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The Role of Hospice and Palliative Medicine in the *Ars Moriendi*

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ABSTRACT: There is disagreement among physicians and medical ethicists on the precise goals of Hospice and Palliative Medicine (HPM). Some think that HPM's goals should differ from those of other branches of medicine and aim primarily at lessening pain, discomfort, and confusion; while others think that HPM's practices should, like all other branches of medicine, aim at promoting health. I take the latter position: using the *ars moriendi* to set a standard for what it means to die well, I argue that if HPM's practices were to aim at mitigating suffering with little regard to promoting health, some patients would die worse deaths than if HPM's practices were to aim at health. According to the *ars moriendi*, flourishing at the end of one's life requires that one exercise her agency and pursue the goods most important to her. On this view, HPM's practices should promote patients' health to enable them to pursue these goods.

Keywords: Hospice and Palliative Medicine, Aristotelianism, The *Ars Moriendi*, Health, Virtue

I. INTRODUCTION

There is a nascent revival of the *ars moriendi*—literally, the art of dying—and the timing could not be more appropriate.¹ Between the COVID-19 pandemic and the looming specter of global conflict, death is increasingly on the public consciousness. Although the reasons for the growing awareness

¹ This revival is due, at least in part, to the work of Lydia Dugdale (2015) and (2020).

of death are lamentable, the awareness *itself* is, to my mind, positive. It is good for each of us to recognize our mortality: everyone we know and love—as well as everyone we do not know and hate—will die. But according to the *ars moriendi*, we should strive to die a good death. In our medically advanced world, most deaths occur in hospitals, attached to a tapestry of tubes and intravenously downing cocktails of medications. One response to this unpleasant, medicalized death is hospice and palliative medicine (HPM), which seeks to allow patients to pass away peacefully, supported by their community, and free of immense pain.

Even at its end, there is more to life than living without pain. While living without excruciating pain is certainly *a* good, it is not the *only* good. Surveys of people who are either at the end of life or who have serious diseases show that they value not only avoiding serious suffering but also strengthening their relationships with their family and friends, being cognitively aware, not being an undue burden on others, and achieving a feeling that their life is complete.² As physician Atul Gawande writes,

The terror of sickness and old age is not merely the terror of the losses one is forced to endure but also the terror of isolation. As people become aware of the finitude of their life, they do not ask for much. They do not seek more riches. They do not seek more power. They ask only to be permitted, insofar as possible, to keep shaping the story of their life in the world—to make choices and sustain connections to other people according to their own priorities (Gawande, 2014, 147).

HPM recognizes these goods, as well as the ways in which patients prioritize these goods, and seeks to promote them.

There is, however, disagreement among physicians and medical ethicists on the precise goals of HPM. Some think that HPM's practices should aim primarily at mitigating suffering; while others think that HPM's practices should, like all other branches of medicine, aim at promoting health. In

² See Singer, P.A., Martin, D.K., Kelner, M., (1999) and Steinhauser, K.E., (2000).

this essay, I take the latter position: using the *ars moriendi* to set a standard for what it means to die well, I argue that if HPM's practices were to aim primarily at mitigating suffering—physical, psychological, social, and spiritual—some patients would die worse deaths than if HPM were to aim at promoting health. Since, I contend, flourishing at the end of one's life requires a person to play an active role in her death, HPM's practices, at their best, enable patients to exercise their agency and pursue the goods that are most important to them.

A few preliminary qualifications are in order. First, pain management is obviously of great importance in HPM; for some, their pain is so great that their entire existence is contorted into perpetual, seemingly unending agony. Cicily Sanders notes some of the experiences of her patients in hospice care before they received pain medication; they claimed that the pain was so severe that it was like a “vice gripping my spine,” and “no matter how kind people were...nothing would console me,” and “all of me is wrong” (Sanders, 2003, 5-6). I am not trying to minimize the positive impact that relieving suffering can have on a person's well-being or dispute the permissibility of, when proportionate palliative sedation fails, sedating patients while *foreseeing* that palliative sedation may greatly diminish their consciousness.³ Managing symptoms and enabling a patient to die well is a delicate balancing act. Second, I will assume a roughly Aristotelian view of medicine: medicine is a practice that aims at health, not a collection of medical experts who provide healthcare services. This is a controversial position in the literature, but I want to make clear which view of medicine I take. Third, when I argue that a particular view of HPM will allow patients to die a “better death,” I am assuming a general perfectionist view of well-being, which broadly says that what is good for humans is the development and exercise of our human capacities.⁴ These capacities include things such as normal human physical, emotional, cognitive, volitional, social, and emotional capacities, but I do

³ See Lo and Rubenfeld (2005).

⁴ See Bradford (2016).

not attempt to give a precise or comprehensive account of what these capacities are. Fourth, I will focus on cases where patients possess a relatively high degree of cognitive function. As we will see, the goods that the *ars moriendi* says that one should pursue at the end of their life are rarely taxing or difficult. But when a person can no longer pursue even these goods—for instance, when patients are actively dying or suffering from late-stage dementia—it is less clear what the *ars moriendi* has to offer.⁵

The roadmap of this paper is as follows. In section II, I argue that we should think of HPM as being a sub-discipline of medicine; as such, I contend that HPM's practices, at their best, aim at promoting health. In section III, I argue that if HPM aims to restore health to the extent that health is possible, HPM is compatible with the *ars moriendi*, with an art of dying well. And in section IV, I apply the two different views of the ends of HPM to a couple of cases to see how the views would work out, including a case that initially appears to provide a counterexample to my argument.

