2015

Ritual and Practice

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Despite five decades of concern, challenge, and alarm, the medicalization of dying in the United States has not abated.[1] Instead, it has accelerated at an exponential rate. In an incisive 2010 *New Yorker* essay titled "Letting Go,"[2] the surgeon Atul Gawande tells the story of Sara Monopoli, a 34-year-old woman who, when 39 weeks pregnant with her first child, discovered that she had incurable metastatic lung cancer. She delivered the baby; then, over a period of seven months, she underwent four rounds of chemotherapy, none of which had much promise of working. (As Gawande notes, "there is no cure for lung cancer at this stage.") During those seven months, she suffered a pulmonary embolism; the cancer metastasized to her brain (for which she underwent more chemotherapy); and her original tumors continued to grow despite all treatments, spreading from her left lung to her right lung, her liver, the lining of her abdomen, and her spine. She, her family, and her medical team fought the cancer and each new assault. Eventually found to have pneumonia, she died in a hospital.

Gawande maintains that this modern tragedy—this almost ritually scripted performance of agonizing, prolonged, costly escalations of technological intervention at the end of life—is replayed millions of times. Though many people do meet death at home, or in long-term care, or suddenly, or under better circumstances, one-fifth of deaths in the United States—and the majority of deaths witnessed by hospital-based medical staff—currently occur in intensive care units.[3]

This book joins the nearly five-decade attempt to analyze the causes of this historically recent and seemingly intractable medicalization of dying and to provide a constructive way forward by positing an ethical framework for dying well in the twenty-first century. Ritual and custom have historically played prominent roles in the art of dying. From the Middle Ages on,

these were particularly well described by the *Ars moriendi*, and in fact such practices served as an armamentarium of sorts to fortify individuals and communities in the face of illness and to help combat the threat of death up until the twentieth century. It seemed plausible, therefore, that an art of dying could be reinvigorated by renewed attention to the rituals and customs associated with dying.

However, the turn to ritual poses certain challenges. The place of ritual in secular culture today is ambiguous. The notion of ritual is often associated with particular religious traditions and so finds an uneasy fit within the secular, scientific context of present-day medicine and often leaves bioethicists shaking their heads. At other times, ritual is understood as a matter of a patient's personal preference—something non-rational, affective, and/or cultural for which space must reluctantly be made within the biopsychosocial context of contemporary medicine in order to honor a patient's autonomy. Such accounts often deflect attention from the highly ritualized nature of present-day medicine (including the practices of bioethics, which is often far more powerful than any religious ritual in shaping people's experiences of illness and dying).

In this chapter I will wrestle with that ambiguity. Careful engagement with the problems associated with a contemporary understanding of "ritual" is beyond the scope of this study.[4] I will not propose a new ritual for the deathbed, nor will I step back and simply propose a framework for ritual at the deathbed. Rather, by returning to the *Ars moriendi* tradition, I will outline important concepts that bioethics and medicine will have to engage if they are truly interested in crafting a new art of dying for the twenty-first century.

I take as a significant point of reference the *Ars moriendi* tradition that emerged in the fifteenth century and informed Western citizens' notion of a good death through the nineteenth century. By attending to the protocols and customs involved therein, a series of components of dying well emerge: communal structures, practices, and virtues. These loci will help us make sense of factors contributing to the demise of this tradition in the nineteenth century—factors that remain operative today, including a new geography of dying driven largely but invisibly by the onset of market economics. I then bring the *Ars moriendi* tradition into conversation with a recent proposal for a new practice at the deathbed: Daniel Callahan's vision of a peaceful death, outlined in his book *The Troubled Dream of Life: In Search of a Peaceful Death*.[5] Yet in Callahan's proposal the wisdom of the *Ars moriendi* tradition runs up against constraints imposed by the methodology of bioethics—constraints that limit the potential of his insights. Although Callahan's proposal falls far short of dying well, his vision of a peaceful, tamed, or (perhaps more accurately) well-managed death may be the best we can do.

Customs Marshaled

What might a contemporary art of dying glean from the historical practices of Western culture surrounding the end of life?[6] It is not uncommon for historical accounts of a topic to picture a "golden age" from which society has fallen. The history of dying in Western culture, however, is somewhat different, insofar as the golden age, by all reputable accounts, stretches "back to the dawn of history and is only now dying out before our eyes."[7] The golden age is, perhaps, only two or three generations distant, so some aspects of the *Ars moriendi* tradition may be able to inform present-day practices.

The classic account of the social shape of dying appears in Philippe Ariès's magisterial study *At the Hour of Our Death*. In this section, I begin with Ariès and then proceed to the tradition of the *Ars moriendi*, examining it through the lens of practice and custom. In doing so, I discover three important aspects of practices at the deathbed: they cannot be abstracted from a broader nexus of rituals, customs, and practices; they are grounded in a framework of virtue and character; and they emphasize the necessarily communal component of a good dying process.

