
A Good Death — Oxymoron?

by Richard A. McCormick

Whenever I think of death, and most especially of a “good death,” I think of this pericope from Luke:

When Jesus was presented in the temple, Simeon said to Mary: “This child is destined to be the downfall and the rise of many in Israel, a sign that will be opposed — and you yourself shall be pierced with a sword — so that the thoughts of many hearts may be laid bare” (Luke 2:34-35).

There is one thing certain about this subject of death: it is guaranteed to lay bare the thoughts of many hearts.

Thoughts on a good death, to be sure, will vary. They will comprise everything from the preposterous to the profound. There are certainly some who would consider no death good unless their dog was wailing at their bedside. Still others would view the lack of make-up as a major failure in good dying. Some want to go fast, without warning. Others want time to “ready their affairs.” Some want to be conscious and prayerful. Others would prefer to slip away in their sleep. *Quot capita tot sententiae* (there are as many opinions as there are people).

An individual’s attitude toward death, especially his or her notion of a “good death,” is probably the precipitate of a mysterious mixture of influences: denial, anger, terror, religious faith (or lack thereof), resignation, family background, culture, health status, life patterns, age, friendships, technology, tolerance for pain and separation, experience with dying of others, and so on. All of these play a real, if obscure, role in the building of our attitudes toward dying.

The very notion of a “good death” is problematic. Death is the end of life as we know and experience it. It is disintegration of a living being, a cessation, a stopping, a separation, a silence. Can that be called “good”? And if so, in what sense? Is it any wonder that the strongest and most urgent inclination of the human person is self-preservation? One recalls with sadness that the first lifeboats from the doomed Andrea Doria to arrive at the Isle de France were full of Italian crewmen. We struggle instinctively and ferociously against death when it faces us. That is why giving one’s life for others is rightly recognized as the greatest act of charity and the purest form of heroism. In some respects, we know ourselves quite well.

In what sense, then, is death good? I suspect that the use of this adjective with death is, first of all, negative in its purpose. It means to identify those possible forms of dying that seem especially demeaning, especially unnecessary, especially dedignifying, especially tortuous. Once these forms of dying are identified, we set about doing all we can to avoid them.

What are some of those forms? Given our cultural denial of mortality, I am sure that many would answer that *any* death is demeaning, unnecessary, dedignifying, and tortuous. Death is the ultimate enemy. This is however, an untenable posture, which is why we refer to this posture as denial. It refuses to face a truth, a reality.

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It is fairly easy to identify the kinds of dying that are especially repugnant and fearsome to us. The first is death at a young age, "death before one's time." The young person has had no chance to experience the deep satisfactions of mature relationships, of intellectual and spiritual growth. He or she has been cheated, in a sense. This is one of the dimensions of the AIDS crisis that is particularly painful: thousands of people cut off in the prime of life.

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Another aspect of dying that many people fear is sudden death. We used to pray in the traditional litany recited daily by Jesuits: *a subitanea et improvisa morte, libera nos, Domine*, (from a sudden and unprovided for death, free us, Lord). The feeling is that a sudden death is somehow a death that is not provided for. That is open to a good deal of qualification and challenge. Nonetheless, to many outside observers, the explosion of TWA 800 over the Atlantic was terrible, not just because people died, but because they died *in that way*. I strongly suspect that the particular dread associated with such sudden death is due, in part, to our sense of total loss of control over the process.

A third aspect of dying that nearly everyone wants to avoid is pain. Here the medical record is not good. Only one in ten physicians admit that she/he received good training in managing pain. Eighty-five percent of physicians assert that the majority of cancer patients are undermedicated. At the same time, experts in pain control insist that the vast majority of dying patients can have their pain satisfactorily relieved. The move to physician-assisted suicide often appeals to a false

premise. As Jay Mahoney, president of the National Hospice Organization, puts it: "There is a perception that a terminally ill patient must choose between a painful existence devoid of value, on one hand, and assisted suicide, on the other. However, there is another, more appropriate option: hospice care" (Potempa 1997).

Physicians admit that part of their problem is the inability to assess pain. Dr. Steven A. King, director of pain service in the department of psychiatry at the Main Medical Center, put it summarily as follows:

The pain associated with cancer can be managed successfully in the overwhelming majority of patients. Unfortunately, few medical schools and residency programs provide teaching on pain and its management and, therefore, many physicians are unaware of the wide array of treatment for cancer pain (King 1991).