II. THE AIMS OF HPM

Suppose that the end of medicine is health. That is, the goal of medicine is to promote the proper functioning of the patient's whole body. "[H]ealth is," As Leon Kass says, "the well-working of the organism as a whole,' or again 'an activity of the living body in accordance with its specific excellences'" (Kass, 1975, 25).⁶ Or, as Aristotle says, health is a "virtue of the body" (*Rhet* I 5, 1361b3; *Phys* VII 3, 246b3-4, trans by Baker (2021)). Human beings are composed of various parts whose well-working allows them to live out distinctively human lives. For instance, a healthy eye is one that allows a person to perceive their environment, and a healthy heart is one that pumps the appropriate amount of blood at the appropriate times. Whether these organs are working well

⁵ See Callahan (2015).

⁶ By saying that medicine aims at the "well-working of the organism as a whole," Kass does not mean that medicine ought to neglect the health of various parts of one's body. Rather, he is saying that medicine should aim at promoting the holistic health of the patient's body, and so a physician ought to seek to treat the parts of a patient's body insofar as the parts affect the patient's health overall.

depends on how they contribute to the person's body *overall*: a person is said to be healthy when their body is functioning in a way that disposes them to be able to exercise their characteristic human excellences. These excellences range from strenuous physical activities like running a 5k or hiking up a mountain to everyday tasks, such as eating and drinking; they also include a wide range of activities that are more cognitively demanding, from engaging in creative thought and solving problems to having casual conversations. Health is what allows a person to engage in these enterprises that are characteristic of us humans as a species.

If health is the well-working of the whole human organism, then medicine is the practice that aims to help a patient exercise the excellences of her whole organism.⁷ Juergen Bludau says that the role of any physician is to provide two things: "as much freedom from the ravages of disease as possible and the retention of enough function for active engagement in the world" (Gawande, 2014, 41). Or, as Curlin and Tollefsen say, "[M]edicine is a paradigmatic practice, elevated to a profession because of its social importance, that aims at human health" (Curlin and Tollefsen, 2021, 4). If a practice does not satisfy these criteria, it fails to be medical practice. A legitimate medical practice must aim at restoring or preserving the health of the patient to the extent that it is possible.

Health is degreed, not binary. A living organism can be more or less healthy. Thus, medical treatments are successful to a greater or lesser extent; the extent to which a given treatment contributes to a patient's health is highly variable. But, insofar as a treatment *contributes* to a patient's health, it is a legitimate medical practice. For instance, if our current medical technology cannot restore a cancer patient to her prior state of health, if it can help her struggles with nausea, constipation, insomnia, and debilitating pain by ameliorating these symptoms, then medicine has

⁷ For an introduction to the Aristotelian view of medicine, which is the tradition I am assuming, see Pellegrino and Thomasma (1981), Marcum (2012), and Curlin and Tollefsen (2021, 20-31). See also Baker (2021) for Aristotle's own view of the end of medicine.

improved her health. The physician is not only treating her symptoms but treating *her*, the patient. By helping her to live out a more normal human life free of wracking pain, a physician is contributing to her health by preserving it as much as possible, which in turn allows her to engage in activities in accord with her human excellences. This contribution of health is the mark of medicine.

However, a standard view of HPM is that one of the primary goals, if not *the* primary goal, of hospice is to alleviate suffering and promote comfort. Health is completely neglected. In the preamble to their standards and practices, the National Hospice and Palliative Care Organization (NHPCO) says,

Hospice affirms the concept of palliative care as an intensive program that enhances comfort and promotes the quality of life for individuals and their families ... Hospice believes that death is an integral part of the life cycle and that intensive palliative care focuses on pain relief, comfort and enhanced quality of life as appropriate goals for the terminally ill (NHPCO 2000).

On this view, relief from suffering and increased comfort is not only an instrumental good meant to achieve other goods but is also something worth seeking for its own sake. “When *cure* is no longer possible,” Hutcheson writes, “hospice recognizes that *a peaceful and comfortable death is an essential goal of health care*” (Hutcheson 2011, 180, emphasis added). On this view, aiming at health and aiming at relieving suffering come apart.

The thought behind viewing HPM as care that aims primarily at relieving suffering seems to be this: when a person enters HPM, she has less than six months to live; she is beyond restoring to health. As Michael Gill writes, “The problem [with claiming that physicians’ only goal is promoting health] is that people with terminal diseases cannot be made healthy. A physician cannot heal someone whose disease is lethal and untreatable” (Gill, 2005, 61). Therefore, the only thing medicine can do for the patient is to ensure that her last months are comfortable, that the patient and her family “may be free to attain a degree of satisfaction in preparation for death” (NHPCO

2000). This is the best that we can offer to those in HPM—not health, but comfort and relief. Medicine has run out of other options.