The Classic Deathbed Protocol

Ariès opens his account in the Middle Ages, at the midpoint of a historical trajectory that stretches from the ancients through to the nineteenth century. He argues that over this two-millennium time frame—amid cultural differences, sociological changes, and technological developments stretching across Europe—dying was "governed by a familiar ritual."[8]

Ordinarily, the dying were the principal directors of their own dying process.[9] Equipped with advanced notice of their impending death, the dying would initiate simple customs or protocols that structured their final hours or days. Certain bodily postures were assumed, and a script was followed.

The dying person began with "a sad but very discreet recollection of beloved beings and things."[10] Forgiveness was asked from companions and family members, who were in turn pardoned, commended, and blessed. After setting communal relationships right, the dying person would turn to God—asking for forgiveness and commending himself to the Lord, being absolved by a priest, and receiving viaticum.[11]

As artistic renderings of such deathbed vigils make clear, dying was a social and communal event. The rooms of the dying became public places, which members of the community—even strangers—would visit freely. The practices of mutual forgiveness and blessing recognized that, in order for a death to be good, the spiritual well-being of the community had to be addressed. By emphasizing the connectedness between the dying person and the community, the historical practices acknowledged that death was as much a "wound" to the local community as to the dying person.[12]

The Art of Dying

In the fifteenth century, the simple deathbed protocol of the Middle Ages deepened into a more extensive set of practices known as the *Ars moriendi*, the art of dying. Arising largely in response to the ravages of the Black Death and its pandemic aftermath,[13] the original *Ars moriendi* literature was essentially a set of instructions for dying well—"a self-help manual for the person who was dying. In times of plague, one could not always count on a visit by the priest. It was to be read (and perhaps memorized) while one was still in good health, but it was to be kept and used in the days and hours of dying."[14]

Allen Verhey, in his book *The Christian Art of Dying: Learning from Jesus*, provides a succinct overview of the six sections of one of the earliest works in the *Ars moriendi* literature, the *Tractatus Artis Bene Moriendi*:

> The first part is a commendation of death. The second part warns the dying person of the temptations confronted by the dying and gives advice about how to resist them.[15] The third part provides a short catechism with questions and answers concerning repentance and the assurance of God's pardon. The fourth part offers instructions on the imitation of the dying Christ and suggests prayers for use by the dying. The fifth part counsels persons, both the sick and those who care for them, to attend to these matters as matters of first importance. Finally, the sixth part provides a series of prayers to be prayed by those who minister to the dying person.[16]

Clearly the practices of the *Ars moriendi* tradition are deeply religious—in fact, deeply Christian. The simple medieval protocol at the deathbed—a largely secular protocol with a brief role for the priest—is presumed and recedes into the background of the text; the focus is on spiritual preparation for dying and death. To "die well" meant not simply to die calmly, surrounded by family members and friends, but primarily to die with one's spiritual house in order.

The Art of Living

To get one's spiritual house in order is no simple task. Thus, the focus of the *Ars moriendi* literature quickly shifted from the deathbed backward in time. Christopher Vogt, in his book *Patience, Compassion, Hope and the Christian Art of Dying Well*,[17] writes that a turning point occurred in the early sixteenth century with the publication of Erasmus's *Preparing for Death* (1533), largely considered one of the seminal works in the genre. The *Ars moriendi* tradition, Vogt writes, seeks to train practitioners on "how to live one's entire life so as to be ready for death." The genre becomes "about the art of living as much as it is about the art of dying."[18]

Thus, preparation for a good death began well before the warning that death was imminent. The primary task of each person was to cultivate the virtues necessary to die well—faith, hope, love, patience, humility, dispossession, and the ability to forgive. The principal way to grow in these virtues over one's life was through Christian practices—frequent or daily examination of conscience, sacramental reconciliation, as well as remembering death throughout life, practicing charity and mercy toward others, and spending time with the dying.[19] Through these practices, one habituated oneself in the virtues and skills required for a good death; through ritual and practice, they became part of a person's nature, making it easier to exercise them on one's deathbed.

Nor was this a solitary task. Verhey's account of the *Ars moriendi* makes clear that communities were considered essential for nurturing and sustaining practices of dying well and caring for the dying. We see this in a text titled *Crafte and Knowledge For To Dye Well*. In its fifth chapter—well before we get to the deathbed—it calls upon friends and caregivers to help the dying person die well and faithfully. Verhey writes:

> It complained about deceptive assurances of recovery, about "false cheering and comforting and feigned behooving of bodily health." It insisted that friends and caregivers tell the sick honestly of their condition, that they encourage the dying to make peace with God and order their affairs, making a will and testament. It urged that friends and caregivers do what they can to help [the dying person] engage in those practices that

could help one to die well and faithfully, and among those practices it counted confession and sacrament and above all, prayer. And it suggested that the whole community, "all the city," should come to the aid of the sick and dying.[20]

The art of dying, at least until the 1800s, took a village, if not a city.

