

Pandemic and the Art of Dying Well

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Despite the enormous death toll of the coronavirus disease 2019 pandemic, conversations about dying well have been sidelined. Health practitioners have instead focused on public health mitigation strategies, therapeutic options, and outcome data. When we have spoken of dying, the conversation usually entails advance directive completion and dying alone as a result of hospital visitor restrictions. If coronavirus disease 2019 should teach us anything, it is that we must be prepared for death in and out of a pandemic. But challenges abound.

Challenges to Dying Well

Many in the West have effectively outsourced care of dying people to health professionals. Before the modern era, death was experienced in homes as part of ordinary life; however, in the last 150 years, the hospital has risen in prominence and proximity. In 1873, the United States had fewer than 200 hospitals. By 1910, the number had expanded to more than 4000, and by 1920, to more than 6000—slightly more than the number today.¹ The proliferation of hospitals not only meant hope for a cure but it also provided care for lonely city dwellers and respite for weary caretakers. It also hid dying and death from view. Death became remote and unfamiliar, and with it, the dying process.

Even when patients move past the cultural barriers to death, they encounter a greater barrier from within medicine's own halls. Medical practitioners have been described as having a detachment and fear of death that may reflect "a sense of impotence, a defeat as a physician."² After all, if science provides the tools for mastery of the human body, then the inability to conquer sickness and death represents absolute failure rather than a mere possibility. When physicians refer to patients' treatment goals as "palliative," some say it with a degree of hopelessness: "The patient is someone else's problem. I cannot do anything anymore."

Not only does the culture of medicine generally shirk death but it also places hope in technological advances. The philosopher Jacques Ellul argues in his book *The Technological Society* that confidence in technical solutions is characteristic of Western society.³ There is a tendency to ask "How?" before asking "Why?"

All technologies develop as a means of manipulating the world and subjecting it to human will, but the notion that human ingenuity can exert technical mastery over death and dying is newer and representative of a development in the history of thought that has necessitated philosophical assumptions about the capacities of human reason. Although the ancients believed wisdom was to be had by examining and conforming oneself to the world, we in modern society seek guidance from our own ideas, which we then apply to the world. We believe in the power of our minds. Applied to medicine, then, patients become the repositories of technical problems to be fixed rather than complex individuals embedded in communities and histories and circumstances.

Of course, many physicians have reservations about the omnipotence of science. They regularly witness how medical technologies fall short. Even those who recognize the limits of biomedicine live in the same sociohistorical context that presupposes human ingenuity as a powerful agent in shaping the world. That philosophical orientation is then contextualized to the medical world, in which the idea that diseases can be overcome through medicine is widely accepted. Our limitations have not been adequately communicated to the public, however. One need only consider the high success rate of cardiopulmonary resuscitation in popular media compared with that in real life. This can also color perceptions of palliative care as the practice of giving up.

A striking example of medicine's omnipotence mindset can be seen in language. The words commonly used to describe disease conceive of death as a failure to avoid. Doctors use the language of military and victory, which patients adopt. Those receiving chemotherapy for incurable cancer cling to the belief that medicine will cure, will "conquer" death.⁴ To borrow from the sociologist Peter Berger, the "plausibility structure" of our culture, that is, the "social context in which any cognitive or normative definition of reality is plausible,"⁵ points to the idea that medicine will defeat cancer. This means that the general belief for many in our culture, whether through entertainment media, popular research for cure campaigns, or innumerable other avenues, is that our medicines are more curative than they actually are. If the hope for a cure becomes engrained and the genuine possibility of death overlooked, then we will not confront the existential weightiness of death as both physicians and patients, and in so doing fail to die well and to help our patients die well.

To be clear, we fully support the innovative care of sick and dying people as well as scientific progress aimed at mitigating disease. These become problematic when they thwart the individual or collective ability to prepare well for death.

Renewing the Art of Dying Well

How then could we renew conversations on dying well in theory and practice? We must move past the categorical error of treating death as a scientific problem. In his essay "The Man of Letters and the Future of Europe," T.S. Eliot notes the effects of relentless industrialization on our ability to think.⁶ We "become mechanized in mind, and consequently attempt to provide solutions

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in terms of engineering, for problems which are essentially problems of life.” We must recognize that an approach that relies on scientific methods and answers cannot address human existential questions. Science describes what is, not what ought to be. We need a fundamental reorientation for healthcare practitioners, who must fight the urge to supplant difficult conversations with procedures or drugs at the end of life.

Furthermore, we must recover an *ars moriendi*, or “art of dying,” as described in L.S. Dugdale’s *The Lost Art of Dying: Reviving Forgotten Wisdom*.⁷ When the bubonic plague struck Western Europe in the mid-14th century, up to two-thirds of the population succumbed. During the aftermath of the plague, a genre of handbooks developed, known collectively as the *ars moriendi*, to help people navigate dying and prepare for death. Although the handbooks adapted to a variety of cultural contexts, they generally held the view that living well is important for dying well and that questions of human finitude are best worked out in the context of community. The handbooks remained in widespread circulation throughout the West for more than 500 years. We believe that such an art of dying is still relevant today.

The idea of death brings into relief that which matters most. It helps to define and refine our goals, priorities, and beliefs. Contemplation of finitude forces us to take stock of our health, consider our frailty, and attend to advance care planning and

questions of long-term care. The prospect of death should give us pause regarding our relationships and how we spend our time. The consideration of who we would want with us as we die should force us to examine the state of our relationships now. With whom do we need to reconcile? Which relationships need to be nurtured?

Living well to die well is not just for patients. When clinicians attend to their own healing to live well, they become better equipped to attend to the lives of others.

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