road. Death is always with us, in the marrow of every passing moment. She is the secret teacher hiding in plain sight. She helps us to discover what matters most. And the good news is we don't have to wait until the end of our lives to realize the wisdom death has to offer. (Ostaseski 2017: 1)

Death has long been used as a reminder of our shared predicament as vulnerable, mortal beings. The notion of death as the great equalizer was perhaps most famously represented by the Dutch Renaissance artist Hans Holbein ([1538] 2017) in a series of 41 woodcut illustrations published as *The Dance of Death* (see Figure 1). Each illustration depicts a member from a cross-section of society as she or he is brusquely wrenched from everyday routine. In these illustrations, Death is sometimes portrayed as

Figure 1. The Nobleman.
Source: Hans Holbein's Dance of Death (1523–5) The Public Domain Review.

a malicious skeleton mocking its victims while dragging them off to the grave. In one image, the Pope is giving a speech at a magnificent crowning ceremony, oblivious to Death, who is smugly reading his notes over his shoulder. In another, an Emperor sits listening to counsel as Death hops on his throne and snatches the crown off his head. At the king's banquet, Death serves the wine; the Queen is greeted by Death dressed as a jester; a duchess is dragged from her bed; a blind man is helped across the street by Death who holds an hourglass over his head. In other depictions, Death appears compassionate, even sad. When leading an old man to the grave or taking a young mother's child, Death almost seems to regret its task.

The Dance of Death serves as a timeless reminder of life's fragility and the inevitability of its end. Reflecting on the series, Kidder (1998) remarks that it was intended to be explicitly didactic. Its goal was to vividly underscore the universality of mortality. As such, it formed part of the *memento mori*, an artistic tradition that urged the contemplation of death and the need for preparedness. Reflecting the emerging humanism of time, Holbein's series also critiques the societal hierarchies starkly revealed by the equality served by Death.

While contemporary examples of the memento mori tradition can be found (e.g. see the contemporary resurgence of stoicism Irvine 2009 or the Mortality Collective 2024), the task of sharing the wisdom of death has been notably embraced by hospice practitioners who have written compellingly about death – not only to support those approaching the end of their lives or grieving loved ones but also, importantly – to share the wisdom gained by working with the dying. They offer lessons for the living. Take for example, the work of Ostaseski (2017), co-founder of the Zen Hospice Project. He describes how engaging with death has taught him to embrace life more fully, to open his heart to the plight of others, and to engage with suffering without being overwhelmed. While acknowledging the difficult, messy, and sometimes cruel realities of dying, Ostaseski also emphasizes that death has deepened his appreciation for life. He characterizes death as a "secret teacher" that is always with us, offering transformational lessons if we pay attention. Death is not only for the dying. In Ostaseski's (2017) words:

> Without a reminder of death, we tend to take life for granted, often becoming lost in endless pursuits of self-gratification. When we keep death at our fingertips, it reminds

> us not to hold on to life too tightly. Maybe we take ourselves and our ideas a little less seriously. We let go a little more easily. When we recognise that death comes to everyone, we appreciate that we are all in the same boat, together. This helps us to become a bit kinder and gentle with one another. (pp. 2–3)

This ability to reveal common ground amidst difference and open hearts towards compassion is one of death's secret powers. Such wisdom is particularly relevant for those engaged in the health field, for death lies at the very core of the health care project. It is, after all, in matters of health that we confront human vulnerability most profoundly. It is in matters of health that we come face-to-face with our own mortality and those of the people we love and care for. Death is not only the terrain of health, but the dominant model of medicine – biomedicine – is epistemologically rooted in death and the dead body. There is an epistemic reason why hospital floor plans are organized around specific organs and systems – the cardiac unit (heart), hepatology (liver), hematology (blood), neurology (brain), and so on (Prior 1988). This structure reflects biomedicine's origins in the study of the corpse (Leder 1992) about which I will have more to say further in the text. For now, it is simply worth noting that the healthcare endeavor is intimately related to death. Given the wisdom to be gleaned from death, one might expect that training in healthcare would naturally foster compassion, open-heartedness and solidarity. It does not – and this contradiction merits some consideration.

