

A Good Death

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The definition of what it means to experience a good death can be as varied as the many human opinions and personalities. Many factors influence these definitions including culture, society and lifestyle.

The idea of dying well can be traced back to the early fifteenth century to the *Ars moriendi*, the treatises on the proper manner of dying. Although this generic title refers to two separate texts, both seek to guide the Christian in the practical technique of dying well, to the glory of God and the salvation of his or her soul (Beaty 1-2). There has been more than one interpretation; the Christian idea of the Last Judgment, which is linked to the individual's history that ends on the last day, has been interpreted as "...no longer situating the judgment in space at the Second Coming, but in the bedchamber, around the deathbed" (Aries 51). This interpretation indicated that each person's life flashes before his or her eyes at the moment of death, and the dying person's attitude at that moment would give life its final meaning (52). If that person was able to resist temptation, all personal sins are erased and he or she dies well (51). A certain control and emotional drama transformed the previous solemn scene at the deathbed. This strengthened the role of the dying person in the process of his or her own death by remaining the center of activity and participating in decisions. During the Counter Reformation of the seventeenth and eighteenth centuries, spiritual scholars and writers attempted to change the still popular belief that it was unnecessary to live virtuously since a good death redeemed everything. They continued to support the contention that "...there was a moral importance in the way the dying man behaved and in the circumstances surrounding his death" (52). This attitude prevailed until the twentieth century and continues today in some of the lesser-industrialized countries. Contemporary American society has translated these values into modern understandings.

The inability for society or self to maintain rational control in any situation arouses issues of fear. When this lack of control is due to illness or death, humans resort to techniques of avoidance or denial to subvert the inevitable. "Illness flies in the face of the ideology of human progress and rationality for it threatens social life, exposes the fragility of social order and erodes individual self control" (Lupton 63). This loss of control is counter to the structure of American society as well as individual security. Rational control equates health, and America is strongly oriented towards youth, life, health, achievement and energy. These American ideals support

the denial of death, and if one does not meet the requirements of these ideals, one does not meet the values of society. Death reminds us that ultimately we don't have much control, and therefore denial of death is rampant and creates a hole in the fabric of society. This desecration is further perpetuated in traditional health care. The goal of health care is to save lives and losing a life can be considered a failure. "Contemporary doctors are trained to treat death as if it's optional instead of inevitable" (Ullmann A12). When an individual exits the normal activities of community, family and lifestyle and moves into the dying role, not only does that patient have to deal with the personal reality of death, he or she must also contend with the potential social death caused by prejudices, attitudes and apprehensions from the surrounding community. Friends and family experience feelings of helplessness, anger and fear (Kastenbaum 89). The patient wants his or her death to mean something, just as life did, and not end in chaotic turmoil filled with pain, isolation and terror. Fortunately over the last 30 years, consistent progress and improvements have been made in the attitudes of the health care system and in society at large, that allows more choices, more control and dignity, and therefore more opportunities for experiencing the inevitable in a positive and supportive environment.

Two events brought the subject of enhancing the quality of life for the dying person to the forefront. In 1967, Dr. Cicely Saunders opened the first hospice in London. Her primary goal was to provide comfort to the dying, and she put a pain management approach in motion that is still in use today. Her model of utilizing an interdisciplinary team approach to assist the patient and family created the foundation for hospices all over the world (Gentile and Fello 147-8). The second event was the publication of Elizabeth Kubler-Ross' book, *On Death and Dying*, where she offered innovative approaches to dying patients through her framework of psychologic stages of dying, which include denial, anger, bargaining, depression and acceptance. She "brought the idea of death and dying 'out of the closet,' making health care providers and society in general more aware that death is a part of life and a legitimate part of clinical care, and that with sensitivity and understanding it can be faced openly and honestly" (147). By the early 1970's these concepts were being integrated into American society and the idea of providing 'a good death' was born.

Harvard psychiatrist Avery Weisman does not completely agree with Ross' contention that her fifth stage, acceptance, is the universally best way to die. He argues that "...an appropriate and befitting death for each person is the death that he or she would choose if such a choice were possible" (Williamson, Shneidman 6). Weisman explains that a befitting death is a death that is as harmonious, responsible, and compatible with

the patient's existing world as it can be, and this varies greatly between individuals (14). He proclaims that an appropriate death has at least the following four characteristics: awareness, acceptance, propriety, and timeliness.