Another dimension of dying that many people fear is the heedless, needless, and useless prolongation of the process by high technology rescue medicine. Christopher Koller states:

Clinically, patients and providers alike often forsake the collective art of caring for the individualized science of curing" (Koller 1993).

Dr. Timothy Quill makes the same point: "We overtrain doctors to extend life. We undertrain them to address human suffering" (Quill 1993). His example: the attempt to resuscitate an eighty-pound, eighty-year-old man ravaged by lung cancer whose bones fracture at the pressure of CPR (cardiopulmonary resuscitation). People just do not like this kind of technological violence disguised as care in the last weeks and months of life.

Many people resent being prisoners of a life-at-all-costs mentality. And with good reason. Lawrence J. O'Connell, president of the Park Ridge Center, recently pointed out that dying in America has three characteristics: 1) alienation

(from family and friends) by the “enforced isolation and regimentation of acute care and skilled settings”; 2) fragmentation — the provision of treatment system by system, organ by organ; and 3) diminishment — the reduction of the person to a case while more personal needs are overlooked (O’Connell 1996).

There are probably many factors responsible for this alienation-fragmentation-diminishment pattern. One certainly is the cultural denial of mortality. Another is the dominant place occupied by technology in modern medicine. I suspect a third is managed care. Seventy-five percent of employees with insurance are now in some form of managed care. Joseph A. Califano Jr. has put it as follows:

Whether its customers are poor or affluent, managed care leaves doctors and nurses little time to counsel patients and sit with them when they are suffering. The two-fold impact of high-tech care and bottom-line managed care puts powerful dehumanizing forces at the front of American medicine and threatens to ignore the needs of ailing individuals to be talked to, as well as to be cut, injected and medicated, as the doctor hurries to the next patient (Califano 1994).

The final dimension of dying that bothers many Americans is that of dependency. One gets the impression that it is almost un-American to be dependent. This abhorrence of dependency is both the result of and a reinforcement for a distorted and one-sided exaltation of personal autonomy. We are obsessed with being in charge. That is why many Americans would define a “good death” as death in my way, at my time, by my hand. That is why *Newsweek*, speaking of physician-assisted suicide, states that “the issue will play out before the Supreme Court as a constitutional clash between personal autonomy and the state’s interest in preserving life” (*Newsweek* 1997). If that is the shape of the Supreme Court’s deliberation, it is not hard to predict the outcome.

But the matter is not so simple. We are not

reducible to our autonomy when we are dependent. In the words of the wise Daniel Callahan:

Why can we not bear a self-understanding that would seem to make us less than our own creations, our own possessions? It can only be because the threat of dependence lies in the insult to a self that has created a myth about itself, a myth of separation and transcendence. But it is a myth. We are not separate and transcendent, even if we can achieve these states now and then in our lives. The inevitability of aging and illness means that our individual transcendence of dependency cannot be, and will not be, permanent. It is a profound error to think we are somehow lessened as persons because dependency will happen to us, as if that condition itself *necessarily* robbed us of some crucial part of the self. It does not. There is a valuable and necessary grace in the capacity to be dependent upon others, to be open to their solicitude, to be willing to lean upon their strength and compassion. To be a self is to live with the perpetual tension of dependence and independence. The former is as much a part of us as the latter. The latter may just feel better and surely flatters us more. It still remains only half the story of our lives, however (Callahan 1993).

The following clip from *USA Today* caught my attention several years ago.

Cynthia Powelson knew it was time to die. She’d tried surgery, chemotherapy, acupuncture and meditation. She couldn’t eat or drink. And her gastric tumor had grown so large she appeared six-months pregnant. Doctors said she wouldn’t live a year. The graduate student, thirty-seven, gathered family at her suburban Rochester, New York, home, married her longtime love, then had her feeding tube removed. She died twelve days later. Life was out of control. Death was on her terms.

Having some say in death, as Powelson did, has become a national obsession (*USA Today* 1993).

I am not criticizing Cynthia Powelson's decision. Nor is it appropriate to glamorize dependence; our discomfort with it is quite understandable. But for too many people dignity is totally incompatible with dependence.

What I would argue is that our notion of dignity must incorporate the reality of dependence. In Christianity, dependence is not viewed as something that deprives us of our dignity, but rather as a sacrament of openness to and dependence on God. In the fragility of dependence, we are invited to cling to and trust a power beyond our control. In this sense, a rejection of interdependence is closely tied to rejection of creaturehood and mortality.