Death and Technological Approaches to Health

Despite the potential for death to serve as a ground for solidarity and compassion, prevailing health discourses have transformed death, fragmenting any notion of a shared death into a myriad of individual disease processes in the hopes of gaining control. This desire for control and to avoid the vulnerabilities that come with being mortal is understandable. Yet it has radically transformed death and reduced its potential for serving as a source of wisdom. To better understand how, it is helpful to turn to Heidegger's theory of technology as it provides a unique perspective on how values can transform reality (Edwards 2000).

In Heidegger's (1977) provocative theory of technology, he claims that technology should not be regarded merely as a collection of devices or

objects but as a way of revealing the world. More specifically, technology is a way of revealing the world oriented by a "will to mastery" or an ethos of "ordering" (p. 6). Put more colloquially, technology is what we see when we seek control. Technology "enframes" (p. 20) the world, according to Heidegger, so that it shows up in particular ways. Consider a painting that has a black frame on it and then replace that frame with a gold one. The painting will be transformed not because its nature has changed but because the frame heightens certain colors and diminishes others. A painting that might leave us emboldened with one frame may leave us melancholic with another. Heidegger's perspective is particularly relevant in the context of health care, because it emphasizes the central role that values – such as care or control – play in shaping reality. From a Heideggerian perspective, values are not secondary considerations; they are constitutive. What Heidegger is claiming in his theory of technology is that, as an ethical orientation or ethos, technology quite literally shapes how the world occurs to us.

The ethos of ordering reveals the world in specific ways. Nature, for instance, shows up as a resource for use – what Heidegger (1977) termed a "standing-reserve" (p. 17). A forest occurs and can indeed be valued by economists as timber to be used for the construction of houses. This is another fascinating aspect of Heidegger's approach to technology. It reverses the presumed relation between technology and science. Rather than technology following science, as the application of scientific knowledge to practical purposes, technology reveals the world for science to know. Specifically, through a technological frame the world shows up as orderable and science – including health science – aims to enact that vision.

While there are certainly limitations to this way of thinking about technology, Heidegger's perspective helps us understand that a defining feature of the scientific revolution was a radical transformation in the way the world occurred (cf. Berman 1981). The world came to be seen not as a living whole that humans were a part of but as a dead, mechanical entity. The modern universe was metaphorically likened to a clock. This mechanical metaphor became the primary means of seeing, then knowing, then acting upon life itself. It is a version of the world inspired by the desire for order, control and autonomy. In such "fantasies of mastery" (Code 2006), death has also been transformed. It has been reduced to a material

and mechanical process: fragmented along causal lines into innumerable disease processes that transpire deep within bodies and at the end-of-life. This scientific representation of death, which I examine briefly further in the text, empties any understanding of death as a "teacher," "leveler," or "companion" of ontological merit, rendering them as merely fanciful or at best poetic notions.

Biomedicine and the Ordering of Death

Research on the medicalization and rationalization of death within sociology and anthropology offers poignant examples of how technological enframing has transformed death (Foucault 1973; Lock 2002; Prior 1984; Seale 1998). Prior to the advent of biomedicine, the vitalist perspective predominated in European medical circles (Foucault 1973). From this perspective, Death was understood to be a force that competed with Life. Death would inevitably win as it must, but the battle could be long and drawn out. When anatomists opened cadavers for study, the lesions they saw were understood to be the effects of this battle: they were caused *by* Death. Death had agency within the vitalist perspective.

However, with the emergence of the mechanical worldview, anatomists no longer believed death was a force battling life (Foucault 1973). Rather, when they cut open cadavers, they saw something entirely different. They saw causes *of* death. Death within this mechanical vision was no longer a cause to be reckoned with but an effect. It was an effect of a series of physiological processes that transpired deep within our bodies. The field of pathological anatomy was born out of this understanding. Death was no longer a capricious force dragging people off to the grave, as captured by Holbein. Rather, death followed mechanical cause-and-effect laws that could be studied, understood, and ultimately controlled (Prior 1984). This was an optimistic time, and it was thought that biomedicine could bring death to heal.