Awareness of imminent death is prevalent when the patient realizes that nothing more can be done to cure or delay the terminal illness. This awareness allows the patient to participate in decisions affecting the outcome and management of care (Williamson, Shneidman 15-6). Most patients realize their status regardless of communication from others.

Acceptance levels vary according to the patient's individual situation and relationships with self, family and society. There can be an implicit acceptance, yet explicitly the patient avoids the truth to protect the family from pain and embarrassment, or to avoid being labeled as unacceptable due to the illness. The patient could appear to accept his or her imminent death but inwardly feel terrified. Acceptance is best achieved through caring social support, where death normalizes as part of life (Williamson, Shneidman 16).

Propriety relates to non-medical aspects of illness that support a good death for the individual patient. Patients want to control their final moments of when, where and how. The dying person chooses what is appropriate for self, and what works with the cultural or social standards to maintain dignity, esteem and respect. These include choosing between dying at home or in an institution, whom the patient accepts as visitors, honoring of individuality, decision-making about current care and possibly post-death planning of activities such as funeral style, and so forth (Williamson, Shneidman 16).

Timeliness relates to when is the ideal time to die. The patient could choose to refuse further treatment and illicit a certain measure of control, or just reach a point of acceptance where he or she clearly recognizes the time is now, and prolonging life would not offer quality of life (Williamson, Shneidman 16-7).

Hospices have become valuable tools in achieving a good death. "The Hospice philosophy encompasses the concept that death is a normal phase of life" (Kastenbaum 125). Their core work is to help the patient and family let go of constrictions between them and actively prepare for death. The healing is the letting go and part of that healing comes through the communication and participation in the lives the patient touches. Hospice gives direction and steps to follow; and provides good, rather than chaotic memories of death. The philosophy of hospice care includes: provide palliative treatment of the whole person, emphasize quality of life, involve and support the entire family and be available at all times (125).

Regardless of these opinions, a good death is how the patient sees it. What would be a good death for one person may not be a good death for another. It is important to recognize one's own values about death and dying and separate them from the dying person's definition of a good death. The process of dying reflects the process of living and the dying person must be allowed to die in character. People are not significantly different when they are close to death than they are in life. Many people are afraid of dying because they don't know how to live. The process is the same. Fear of life and the inability to engage in a full life also means fear of death and an inability to accept it. "The man who is not frightened of life is not frightened of being completely insecure for he understands that inwardly, psychologically, there is no security. When there is no security there is an endless movement and then life and death are the same" (Krishnamurti 105). An angry life could mean the person would have an angry death. If anger is familiar in life it will be familiar in death. A devoted mother could desire to have her children with her, whereas children around a single person who has had minimal contact with them could be uncomfortable and disruptive. Meet the dying person where he or she is at the moment and be with that person; often times just being present provides comfort. Dying is an intimately individual experience. The patient can feel lonely and isolated and needs to connect with someone. This connection can transform loneliness into peace, which makes death more acceptable and the transition smoother (Froemke, et al.).

There are several components included in the idea of dying well. Ultimately important is for the patient to be as pain-free and as comfortable as possible. Emotionally, the patient needs to process, grieve and communicate. When a patient realizes he or she is going to die, there is an implicit doorway that opens for a great transition. Initially the patient falls apart in great despair and grieves for his or her life and loss. Only then can the patient come to terms with life and assess the life choices he or she has made. It is important for the dying person to evaluate those choices and acknowledge what he or she is pleased with and thankful for, as well as look at the situations that are still unresolved and filled with regret. Crucial to peace and emotional comfort are working out family and life situations, asking for forgiveness and forgiving. Finally, the dying patient must deal with the good-byes with family and friends (Lowenberg, class lecture; Froemke, et al.).