An Anglican study group caught this very well when it stated:

There is a movement of giving and receiving. At the beginning and at the end of life receiving predominates over and even excludes giving. But the value of human life does not depend only on its capacity to give. Love, agape, is the equal and unalterable regard for the value of other human beings independent of their particular characteristics. It extends especially to the helpless and hopeless, to those who have no value in their own eyes and seemingly none for society. Such neighbor-love is costly and sacrificial. It is easily destroyed. In the giver it demands unlimited caring, in the recipient absolute trust. The question must be asked whether the practice of voluntary euthanasia is consistent with the fostering of such care and trust (General Synod Board for Social Responsibility 1995).

Rand Richards Cooper vividly addresses the issue of dependency in an excellent article entitled "The Dignity of Helplessness" (Cooper 1996). After describing his retching nausea while in Nairobi as he attempted to aid a crippled boy who had defecated in his pants, Cooper mentions an acquaintance, in mid-sixties and in good health, whose goal at the time was to avoid becoming a helpless burden. "Once I start shitting my pants,"

his friend said, "that's it. Take me out and shoot me."

Cooper, with the eye of a novelist, sees much more in these occurrences than burden and helplessness. As he summarizes:

My point is that we experience a profound aspect of our humanity precisely in our intimate and awful knowledge of each other's physical neediness; and further, that what we draw from this knowledge constitutes not only a spiritual good but a social good. If, following the quality-of-life, take-me-out-and-shoot-me principle, we end up using assisted suicide to preempt the infirmities of old age and terminal illness, how well equipped will we be to encounter infirmity elsewhere? How to become fluent in help if we have banished helplessness from our vocabulary?

These, then, are aspects of dying that make for a "bad" death: death at a young age, sudden death, painful death, technological prolongation of the dying process, and prolonged dependency. Other dimensions could be listed as well, such as isolation and abandonment, but I have listed these as implications of the overuse of acute care.

Daniel Callahan has brought together many of these points in his personal definition of a peaceful death.

- I want to find meaning in my death or, if not a full meaning, a way of reconciling myself to it. Some kind of sense must be made of my mortality.
- I hope to be treated with respect and sympathy, and to find in my dying a physical and spiritual dignity.
- I would like my death to matter to others, to be seen in some larger sense as an evil, a rupturing of human community, even if they understand that my particular death may be preferable to an excessive and prolonged suffering, and even if they understand death to be part of the biological nature of the human species.

- If I do not necessarily want to die in the public way that marked the era of a tame death, with strangers coming in off the streets, I do not want to be abandoned, psychologically ejected from the community, because of my impending death. I want people to be with me, at hand if not in the same room.
- I do not want to be an undue burden on others in my dying, though I accept the possibility that I may be some burden. I do not want the end of my life to be the financial or emotional ruination of another life.
- I want to live in a society that does not dread death — at least an ordinary death from disease at a relatively advanced age — and that provides support in its rituals and public practices for comforting the dying and, after death, their friends and families.
- I want to be conscious very near the time of my death, and with my mental and emotional capacities intact. I would be pleased to die in my sleep, but I do not want a prolonged coma prior to my death.
- I hope that my death will be quick, not drawn out.
- I recoil at the prospect of a death marked by pain and suffering, though I hope I will bear it well if that is unavoidable (Callahan 1993).

What do we have here? Certainly not the constituents of a “good death.” All we can say is that we have identified those dimensions that are obstacles to a quiet and peaceful death, what Callahan calls the “context for a peaceful death” (Callahan 1993). This is a negative exercise.

Can we be more positive? I think so. I will use two contrasting examples to make my point.

William S. Paley, the founder of CBS, asked as he was dying, “Why do I have to die?” Obviously, this was a protest and a rejection from a man used to power and getting his own way. Joseph Cardinal Bernardin, when informed in August 1996 that his cancer had returned, said: “Now I will have the chance to put into practice what I have been

telling patients all year — death is my friend.” When told a few days before his death that “you will die this week,” Bernardin responded, “I am ready.”

Bernardin’s oncologist, Ellen Gaynor, OP, MD, noted with remarkable perceptiveness:

Inner peace such as Cardinal Bernardin displayed does not just happen; it had to be nurtured over a lifetime (Gaynor 1996).