I want to summarize a few key points from research on the rationalization of death to show how death occurs in this technological vision and why it is difficult for death alone to serve as a ground for care (see Table 1). A technological death is no longer a capricious or vital force. It is not a companion nor teacher, walking alongside us, reminding us of the fragility of life. Rather, death has been temporally reduced, ultimately to the

Table 1. Technological death

Some of the ways the ethos of ordering reveals death
Death occurs as a pathophysiological process occurring in the body
Death is fragmented along causal lines
Death is reduced to a definable moment at the end of life (e.g. brain death)
Death becomes the purview of scientific expertise
The dominant language for death is medical (e.g. disease and risk discourses)
The dominant relationship to death is antagonistic (e.g. death is an enemy)
While death may not be avoidable, each instance is potentially preventable

briefest of moments, and pushed to the end of life (e.g. as with definitions of brain death, cf. Lock 2002). It has become little more than a blip that can be represented as the cessation of the heartbeat on your favorite medical TV show. The flat line, that is death.

Not only has death been reduced to a moment at the end of life, it has also been confined to our bodies, first in organs, then as biomedicine progressed, it receded further into our cells and then our genes (Jewson 1976). Shifts in medical models also transformed death, though it always remained orderable. As lifestyle and environmental perspectives developed, we came to see death in pollutants and behaviors like smoking or unprotected sex. COVID-19 has taught us to see death in handshakes and hugs. Thanks to health discourses, death has made it back into life (Bauman 1993). It is everywhere, but now in the form of risk. Additionally, another crucial transformation is that death can only be seen and truly known by select experts and certainly not by artists like Holbein (Banerjee 2008). The modern relationship to death has come to be mediated by the scientific and medical profession. I wait anxiously for blood test results or MRIs to see how close my relationship to death is.

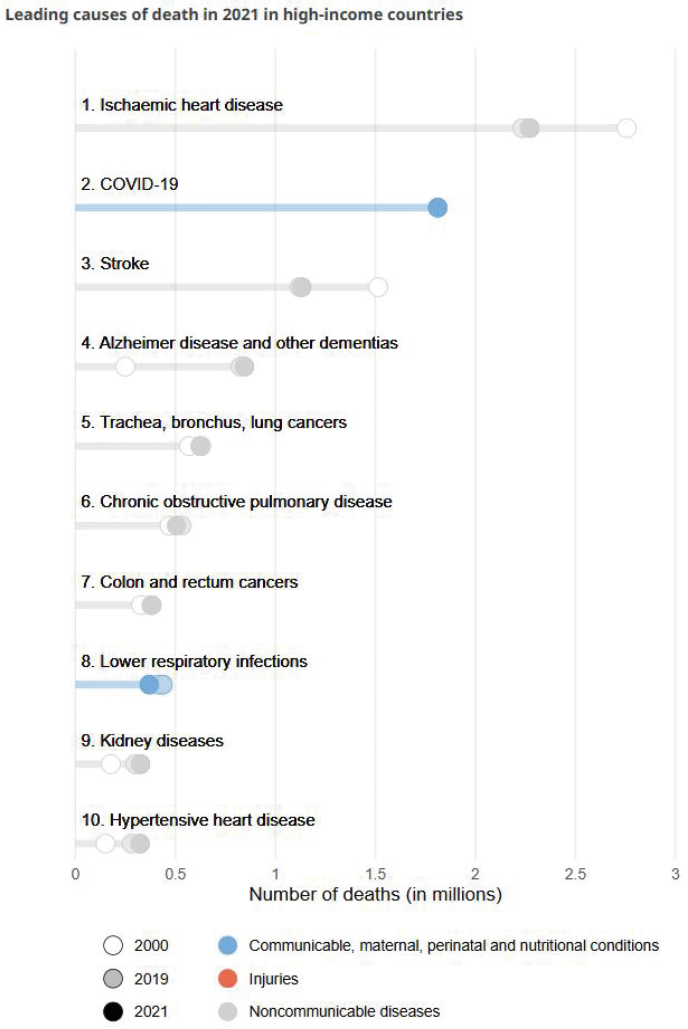
Within this technological frame, death is paradoxically everywhere and yet diminished. It has come to be conflated with disease, as Tolstoi (1903) famously captured in the short story the *Death of Ivan Ilych*. Death no longer stands on its own. Moreover, these disease and risk discourses have a defining feature, as Prior and Bloor (1992) point out: they represent death as rationally ordered and even calculable. It is a vision in which death can be ordered. We can see this representation of death in Figure 2,