Thus, the protocol at the deathbed was located within a broader set of practices, sustained by communities, that preceded and followed it.[21] This wasn't a new development with the *Ars moriendi*. Ariès notes, for example, that "before [medieval knights] left for the Crusades without hope of return, they received absolution, which was given in the form of a benediction. ... This same ceremony would be repeated, perhaps more than once, after their death."[22] In other words, customs at the deathbed presumed, drew on, and reprised rituals, practices, and customs that shaped people's lives; they were of a piece and situated within a broader nexus of intellectual, religious, and cultural traditions. Equally, they segued seamlessly into practices initiated at the moment of death.

Conventions Lost

No one would dispute that the complex religious and communal approach to death and dying that shaped Western culture until and throughout the nineteenth century has largely been forgotten. Callahan observes that we have lost "all those attendant rituals, habits, and practices that were able to give cultural meaning to death, to give it a familiar place in public and private life."[23] Ariès marks the turning point at the beginning of the eighteenth century and notes that since the end of World War II "we have witnessed a brutal revolution in ideas and feelings ... . Death, so omnipresent in the past that it was familiar, would be effaced, would disappear. It would become shameful and forbidden."[24]

Any attempt to reprise an art of dying, or even to develop an ethical framework for dying well in the twenty-first century, must examine more closely the factors contributing to this revolution. Here I provide snapshots of two of the factors: market economics and a new geography of dying.

A New Geography of Dying

The *Ars moriendi* and the history narrated by Ariès presumes a particular role for the dying person. But by the middle of the twentieth century that

role was lost, and the loss significantly compromised any attempt at an art of dying. Verhey explains how this happened:

> When dying was moved to the hospital ... there were some profound, if unintended, consequences for the dying role. Most notably, it was simply undercut, replaced by the "sick role." ... The dying were no longer treated as if they were dying; they were treated like anyone else who was recovering from major surgery or a serious disease. You do not go to the hospital, after all, to die. You go there to get better ... . So, suddenly, no one was "dying" anymore. They were just "sick." That spelled the end of the "the dying role" with its rituals and community. All that was left was "the sick role" and, of course, death itself.[25]

Two immediate factors contributed to this elision of the dying role—changes in the causes of mortality and in the geography of dying. First, the nature of the dying process is now, of course, quite different. With infectious diseases being mostly a thing of the past in the United States, dying has become a long and lingering process.[26] The leading causes of death today are chronic and degenerative disease—heart disease, stroke, dementia, cancer—"in which drugging and narcosis effectively hide the biological events that are occurring."[27] Dying, therefore, is no longer a discrete event but can be extended over months or years. Those who accompany this process are accompanying something different than before.

Advances in modern medicine are largely credited for these changes. Yet Aries and others recognize that the loss of the art of dying and its rituals began well before medicine began to be effective. What additional factors, then, precipitated this brutal revolution? Verhey alludes to one factor briefly in the passage quoted above: By 1950, the place of dying had largely shifted from the home to the hospital. This shift, however, had begun much earlier, as Rob Moll notes in his book *The Art of Dying*: "In 1908, 14 percent of all deaths occurred in an institutional setting, either a hospital, nursing home or other facility. Just six years later the figure had jumped to 25 percent. By the end of the century it was nearly 80 percent."[28] How do we account for such a radical change in such an important social practice? One answer lies in the radical economic revolution that occurred a century earlier.

Visible Effects of the Invisible Hand

The reasons for this shift in the geography of dying are many. Yet as of 1914, the conquest of infectious diseases and the advent of a significant array of effective therapies had yet to occur. Surgeries were at last aided by

antiseptics and anesthesia, and accuracy in diagnosis did accelerate beginning around 1870, but for the most part truly effective therapies remained future realities. Nonetheless, by 1914, the profession of medicine had succeeded in its efforts to consolidate its authority and increase its market power—efforts that began with the establishing of the American Medical Association in 1846.