“Good death” is an oxymoron for a person like Paley. Not so for Cardinal Bernardin. What makes the difference is the inner peace with which Bernardin viewed death and faced his own dying. When I say “his own dying,” I do not mean the idea of death, of one’s mortality. That is an abstraction. It is an easy admission. I mean a deep-down, existential coming-to-terms with the fact of my own death, the kind of acceptance that has the potential to change a life.

What I find unsatisfactory and even troubling about Callahan’s listing above is that by and large it deals with the esthetics of the dying process. I see no basis in that listing for the kind of inner peace Bernardin displayed. Without that inner peace, even the idea of peaceful death (to say nothing of a good death) is illusory.

At this point, we must ask: what is the source of this inner peace? To me, there is absolutely no doubt or hesitation about the answer. Bernardin’s dying was buttressed by his religious faith, which roots in the belief that in and through Jesus Christ we are offered eternal life.

Hans Küng has caught this very well. He writes:

Those who trust in God at the same time trust that death is not the end. In the light of the Eternal One, who alone can grant “deep, deep eternity,” the death of mortal life becomes transcendence into God’s eternal life. As the old prayer for the dead has it, “*Vita mutatur, non tollitur*,” life is transformed, not take away (Kung 1995).

That is why we read in the *Anima Christi*, a

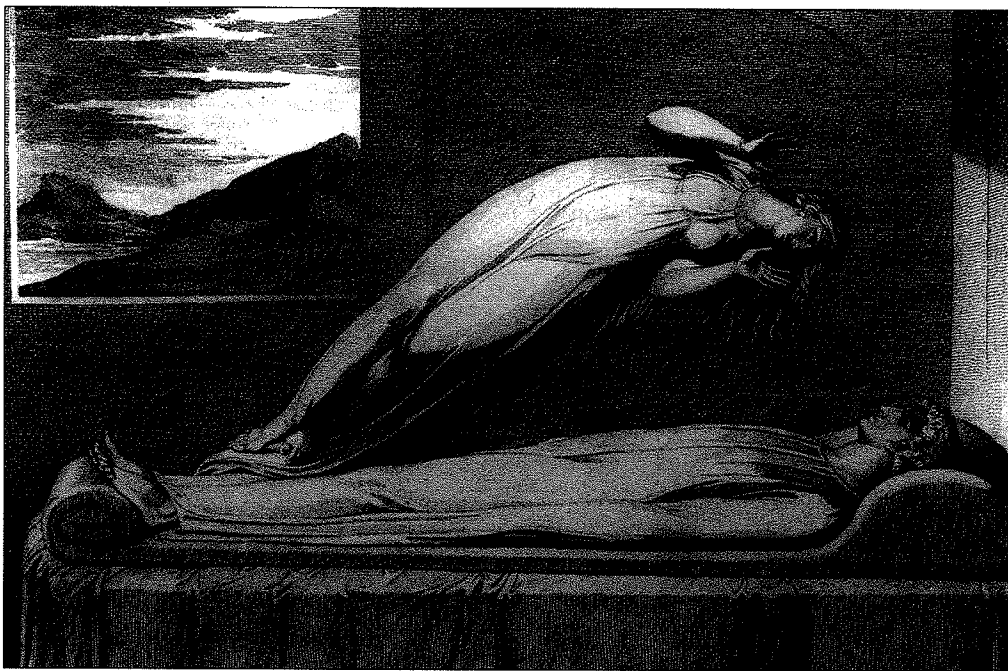
prayer very dear to Jesuits: "*In hora mortis meae, voca me. Et jube me venire ad te, ut cum sanctis tuis laudern te in saecula saeculorum*" — In the hour of my death, call me. And command me to come to you that I may, together with your saints, praise you for all eternity. But uttering this at the time of death is not enough. As Dr. Gaynor noted, the inner peace generated by faith does not just happen. "It has to be nurtured over a lifetime." When that nurturing does not occur, the notion of a "good death" is doomed to remain an oxymoron. But when it does occur the ugly reality can be transformed.

As the post-consecration acclamation of faith puts it: "Dying you destroyed our death. Rising you restored our life. Lord Jesus, come in Glory!" That is not only a profession of faith. It is a celebration. It stands behind the concluding words of Monsignor Kenneth Velo's inspiring homily at Cardinal Bernardin's funeral (*Origins* 1996):

"Cardinal. Eminence. You're home.
You're home."

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The Soul Hovering Over the Body

Nineteenth Century Etching

William Blake