in the World Health Organization's (WHO 2024) graphic of the top ten causes of death. "Why do we need to know the reasons people die," the WHO (2024: n.p.) asks? They answer: "It is important to know why people die to improve how people live. Measuring how many people die each year helps to assess the effectiveness of our health systems and direct resources to where they are needed most." Yet, in this representation, death is not portrayed as a unifying shared experience. A universal rationale for care is hidden and resources will not be directed there. Instead, death is shattered into specific diseases, and citizens are encouraged to mobilize around each, channeling funds and a hope for cure, while wearing red (AIDS), pink (breast cancer), and purple (Dementia) ribbons.

Equally important, in relating to death through disease an antagonistic relationship is cultivated. Taking the example of high blood pressure (hypertension), I have elsewhere observed (Banerjee 2008) that health education operates as a "metaphysical trojan horse," seemingly providing medical facts while training people to relate to mortality in terms of problems that can and should be managed. This sets up a hostile relationship with death, while obfuscating any other way of relating to mortality. Care and compassion are not called for. Indeed, such attitudes might be naive. Hypertension, for instance, is commonly represented as a "silent killer." Being killed is very different from dying. Not only is it not normal to be killed (even though heart disease is one of the most common causes of death in high-income countries) but one does not typically approach killers with compassion. In an orderable world, such disorder is criminal. In its silence, this killer must be sought out.

Given the prominence and power of these health narratives, it should not be surprising that when the time for dying comes, many people are unprepared (Gawande 2014). Nor should it be surprising that many scholars concerned with aging and the twilight of life, such as Davis (2020) or Lamb (2017), are critical of health discourses' emphasis on agency and autonomy. These are all astute and compelling observations, but they frame the problem with death as a later life concern. Our relationship to death has relevance much earlier. The biomedical approach to death – and the fantasy of mastery that underwrites it – shapes how mortality is understood and related to throughout life. Thus, it should also not be surprising that a strong caring infrastructure is lacking or that even considering such a venture might be akin to giving up or acting recklessly in the face

Figure 2. WHO Leading Causes of Death.
Source: WHO (2024, August 7), *The Top Ten Causes of Death*, The World Health Organization. Geneva. https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death (Accessed: December 8, 2025)



of a death that should and can be ordered. Like death, care is pushed to the margins in the hope for control.

Beyond Ordering: The Ethos of Care

There is nothing inherently wrong with the will to mastery. To be sure, seeing death in mechanical terms has been incredibly useful, enabling some understanding of "how we die" (Nuland 1993) and some measure of control over the manner and time of dying. Rather, given the limits of a technological orientation – which are becoming apparent in more than the health field – my concern is how else may we relate to death? What values could orient us and what worlds may this open?

Care is one possible value orientation. Building on Heidegger, as a value orientation, care also reveals worlds. Care theorists like Joan Tronto can look at democracy and see an entirely different world, a set of problems and possibilities, that have to do with democracy's capacity to support care. Similarly, Pat Armstrong, the lead author of the *Care Economy Statement*, can listen to economic discourses and immediately hear the way care is presumed to be an exception and expense: in both cases occurring as unnecessary, unfortunate and avoidable. Centering the ethos of care offers a unique perspective on the world, highlighting necessary actions and the knowledges required to support them. Care also brings certain ontological features of the world into focus – interdependence, relationality, plurality, dynamism, emergence, and more – that stand in stark contrast to the mechanical worldview (Banerjee 2023b).