Contributing to consolidation of medical authority was a reconceptualization of the hospital that began around 1900. As Paul Starr notes in *The Social Transformation of American Medicine*, the number of hospitals in the United States increased from 200 in 1873 to 4,000 by 1910, and to 6,000 by 1920.[29] Then, as now, hospitals were expensive propositions, and Starr details how physicians—formerly with little reason to ally with hospitals—were incentivized to refer patients to hospitals in this period, for mutual financial benefit.[30]

But why would patients go? For Starr, one piece of the answer lies in the radical changes in communal and familial infrastructure wrought by the socioeconomic changes of the Industrial Revolution:

> Changes in both the family and hospital affected their relative capacity to manage treatment of the sick. The separation of work from residence made it more difficult to attend to the sick at home. With industrialization and high geographic mobility in America, the conjugal family also became more isolated from the threads of kinship, and so fewer relatives were close by in case of illness ... . Also, urban growth led to higher property values, forcing many families to abandon private houses for apartments in multi-family dwellings, which limited their ability to set aside rooms for sickness or childbirth. A 1913 analysis of the decline of home care of the sick noted, "Fewer families occupy a single dwelling, and the tiny flat or contracted apartment no longer is sufficient to accommodate sick members of the family. ... The sick are better cared for [in hospitals] with less waste of energy, and their presence in the home *does not interrupt the occupations and exhaust the means of the wage earners* ... . The day of the general home care of the sick can never return." Industrialization and urban life also brought an increase in the number of unattached individuals living alone in cities ... . In England and America, many of the first hospitals to care for private patients were built with lodgers and apartment-house dwellers especially in mind.[31]

Thus, the late 1700s—a period Ariès characterizes as a turning point in the practices of dying—also witnessed the emergence of the Industrial Revolution and a new form of capitalism in England. The relocation of labor from rural communities to urban factories inflicted radical, often brutal changes in the infrastructure of families and communities.[32] The internal logic of capitalism reconfigured workers as efficient machines whose work must not be interrupted, even to care for the sick.

Economic changes are not simply objective and material; rather, as the economist Karl Polanyi writes in *The Great Transformation*,[33] economies are necessarily shaped by and forward powerful philosophical claims about people and society. Economies, politics, religion, social relations—and, we could add, medicine—are, for Polanyi, intrinsically embedded in one another. In his introduction to Polanyi's book, the economist Joseph Stiglitz writes that "rapid [economic] transformation destroys old coping mechanisms, old safety nets, while it creates a new set of demands, *before new coping mechanisms are developed*."[34] Thus, one could argue that a semi-proximate but often invisible cause of the brutal revolution in the shape of dying was the rapid and radical economic transformations that occurred at the end of the eighteenth century. Two hundred years later—a short time within the history of human culture—that we remain shackled to deformed dying processes is due largely to the continued yet invisible effects of an economy that increasingly subordinates all aspects of human life to the logic of the market.[35]

A Protocol Reclaimed?

If the foregoing is plausible, an ethical framework for a new art of dying in the twenty-first century will have to consider factors not ordinarily within bioethical methodology—questions of the infrastructure of care for the sick (geography and architecture and structures of communities); and the fundamental relationships between economics, medicine, and bioethics.[36]

In this section I will suggest one additional shift that occurred at the end of the eighteenth century, one that should be seriously addressed in any attempt to craft a new art of dying: the eclipse of virtue ethics as the dominant framework for ethics. I will use a proposal for improving end-of-life care offered by Daniel Callahan to explore this shift.

Toward a Peaceful Death

In his book *The Troubled Dream of Life: In Search for a Peaceful Death*, Callahan makes a proposal for "a peaceful death," an approach to dying that he believes combines the advantages of the historic "tame" death and the benefits of contemporary medicine. For Callahan, such a death would

have four basic characteristics: it would be accepted by the dying person, it would minimize pain, it would maximize consciousness, and it would occur within community. In his words, a peaceful death is

> a dying that is accepted without overpowering fear and a death that has lost its power to terrorize ... [by] a self that understands that control over fate will pass from its hands ... . It should also be a death marked by consciousness, by a self-awareness that one is dying, that the end has come– but, even more pointedly, a death marked by self-possession, by a sense that one is ending one's days awake, alert, and physically independent, not as a machine-sustained body or a body that has long ago lost its mind and self-awareness. Equally, it should again be death in public, by which I mean a time when friends and family draw near, when leave can be taken, when the props and devices of medicine can be put aside save for those meant to palliate and assuage.[37]

Callahan's peaceful death bears great resemblance to Ariès's description of a tame death, at least formally. Yet the substantive content of the interactions between the dying person and those who gather around her, or of the dying person's reason for a calm acceptance of death, is left undefined.

