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The Art of Dying

by Mellisa H. Pogirski

This world is the land of the dying, the next is the land of the living (Tryon Edwards, 1809-1894).

How is it that every day of our lives brings us closer to death, yet that possibility seems so removed? When a terminal illness arrives, suddenly everything changes and we are left dealing with our own mortality. Death is no longer a possibility but a reality. In this most vulnerable state the physician is called upon to participate in a role historically reserved for clergy and religious counselors (Groopman, 2002).

During the Middle Ages and the Renaissance, the concept of *ars moriendi* – “the art of dying” developed. Death was a process of purification and identification with the death of Jesus on the cross. This “art” even instructed how to mentally approach death. In 1491, William Caxton, in his *Treatises*, declared: “This time of your departing shall be better to you than the time of your birth, for now all sickness, sorrow and trouble shall depart from you forever. Therefore be not aggrieved with your sickness and take it not with grutching but take it rather all by gladness (quoted in Groopman, 2002).”

Medicine today defines a “good death” as the experience of as little physical pain as possible. The practice of euthanasia and physician assisted suicide are just two examples ways to provide such a “good death.” Yet *ars moriendi* seems to indicate that historically a “good death” involved much more. Developing a perspective on leaving life seemed just as important as the physical act itself. The question becomes how best to approach death and yet maintain a high regard for the value of all human life, even the terminally ill.

A major concern today focuses on the information terminally ill patients receive. In January of last year, an academic study was conducted to determine if patients who received information about their condition were able to make effective choices about their treatment plan. Nine oncologists consented to have 118 patient consultations taped and evaluated. Even though the oncologists knew these conversations were being taped, one quarter of the patients were not told their illness was incurable, and a similar number were not informed of the side effects associated with the proposed treatments. Only 4% of the 118 patients received what the researchers considered adequate information. In 90% of the taped consultations the oncologist failed to ask if the patient understood the information presented. These findings were consistent with earlier studies that found that one third of all patients diagnosed with incurable metastatic cancer believed their treatment would actually cure them (Groopman, 2002).

In an average month, an oncologist will inform thirty-five patients that their condition has declined, the cancer has metastasized, and further treatment would be futile. Medical technology has advanced so rapidly that, in the words of Daniel Callahan, “Death by disease has become the equivalent of death by malicious human intent (1994).” The physician is often stuck between what modern medicine can accomplish and what could be accomplished with proper new technology. The uncertainty faced by both physician and patient leaves only enough hope to seek what may be described as the art of dying.

Three key principles guide Christians in decisions concerning the end of life: the sacredness of human life, God's sovereignty over life and death, and Christ's extensive compassion (Sullivan, 2002). The intrinsic image of God in man laid the foundation for the essential aspects of what makes man human. Our bodies now belong to Christ for we have been bought with a price, and we are not our own (I Cor.6: 19-20). God is in control and very aware of our suffering. As cited by Sullivan concerning end-of-life decisions, "comfort and company" are the only moral requirements (2002). Palliative treatment and a support in the struggle to welcome death are more receptive to the value God places on human life. The art of dying has been lost in part because we have lost the art of living.

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