Among the most significant differences in the world of care is the acceptance of mortality. Care reveals a world in which we are mortal and our "fundamental vulnerability" (Baars 2012: 81) is brought to the fore – not in a fragmented, bio-mechanical sense – but as a *condition* of our existence. Take a moment to consider what Mol (2008) writes about the logic of care:

> [I]n care versions of the world, the hope that one might live happily ever after is not endlessly fueled. You do your best, but you are not going to live "ever after." Instead, at some point, sooner or later, you are bound to die. Along the way, there will be unfolding tensions and shifting problems. Care is attentive to such suffering and pain, but it does not dream up a world without lack. Not that it calls for cynicism either: care seeks to

> lighten what is heavy, and even if it fails it keeps on trying. Such, then, is what failure calls for in an ethics, or should we say an ethos, of care: try again, try something a bit different, be attentive. (pp. 12–13)

In the above quote, Mol (2008) recognizes that it is possible to inhabit different versions of the world. In the version of the world revealed by the ethos of care, we show up as mortal, vulnerable, and prone to suffering and failure. Vulnerability, failure, death are baked into a caring world. Thus, who we are, what we do, how we discern and know must occur differently than in the version of the world revealed by dreams of mastery. For instance, in the face of "lack," Mol imagines a form of agency that, as I understand it, holds in tension the will to mastery with a recognition of limitation. Care accepts mortality, but it is not passive. Care does not surrender. Neither does it dream up a world without "lack." Human agency and the respect for limitation are held together. Thus, the "art of care," as Mol (2008: 32) explains, "is to act without seeking to control. To persist while letting go."

Care and mortality call forth one another. Personally, I have found that when I engage with care theories and practices – or in those moments when I am providing care – I am more attentive to mortality. And conversely when I pay attention to mortality, the centrality of care to living well becomes apparent. Because of this intertwining, I suggest that centering mortality can assist in calling forth care. In what follows, I outline some of the elements of life relevant to care that mortality reveals.

Mortality as a Condition of Being

> Mortality, n.
> 1.a. The condition of being mortal or subject to death.
> (Oxford English Dictionary 2023)

While a fragmented death may be a difficult catalyst for solidarity, mortality may prove more productive. As the Oxford English Dictionary definition above indicates, mortality is a condition. It is not a moment at the end of life. It is not something that happens to us. It is a state of being. It is ongoing, something that we all are at every moment: subject to death.

This ever-presence is useful. We all are mortal now. We are mortal at age 5, 21, 43 and 75. We are mortal in the morning and at night. Our mortality is something we share in the present moment. Mortality puts us in the context of a finite, vulnerable life, not as a future possibility, but as an immediate condition of being. In this way, mortality serves as a frame that highlights numerous aspects of our being that have significance to care (see Table 2).

Most obviously, mortality draws attention to the fact that we die. As an inevitability, dying becomes much more than a medical matter (Davis & Scherz 2020). It is an ethical, existential, spiritual and relational process. As noted previously, there is wise scholarship from the hospice and palliative care community offering profound insights about how we can support the dying while preparing for the process ourselves (Mannix 2018; Miller & Berger 2019; Tisdale 2018). Some of the best writing about the end-of-life, whether scholarly or literary, holds profound wisdom for the living (see, e.g., Broyard 1992, or Kalanithi 2016, for excellent literary examples). This literature questions the divide between life and death, suggesting there is much the living can learn from the dying. What's more, recent trends in palliative care, specifically the Compassionate Communities movement, are aiming to inspire lay engagement with death, recognizing dying is not just a matter for professionals (Kellehear 2013). These efforts are blurring the professional boundaries that have kept death outside life and putting death back in conversation with living well.

Less obviously, but more importantly for the universality of care, mortality draws attention to the fact that we are fundamentally

Table 2. Mortality as a frame

A partial list of those aspects of life revealed by mortality
Mortality highlights the relevance of death throughout life
Mortality highlights our shared vulnerability
Mortality draws attention to finitude
Mortality reveals that meaning matters
Mortality highlights our connection to nature
Mortality draws attention to dying

vulnerable – we are subject to accidents, mistakes, misfortunes, diseases and ailments of an innumerable variety. As a frame, mortality reveals these disparate vulnerabilities and weaves them together into a whole such that they stand out. There is no escaping. Harms can happen predictably or unexpectedly and, in both cases, well before the end of our lives. Even if we are fortunate to live a long life, this will only increase the chances of living through loss (e.g. of those we love, perhaps even our children). By highlighting our shared and ever-present vulnerability, the frame of mortality as a "condition" encourages us to recognize why care matters for all of us, not just for some, not just for the weak, or morally suspect. Mortality reminds us, as Mol (2008) points out, that there are limits and that fantasies of mastery are not the only dreams one can live.