How does Callahan envision the dying person arriving at the point where death has lost its power to terrorize? Here, his proposal echoes the *Ars moriendi* tradition. Callahan rightly sees that at the heart of the question is character. Again and again throughout his analysis, Callahan locates a source of the solution to the problems posed by contemporary forms of dying in the "interior life," in inward attitudes. Following Victor Frankl and others, Callahan argues that the primary location of self-determination, self-definition, and real control over the self is the inner life:

> The idea of a right to self-determination and self-definition is surely not meant to preclude the shaping of our inner life. ... But that capacity to shape an attitude inwardly is not taken as the interesting or important or meaningful part ... . We do not readily talk about how to shape our interior life in the face of death, because we think its meaning to be private, not easily shared or explored with others. ... [But] what enables people to endure, and to do so with dignity and grace, is not their ability to change their circumstances, but what they make of them; and what they make of them turns *on the kind of people they are*.[38]

Thus, Callahan's peaceful death turns on the character of the dying person. How one approaches dying will, for the most part, be consistent with or result from the character and virtues the patient has developed over the course of his or her life:

> What we truly need is the capacity to master our dying, which is not the same as controlling it. Mastery requires that our interior self be in charge of itself, even when death is coming and control over the body has been, as it must be, lost ... . How should I want to live in order that I may die well? ... How should I begin to prepare myself for self-mastery, for pain and death? ... What kind of person do I want to be in my living and my dying? ... How we die will be an expression of how we have wanted to live, and the meaning we find in our dying is likely to be at one with the meaning we have found in our living.[39]

Thus, mastery of one's dying is the last step in the art of living.

The Art of Dying After Virtue

Yet unlike Erasmus and the *Ars moriendi* tradition, Callahan stops short of providing content for the lifelong process of preparing for death. He doesn't specify at length which character traits will be necessary for a peaceful death; nor does he propose how people are to achieve such a character, or what rituals or practices would be necessary or even helpful for engendering such traits.[40] In other words, Callahan's wisdom and insight point him toward an answer to the problem of contemporary dying: that we need a new *Ars moriendi*. But Callahan's ability to embrace fully his own answer is limited by a set of intellectual commitments that he himself had a part in creating: the formal, procedural logic embraced so passionately by bioethics. Bioethics eschews the ability to determine the truth of any particular end or good, and purports, via the principle of autonomy, to provide procedures by which individuals may pursue privately determined ends. Bioethics claims that all it can provide is formal processes within which individuals and communities can apply their own particular substantive visions.[41] Within this framework, only two options are available for a new *Ars moriendi*: either it would invent a generic and putatively neutral "art of dying in hospitals" available to all patients, or it would call for medicine simply to make a space for individual patients to draw on rituals from their own traditions or invent rituals of their own making.

Callahan proposes the first option but tacitly recognizes that this approach cannot but fail. He argues in *The Troubled Dream of Life* that we Americans, in order to reform our dying processes, will have to create a "common view of death"[42] and a "new understanding of the self."[43] He recognizes that, despite claims about American pluralism, there is a dominant and operative view of death and of the "ideal modern self." He describes how these ends and norms are part and parcel of the often violent and dehumanizing "rituals" currently practiced at the bedsides of dying patients, in

emergency rooms, in intensive care units, and in nursing homes. Equally, he acknowledges that changing these rituals—changing the medicalization of death and the violence inflicted on the dying under the auspices of medical care—will require new (and particular) understandings of death and the self.

Moreover, Callahan acknowledges that operative rituals and concepts don't simply promote individually defined goods of patients, but primarily embed, embody, and promote the goods of the current social order within each particular patient, within each patient's local community, and within the health care institutions in which they are practiced. After outlining his proposal for a peaceful death, he tellingly writes "I call such a death a 'moral good' because it allows us to achieve important personal and social ends."[44] To link practices surrounding dying to broader social ends confirms the interconnectedness of any particular ritual with the intellectual, cultural, and religious traditions of the time and the place. Thus, in order for a proposal like Callahan's to advance, a new art of dying will have to look beyond bioethics to an ethical framework more adequate to the task. The philosopher Alasdair MacIntyre has outlined such a framework in a groundbreaking book titled *After Virtue*.[45] As Ariès and others make clear, the *Ars moriendi* was and remains embedded in a virtue framework. A thorough account of virtue ethics and MacIntyre's contribution to contemporary understandings of this framework is beyond the scope of this chapter, but for present purposes two points must be made.

The first point is MacIntyre's insight into the dynamic relationship between character/virtue, practices, and social ends. To reprise his now-classic definition of 'practice':

> By a 'practice' I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence [e.g., virtues], and human conceptions of the ends and goods involved, are systematically extended.[46]

Callahan, in invoking personal and social goods as the criteria for assessing a death as morally good, intuits this connection between practices, ends, and, as the *Ars moriendi* tradition recognizes, virtue. To envision and seek to achieve certain standards of excellence with regard to dying

has historically entailed a coherent and complex cooperative social practice that has achieved such excellence by realizing certain intrinsic goods. In doing so, the communities' ability to achieve those goods, and their understanding of a good death, was extended. The skills needed to achieve those goods—skills cultivated by the practices—were the virtues. That these goods are *internal* goods or ends is also important. Readers of a certain age may remember a dystopian 1973 film titled *Soylent Green*. Central to it is a practice that looks much like Callahan's peaceful death—an experience to which many citizens look forward as a relief from the gray, grim realities of their day-to-day lives. In a plot twist, it is revealed that this somewhat elaborate, much-anticipated and intentionally peaceful dying process (initiated when the dying are fully conscious and free of pain) aims at an external good: the practice turns bodies into raw materials for the production of Soylent Green, a food for an overcrowded planet.