Important conversations with the physician are incisive in continuing to experience a meaningful life throughout the dying process (Ullmann A1, A12). Tacoma, Washington physician Dr. Stuart Farber states that as a physician, he has to come to terms with death to help someone else die. He says doctors can't be miracle workers with terminally ill people and

therefore don't get the same type of satisfaction. This forces them to confront their own mortality. Dr. Farber states, "But the reality is when you talk to patients who are dying they need somebody—and that somebody is usually their doctor—to help them through this experience." He also acknowledges that some patients don't want to be led into death, and those of other cultures who may have separate or different rituals about dying need special considerations, too (A12). The dying patient's wishes need to be honored as much as is feasible and cultural resources must be consulted as needed to preserve dignity. "With time and guidance, dying people can continue to grow as individuals, heal old rifts, share life stories, graciously allow others to care for them" (A12). A dying patient also needs the opportunity to explore spiritual issues if he or she so chooses. A consultation with a clergy or other person appropriate for the patient's belief system can assist the patient in maintaining faith and alleviating fear.

Oncologist Dr. Frank Senecal believes in telling his patients how they are going to die to alleviate the fear. This gives a sense of knowing and control. "It's not a desperate situation. Often the process of dying is the patient going to sleep," (Ullmann A12). His conviction is to be honest and objective in a compassionate way. Even people who don't want to know they are dying need time to prepare. "If the doc doesn't address it, there's no chance," he says. "We've got to do that" (A12). Senecal says it is critically important to tell people when treatment is not working. He noted two cases where he did not communicate the impending death to his patients and both died without having an opportunity to say good-bye to their families. This aspect of the process is key for experiencing a good death. Good-byes provide closure for the patient and helps with the grieving for family and friends.

Dr. Jim Dunn states that a primary concern in dealing with dying patients is to find out what they want for themselves. Some dying patients want to keep their senses as sharp as possible and are willing to experience a certain amount of pain to have that. Others want their suffering eased at all costs and the availability of adequate levels of pain medication is vital to their ability to feel a sense of control and comfort. Dr. Dunn wants to honor their request (Ullmann A13).

Other issues define the level and extent of care the patient desires. The family needs to know that if the dying person chooses to die at home and it is feasible, assistance and support are available. It could be an intimate and rich experience for the family to go through together (Kastenbaum 124-5). Living wills function as a way to communicate the wishes of the dying when they might not be able to provide the information verbally. Information about the type of medical interventions the dying person

desires or limits are enclosed in the living will. Although most people do not have living wills because it connotes personal death, these preparations provide a sense of personal control in the process of death (14). Even though the death might be quicker without technological intervention, prolonging life under certain circumstances can displace the patient's dignity and prolong suffering. Again, these issues build a framework of support to address and satisfy the needs of a dying patient in order to facilitate dying well.

A description of a good death would highlight implicit values that reign in our society today: the control over one's process of death, the closeness of friends and family, personal choice of where to die, the organization of one's affairs, clear communication and sharing, security that remaining members of the family are provided for, and having died, returning to the roots where one began. Idealistic as it may seem, most of these values surface in society in decisions of arranging a good death. The honoring of one's spirituality is also moving to the forefront in contemporary society. Religious or spiritual support can nourish the dying person and provide direction and faith in making peace with self, life and God. Spiritual resolution provides strength of conviction, solace for those grieving and gives one a sense of comfort. This assists in letting go gracefully to 'a better life'. It is also important to honor the dying patient's approach to religion or spirituality, which might include no faith or unfamiliar practices. As stated earlier, the dying person must be met where he or she is at that moment, and unconditional love and support provide a judgment-free environment for the patient.

There can also be a spiritual connection between the dying person and the caregiver, who relate together openly in an implicit honoring of shared truth. By working to eliminate the separation caused by duality, they come together in a neutral and common ground of being. Listening with an open heart transcends barriers of separateness and brings the dying person and the caregiver together in compassion and understanding (Levine 255).

Education is a key factor in accepting death as part of life. "One does not have to be dying oneself, however, to reap benefits... 'a positive confrontation with death can be a personally liberating experience...it can help us develop our individual identity and give us the security we need to live our lives courageously'" (Lofland 97). Unfortunately, often times this education occurs only when the person has entered the dying role. Even then, education benefits the patient by providing tools to affect and control parts of the dying process.

Dying a good death is intimately individual and utterly subjective, yet certain factors transcend personal, social and institutional differences. A sense of control is vital, communication facilitates a sense of resolution

and completion, and the ability to accept death as part of life helps one let go and consciously participate in the transition.

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