Mortality also draws attention to finitude. Indeed, mortality is a specific instance of finitude (Baars 2017). But only one instance. Finitude is broader category, though it lacks the personal resonance of mortality. Finitude points to the ever-presence of change – things come and go – impermanence is the norm. This awareness invites us into a very different world than the one revealed by the ethos of order. It is not a mechanical world of stable, autonomous parts. Instead, it is a fleshy, fragile world where change and uncertainty are inescapable. Expecting stability from an impermanent world inevitably leads to suffering. Thus, one task mortality reveals for a truly caring health sector is helping people to live and love well in the face of finitude, where the very people and things we cherish will shift, change, decay, or die. Embracing mortality thus awakens us to our finite nature and the nature finitude.

The concept of mortality also highlights the significance of meaning. Finite time lends a poignancy to existence. Gerontological research finds that as people become cognizant of endings – of any sort, not just death – priorities change (Carstensen 2021). One of the great psychological insights of the European existentialists – and of many spiritual traditions as well – was that confronting mortality could be ethically productive (Yalom 1980). It could become a useful tool for those wanting to live an authentic life. The noted Austrian psychiatrist, Victor Frankl (1959), used the deathbed as a therapeutic technique. He would ask his clients, who were struggling with difficult decisions, to imagine themselves on their deathbed looking back at the present. What would they wish they had done? The deathbed scenario was an impetus to free them

from constraints, such as tradition or the desire to please. Recognizing that at the end of their life, they only had themselves (and maybe their god) to answer to, what should they do? Anecdotes abound of people, who upon a brush with death, have reimagined and reorganized their lives: quitting a job that was meaningless, committing to a relationship that was stuck, spending more time fishing or with friends. The reflections, changes and resignations the COVID pandemic inspired may yet be another example of how engaging mortality provokes a search for meaning. There is a reason that Cicero believed contemplating death was the start of philosophy and Buddhist monks meditate on impermanence. Paying attention to mortality reveals the importance of meaning in our lives and opens avenues for caring (e.g. spiritual and narrative care). It recognizes that meaning matters, sometimes more than life itself.

Finally, centering mortality reminds us, although more indirectly, that we are fleshy creatures and part of the cycle of nature. Modernity pitted civilization against nature. Whereas life in the state of nature was represented as nasty, brutish, and short to paraphrase Hobbes (1651[1985]: 186), humans (or perhaps more accurately at the time, white European men) were imagined as somehow above nature, separate and, thanks to science, in control. There is a growing understanding, albeit slowly and unevenly, of the harms of this vision, and that humans have always been part of nature, inextricably in relationship with it (Walter 2023). As with any relationship, there is room for tensions and contradictions. There is power in working with nature. And there are times to push against nature, directing its force like a sailor capturing the wind, to go where we want to go. Attending to our mortality serves as a caveat: much as we push against the winds, we are part of this ecology. Ultimately, we tire, stop and dissolve, becoming fodder for future life. As part of this ecology, mortality calls us to care not only for ourselves but to better manage our interdependence with other species and the natural environment itself.

The above elements are not the only ways that mortality matters (see, e.g., the Mortality Collective 2024). Nor are they all that the frame of mortality invites us to see. Rather, these are just some elements that might inspire reasons to care: to care at the end of life, throughout life, in the face of change and loss, and for the natural world. Mortality is not something that happens to us, over there in the beyond, in the dying. It is who we are. And it is who we must learn to be.

Mortality as Intersectional Analysis and Frame

> Dependence on care has been pathologized, rather than recognized as part of our human condition. (The Care Collective 2020: 23)

As a frame, mortality normalizes impermanence and uncertainty. It foregrounds our shared vulnerability. The world revealed by mortality is a messy, fragile one. It is a world that needs care. Conceptually, mortality enables a sort of intersectional analysis, bringing together categories that have been kept apart. Our shared vulnerability manifests in a variety of manners that get named and isolated: congenital heart disease, Alzheimer's, myopia, chronic obstructive pulmonary disease, leukemia, schizophrenia, hearing loss, depression, Parkinson's disease…the list is near endless. Fields of scholarship construct silos around each category until the whole disappears. Reductionist expertise obfuscates the wisdom of death. When seeing across categories is no longer a habit of mind, it needs to be intentionally cultivated. Mortality as a frame enables an intersectional weaving of these categories until they reveal the fundamental vulnerability that lies throughout.