A second observation made by MacIntyre takes us back to the eighteenth century. In his historical account of the development of contemporary ethics, MacIntyre argues that virtue ethics, as outlined above, was the dominant moral schema for most of Western history. According to MacIntyre and Ariès, the virtue tradition and the traditions of the *Ars moriendi* map the same chronological period. For MacIntyre, it is the end of the eighteenth century, when Enlightenment philosophers attempted to replace virtue ethics with the philosophical precursors of contemporary bioethics, and it was the failure of that project at the end of the nineteenth century that caused moral theory to fragment into the emotivism and philosophical chaos that mark present-day moral discourse. This is also the point where Ariès sees the *Ars moriendi*—a thick instantiation of the virtue tradition—beginning to unravel. Both shifts are concurrent with the rapid socio-cultural transformation initiated by the attempted shift to a self-regulated market economy and the advent of the Industrial Revolution.

In other words, an argument could be made that our current dying processes, which many rightly understand as deeply deformed, are inextricably of a piece with particular ethical and economic schemas of recent vintage. What we require are not new "rituals" for the dying process but new *practices*—practices that can vibrantly acknowledge the goods and ends sought, the virtues required, and the role of powerful but largely invisible cultural factors, such as economics, in limiting or enhancing our ability to die well.

Conclusion

From Jessica Mitford to Philippe Ariès to Daniel Callahan to Atul Gawande, bioethics has walked alongside health care, watching—and perhaps abetting—the ever-increasing medicalization of dying. In seeking to move toward an ethical framework for dying well in the twenty-first century, this book places the challenge for change squarely in the hands of bioethics. How might this essay contribute to that larger project? I conclude with five observations and a constructive proposal.

First, any framework for dying well will require bioethics to take serious stock of the limits of its own formal, procedural methodology. Those committed to the project of dying well concur: such a project is a virtue-based project. If bioethics is to contribute to this project, it will have to re-invent its own ethical framework to incorporate properly a virtue methodology.

Second, to do so will require that bioethics learn how to facilitate—in a real and constructive way—substantive clinical and cultural conversations about goods and ends.[47] Were bioethics to assist medicine in developing a protocol for dying well in the clinical context, serious questions would have to be asked about the social ends such a protocol sought to produce.

Third, bioethics will have to ask serious questions of economics, and not simply to tally the high costs of medical care at the end of life in a cost-benefit equation or puzzle over the challenges of who should pay for what. A serious ethical framework will have to attend to the myriad and powerful ways that present-day economic systems and philosophies quietly and often invisibly shape those who enter the clinical setting, determine the infrastructure within which patients and health care coexist and influence the biotechnology and health care industries.

Fourth, in addition to moving beyond the limited methodology of bioethics, an ethical framework for dying well will have to move beyond the clinical setting and reconstruct the geography of dying. If we are truly interested in reducing the medicalization of dying, the most logical step is to return dying to its proper, non-medical location: the home, or at least the local community. Looking beyond the ICU, how might health care practitioners and institutions help communities to care for the dying? Might congregations, for one example, reimagine how they care for the sick? Instead of sending communion ministers to health care institutions, might congregations repurpose vacant rectories as places to care for dying parishioners for whom home care is not a possibility?

Fifth, as the *Ars moriendi* literature ancient and new suggests, to focus on the deathbed is to miss the point. The art of dying is not simply a ritual that occurs after medicine has done all it can and "the props and devices of medicine [are] put aside."[48] From Ariès to Callahan and beyond, those seeking to reform the dying process make clear that practices at the deathbed must be related to a broader set of practices cultivated throughout life (and after death). The art of dying—which is really the art of living—is a lifelong process, cultivated in the home, in the congregation, and in the community. There the particular contents of different traditions may flourish, and the development of the virtues needed to die well (and, of course, to live well) may be pursued through specific rituals and practices accompanied by spiritual formation.

Allen Verhey proffers one of the most thorough proposals for such an art of living and dying in his book *The Christian Art of Dying*. As he makes clear, a contemporary *Ars moriendi* will entail a set of *practices*, understood in a MacIntyrean sense. These practices will be community specific and tradition specific, and will be practiced over a lifetime, by community members, for and with dying people, both for the dying and for the healthy—so that when the latter enter the dying process, they will be prepared to die well.[49] Any ritual at the deathbed will be one that caps this process, that flows from this broader set of practices.