This process of seeing across difference can support solidarity and collaboration. I want to consider two productive intersections. First, looking towards the end-of-life, as I have already noted, there are potential synergies between gerontology and hospice/palliative care. People working in these fields are concerned with care, working to cultivate community, meaning and joy, under circumstances where mortality is most obvious. Brassolotto and Banerjee (2024), for instance, have written about the ways the age friendly and compassionate community movements may collaborate to lay the ground for a more "death friendly" society in "which people do not fear getting old or alienate those who have" (p. 311). Such synergies become easier to see when mortality highlights common concern.

Similarly, looking earlier on in life, attending mortality reveals productive intersections between disability and aging. For the most part, older adults with impairments are not typically regarded as disabled in the same way younger people are (Leahy 2018). Indeed, for an adult over 65 the experience of an impairment may well be what defines them as "old." This siloing is reflected in the distinct disciplines, theories and policies targeting people with disabilities and older adults. Public policies,

for instance, tend to assume that people are either disabled or old, not both. However, some scholars are challenging these conceptual separations, asserting the need, as Leahy (2018) puts it, "for a realistic engagement with the nature of humanity, including its limitations" (n.p.). As with the scholarship on ailment, what is called for is a general vision of "human nature that has limitation and vulnerabilities and is ultimately mortal" (n.p.) as a basis for theorizing. In other words, rather than start from aspirations for control and notions of productivity, success and activity, one begins from an acknowledgement of fragility and limitation (Grenier et al. 2017). The concept of "debility" has been proposed to encompass experiences of disability as well as senescence and chronic illness (Livingston 2005). The aim behind the move from disability to debility, as Puar (2009: 166) explains, is to deconstruct the construction of the able-bodied self – not "to disavow the crucial political gains enabled by disability activists globally, but to invite a deconstruction of what ability and capacity mean" – so we can better address the truth of our vulnerability.

Debility, ailment, fundamental vulnerability, and mortality are all concepts facilitating an intersectional weaving of categories that reveal the truth of shared vulnerability. As Garland-Thomson (2009) writes:

> Each one of us ineluctably acquires one or more disabilities – naming them variably as illness, disease, injury, old age, failure, dysfunction, or dependence. This inconvenient truth nudges most of us who think of ourselves as able-bodied towards imagining disability as an uncommon visitation that mostly happens to someone else, as a fate somehow elective rather than inevitable. (p. 19)

Just as there are many tricks by which I can momentarily convince myself I am not vulnerable, there are also many tools by which one can reveal common ground. Mortality is not merely an "inconvenient truth" but a frame that normalizes shared vulnerability and may open hearts and collective efforts towards compassion and kindness.

Confronting the Terror of Death and Care

> Recognizing our needs both to give and receive care not only provides us with a sense of our common humanity, but enables us to confront our shared fears of human frailty, rather than project them onto those we label as "dependent." (The Care Collective 2020: 30)

Finally, I recognize the limits of the assumption that confronting mortality leads to compassion, open-heartedness and solidarity. It can. But that is not always the case. Far from it. Indeed, Becker (1973) won the Pulitzer Prize for his work on the denial of death. He argued that the "terror of death" was an existential driver towards domination. Impermanence, he claimed, could make people feel small and insignificant, prompting them to turn towards compensatory forms of power. They may seek solace in grand narratives and heroic actions or equally in the exploitation and oppression of others. These claims may sound far-fetched, but there is a growing body of evidence from the field of terror management studies that indicates Becker's suppositions are well-founded (for a review, see Solomon et al. 2015).

Along similar lines, Rowe (2024) has compellingly argued that the fear of death lies at the center of capitalism's fixation on unending growth and incessant accumulation. Certainly, the neoliberal vision of society is one of competition and power over others, where the archetypical subject is an entrepreneurial hero, incessantly striving for wealth and status. Even the rise of Trump has been interpreted as a heroic fantasy of people "who are awash with anxieties about death, weakness, impotence and loss" (Devega quoted in Rowe 2016).