Short of this, dying well or a good death will remain extraordinarily difficult to accomplish in the clinical context. At best, we may be able to move toward a tamed death—or at least a less medically malformed dying process. Following Ariès and Callahan, such a process would seek to do the following:

- make the dying the principal directors of their own dying process
- ensure that the dying know that they are dying
- enable the dying to take stock of their life, to express both gratitude for the goods of their life as well as sorrow for its closure
- integrate practices of reconciliation between patients, their family members and friends, and health care practitioners
- integrate patients' communities into the dying process
- acknowledge and tend to the wounds that death inflicts on patients' communities.

Would any of this—as minimal as it is—be possible within present-day medicine? Palliative medicine has laid the groundwork for such a tamed or

well-managed death. But, building on Farr Curlin's assessment in chapter 4 of this volume, it may well be the case that dying is being deformed in new ways in the context of palliative care. A main question—and a question currently unavailable to bioethics—remains the question of ends. Were we to affirm this practice of a tame death, we would have to ask the question "Tame for whom?" Do we seek a tame death for the good of the patient, or for the good of the hospital and the medical staff? The "goods" sought don't have to be at odds, but they probably will differ. Insofar as the nature of those goods and ends will necessarily shape the practices and protocols themselves, it will be important to ask whether the protocols serve primarily the patients or the institutions.

Notes

1. See, for example, Jessica Mitford, *The American Way of Death* (Buccaneer Books, 1993; originally published by Crest Books in 1964); Philippe Ariès, *Western Attitudes Toward Death from the Middle Ages to the Present* (Johns Hopkins University Press, 1974); Ernest Becker, *The Denial of Death* (Simon and Schuster, 1973); Ivan Illich, *Medical Nemesis* (Pantheon, 1982).

2. Atul Gawande, "Letting Go: What Medicine Should Do When It Can't Save Your Life," *The New Yorker*, August 2, 2010.

3. Abraham Verghese, "Letting Go" (review of *Knocking on Heaven's Door*, by Katy Butler), *New York Times*, September 6, 2013.

4. For more background on the limitations of contemporary understandings of the notion of ritual, see Catherine Bell, *Ritual Theory, Ritual Practice* (Oxford University Press, 1992); Ronald L. Grimes, *Ritual Criticism* (University of South Carolina Press, 1990); Talal Asad, *Genealogies of Religion: Discipline and Reasons of Power in Christianity and Islam* (Johns Hopkins University Press, 1993); and Arthur W. Frank, "For a Sociology of the Body: An Analytical Review," in *The Body: Social Process and Cultural Theory*, ed. Mike Featherstone, Mike Hepworth, and Bryan S. Turner (SAGE, 1991).

5. Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (Simon and Schuster, 1993).

6. It must be noted that the *Ars moriendi* literature is culturally limited. Moreover, the topic of this book is extraordinarily specific to the US. The geography of dying and the causes of mortality in much of the developing world today remain the same as in the West up to the nineteenth century. It would be interesting to examine contemporary attitudes toward and practices surrounding dying in non-Western contexts, to see what we, in the US might be able to learn from our global counterparts. This process is known as "reverse innovation." See M. Therese Lysaught, "Reverse Innovation from the Least of Our Neighbors," *Health Progress* 94, no. 1 (2013): 45–52.

7. Philippe Ariès, *At the Hour of Our Death: The Classic History of Western Attitudes Toward Death Over the Last One Thousand Years* (Seuil, 1977; Vintage Books, 1981), page 5 of Vintage Books edition.

8. Ibid., 6. As discussed in the references in footnote 5 above, the analytic concept of "ritual" was established in the nineteenth century; thus, Ariès is using the term anachronistically here.

9. Not all deaths were ordinary or fit this pattern. Ariès helpfully discusses other situations—the death without warning (*mors repentina*) and the death of the saint. "When [death] did not give advanced warning," he writes (ibid., 10), "it ceased to be regarded as a necessity that, although frightening, was expected and accepted, like it or not. It destroyed the order of the world in which everyone believed; it became the absurd instrument of chance, which was sometimes disguised as the wrath of God. This is why the *mors repentina* was regarded as ignominious and shameful."

10. Ibid., 9.

11. Ibid., 14–18.

12. Ibid., 559, 603, 604.

13. Allen Verhey, *The Christian Art of Dying: Learning from Jesus* (Eerdmans, 2011), 80–86.

14. Ibid, 81.

15. Although there was some variations from tract to tract, the standard temptations in this literature were: to lose faith, to despair, to impatience, to pride, and to avarice or grasping after one's possessions (see ibid., 110–134).

16. Ibid., 87.

17. Christopher P. Vogt, *Patience, Compassion, Hope, and the Christian Art of Dying Well* (Rowman and Littlefield, 2004).

18. Ibid., 17.

19. Ibid., 22–29.

20. Verhey, *Christian Art*, 298.

21. Although Ariès's book is titled *At the Hour of One's Death*, the focus of most of the text is not in fact on the deathbed or dying process. The bulk of the 700-page book details practices that occurred *after* death, including funerals, cemeteries, and burial practices, tracing the shift from unmarked common graves and charnel houses to cremation and columbaria. Ariès's study reveals that even dead bodies are

sites of cultural production, reproducing in their decaying materiality the norms and commitments of their cultural contexts.

22. Ariès, *Hour of Our Death*, 140.

23. Callahan, *Troubled Dream*, 33.

24. Ariès, *Western Attitudes*, 85.

25. Verhey, *Christian Art*, 14.

26. This is, of course, not the case in much of the world, where infectious diseases, injuries, and accidents continue to be leading causes of morbidity and mortality.

27. Sherwin Nuland, quoted on p. 8 of Rob Moll, *The Art of Dying: Living Fully Into the Life to Come* (Intervarsity, 2010).

28. Moll, *The Art of Dying*, 15–16.

29. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Basic Books, 1982), 73.

30. Ibid., 162–169.

31. Ibid., 73–74, emphasis added.

32. For compelling accounts of the powerful and violent effects of the economic destabilization wrought by the first waves of the Industrial Revolution on the poor and working class, and analyses of the philosophical commitments attending these changes and their social ramifications, see Karl Polanyi, *The Great Transformation: The Political and Economic Origins of Our Time* (Beacon, 1944) and Richard Henry Tawney, *The Agrarian Problem in the 16th Century* (Longmans, Green, 1912).

33. Polanyi, *The Great Transformation*, 1944.

34. Joseph Stiglitz, "Foreword," in second edition of Polanyi, *The Great Transformation* (Beacon, 2001).

35. "Deformed" is the term Callahan uses to refer to present-day clinical dying processes. See Callahan, *Troubled Dream*, 188.

36. I begin to address these connections in my article "And Power Corrupts ... : Theology and the Disciplinary Matrix of Bioethics" in *Handbook of Bioethics and Religion*, ed. David E. Guinn (Oxford University Press, 2006).

37. Callahan, *Troubled Dream*, 53–54.

38. Ibid., 129, 131, emphasis added.

39. Ibid., 147, 149.

40. Callahan does offer some character traits. On page 126 he writes "I want to invoke instead an image of the self that is more flexible, less manipulative, more interdependent with others, more open to risk, a self appropriate to a peaceful death." He doesn't offer correlative suggestions of how these character traits might be developed, especially in a social context that shapes us toward the "ideal modern self" (120–121).

41. John Evans provides an excellent analysis of bioethics' adoption of instrumental, formal rationality in *Playing God: Human Genetic Engineering and the Rationalization of Public Bioethical Debate* (University of Chicago Press, 2002).

42. Callahan, *Troubled Dream*, 14–15.

43. Ibid., 126.

44. Ibid., 200.

45. Alasdair MacIntyre, *After Virtue: A Study in Moral Theory* (University of Notre Dame Press, 1981).

46. Ibid., 175.

47. Though this point doesn't follow directly from the foregoing analysis, any ethical framework for dying well must attend to the social location of this conversation. Much of the conversation on dying well rings very Caucasian, American, upper middle class, and male. Few data or narratives are drawn from communities of color or from lower socioeconomic tiers. Assumptions about the values that dominate end-of-life processes often sound quite gendered. And, as I mentioned earlier, the *present* dying process in *most* of the world is far from hyper-medicalized. We have an ethical and intellectual obligation to seek wisdom and insight from these "other" social locations, which are often right in the midst of our own.

48. Callahan, *Troubled Dream*, 54.

49. Rob Moll captures the power of this community-centered *Ars moriendi* for those who are not yet dying: "As anyone who has observed a good death can attest, it is in many ways a life-changing event for those watching. While tremendously sad and even horrible, a good death can also be beautiful and deeply moving. Such deaths were to be shared by members of the Christian community who were thereby encouraged in their faith. When death is public it is harder for the rest of us to become afraid of it. There is less mystery as we see how the physical body ceases to function. There is less fear as we see caregivers assist the dying in their last moments. There is more hope as we watch, even for a moment, the veil lifted and a dying person drawn into eternity. When we've seen a friend or loved one die, it's easier to learn to die. We can rehearse in our minds our own death, we learn what to do when others who we love face death, and we live better lives with eternity in mind." (*The Art of Dying*, 64) People so formed will probably behave very differently when they reach a clinical crossroads.