Given the terror of death, it does not strain one's imagination to posit that recognizing a universal need for care could be terrifying. To what degree, then, may the denial of care be a denial of death? Care drops us quite literally in the misery of mortality. Caring, as the Care Collective (2020: 27) observes, "puts us in contact with what may be the most daunting, even at times the most seemingly repellent or shameful, aspects of people's mortal, embodied selves." They go on to suggest that this contributes to the relegation of carework to marginalized groups, as this helps some people avoid (at least temporarily) "the sign of our inescapable corporeal existence and hence our mortality" (p. 28).

From this perspective, fostering a caring society involves grappling with mortality *and* the fear it provokes. This is not a concern to be left to the end-of-life. Arguably, approaches to mortality form the bedrock of the societies we inhabit: heroically careless or compassionately caring. Thankfully, research reveals that terror is not the only response and responses can be shaped (Park & Pyszczynski 2016). There are, for example, a variety of wisdom traditions and cultural practices that grapple with death in positive ways. Rowe (2024), for instance, suggests that meditation

and certain rituals can act as technologies that transform our relationship to death. More broadly, contemplative traditions – particularly of the yogic and Buddhist varieties – explicitly engage impermanence. They provide values, knowledges and resources that can support people in finding contentment under conditions of impermanence (Banerjee 2023a). Such traditions teach us to think about mortality in ways that open into love and compassion. They hold the good with the bad while enabling a poignant connection to life.

Such practices alone will not be sufficient to "vanquish systematic injustice," as Rowe (2016: n.p.) acknowledges. Worse, they risk becoming individual solutions to collective problems. In writing about death studies, Walter (2025) acknowledges that anglophone research is suffused with individualistic concepts and concerns. Death anxiety, for example, is typically understood as an individual challenge to be addressed through self-care. In this paper, I am suggesting that the anxieties produced by mortality and care also operate at a societal level and therefore require collective responses. This is why I draw on care theories that not only recognize care's unique relation to mortality but also strive to transform societies and economies. In contemplative studies, there are also scholars who are exploring the socially transformative potential of wisdom traditions (cf. Klein Schaarsberg 2025; Loy 2003; Rowe 2024). It is in that spirit that I suggest considering them. While modernity is not homogenous, for instance, palliative care has emerged within the modern health care system (though of course not without struggle), learning from nonmodern and non-western traditions may prove a fruitful way of moving beyond the pervasiveness of technological rationalities. Contemplative traditions offer values – such as receptivity and presence – that reveal the world differently and provide ways of understanding agency beyond the will to order. They may, therefore, complement care theories and have something valuable to contribute to the development of a caring society – one capable of confronting limitation with greater openness and acceptance, thereby helping to address the existential fears that feed carelessness.

Conclusion

In this paper, I have argued that centering mortality – as a condition of being rather than merely the end point of life – can contribute to a

more caring society. Centering mortality may act as the grounds for solidarity, bringing to the fore aspects of our being that have typically been pushed to the sidelines, such as our shared vulnerability, the pervasiveness of impermanence, the significance of meaning and our connection to nature. When mortality is accepted, it becomes clear that we need other approaches beyond seeking control. However, a shift in values is no small thing. I have drawn on Heidegger's (1977) theory of technology to argue that values can be constitutive of reality. They shape what we see, what we aspire to do, and what we need to know to do it. For instance, the ethos of control has fragmented death into individual disease and risk pathways, such that it no longer functions as a point of solidarity. Hence the need for the concept of mortality. What's more, mortality and care call forth one another. This may be one of the challenges of caring, that care may provoke both fear of mortality and less than compassionate responses. I therefore conclude by recognizing that building a more caring society will require developing the knowledges and skills to engage with our shared vulnerability in ways that do not close down into fear but open up into care, compassion and even love. This will need to be both an individual and a collective project.

Acknowledgements

The writing of this paper was supported by funding provided by Research NB Research Chair in Community Health and Aging. I wish to acknowledge the many friends and colleagues who have helped me think through these ideas along the way, including Pat Armstrong, Susan Braedley, Bill Randal, Gary Kenyon, Julia Brassolotto, Mathura Mahendren, and Sally Chivers, whose kind comments on a first draft sustained my writing.

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