On this view, the limits to the means that HPM has at its disposal to prevent suffering are unclear. It seems that no forms of suffering are off limits. What means does HPM have at its disposal to relieve suffering? And what kinds of suffering should HPM prevent? As Curlin notes,

The World Health Organization defines “palliative care” as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (Curlin, 2015, 56).

However, as Jeffrey Bishop et. al (2008) argue, by increasing the scope of care to the “biopsychosociospiritual” aspects of the patient’s wellbeing, this view of HPM has set itself up to tackle every dimension of the dying patient’s life. The *Clinical Practice Guidelines for Quality Palliative Care* says the following,

Palliative care attends to the physical, *functional*, *psychological*, *practical*, and *spiritual* consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness (Periyakoil et al., 2019, 2).

Unlike the rest of medicine, the whole of the patient's life is subject to treatment.⁸ All suffering is a pathology that HPM is fit to tackle.

Suppose, instead, we agree with Curlin (2015) and think of HPM not as a distinct practice apart from medicine but as a sub-discipline. As a branch of medicine, HPM would aim at relieving suffering for the sake of promoting or preserving health. HPM could do this in one of two ways. First, an HPM provider might judge that lessening a patient’s suffering by getting her pain under control is the best course of action to directly promote her health. HPM would see pain as an

⁸ It is worth noting that according to Engel’s (1977) “biopsychosocial” model of medicine, not only HPM but *all* branches of medicine would seek to treat every aspect of a patient’s life. See Bishop (2011) for an historical analysis of what he thinks led to the rise of Engel’s model.

impediment to health, and so HPM would address pain to remove this impediment. Second, a provider might judge that treating a patient's symptoms would indirectly promote her health or, at the very least, preserve her current level of health. While there are still many cases in which a person should be palliated and would foreseeably experience a diminished consciousness, HPM would practice this only if palliation does not hinder her health. What HPM could not do on this view, however, is treat the patient's symptoms with no concern to her overall health. That is, HPM could not act contrary to promoting health.⁹

These two views within HPM—viewing the relief of suffering as a means and viewing the relief of suffering as an aim—can be at odds with one another. As Curlin and Tollefsen write, “Palliating disabling symptoms with an eye to preserving and restoring a measure of health differs fundamentally from palliating symptoms without respect to whether doing so will restore health” (Curlin and Tollefsen, 2021, 143). The former focuses on empowering the patient to die well by lessening their suffering in order to allow them to engage during their own death, while the latter focuses only on lessening the patient's suffering, potentially usurping the patient's role in engaging during their death. This seemingly subtle difference between the two views can have significant consequences. As Curlin writes, “When efforts to relieve suffering and to improve quality of life are decoupled from the goal of preserving and restoring health, HPM practitioners begin to see all forms of suffering, including existential and spiritual suffering, as conditions that call for treatment” (Curlin, 2015, 57).

While this distinction may seem like mere hairsplitting, it can bear greatly on how we go about problems at the end of life. If we say that the proper end of HPM is health instead of a pain-free death, the patient is free to pursue more goods. Palliating suffering becomes only *a* good at the end of one's life, not *the* good. In the *ars moriendi*, one must be consciously aware of both their

⁹ For instance, “palliative sedation to unconsciousness” (Quill et al. 2009) is impermissible.

surroundings and their own impending death in order to die well. Let us take a closer look at the *ars moriendi* to see how this distinction plays out.

III. THE *ARS MORIENDI*

The *ars moriendi* developed in reaction to the Catholic Church's inability to cope with the catastrophic effects of the Bubonic plague.¹⁰ It can be traced back to two anonymously written documents from the early 15th century; the *Tractatus artis bene moriendi* and a shorter version of this work, which was largely composed of images of the vices that might trouble one at their deathbed and their corresponding virtues. Over time, the *ars moriendi* grew into a whole genre. While early medieval versions focused only the deathbed, authors in later centuries write about how one should live before they even reach the point of actively dying.¹¹ According to these authors, to prepare for a good death, one should endeavor to suffer well, trust and love God, and grow in the moral and theological virtues.

As Dugdale (2015), (2020) has argued, the *ars moriendi* need not be reserved exclusively for religious believers. A modern art of dying can accept many of the principles of the traditional version, such as acknowledging one's finitude and living and dying in vibrant communities. She gives a few different pieces of advice for how we might live to die a good death. To give a few examples, she says that, first, given the importance of community, those who are frail and elderly should strive to avoid stays at the hospital that would isolate them. Second, when deciding whether to undergo treatments, one should acknowledge their finitude. Even if a treatment might have a chance of slightly prolonging a patient's life, its benefits might not outweigh its costs, especially if the treatment would hinder the patient's ability to pursue her other goals. Third, one should be given the opportunity to

¹⁰ See Dugdale (2020), Vogt (2004), and Vogt (2021) for brief introductions to the history of the *ars moriendi*.

¹¹ For examples, see Erasmus's (1998) *Preparing for Death*, Robert Bellarmine's *The Art of Dying Well* (1989), and Jeremy Taylor's *The Rule and Exercises of Holy Dying* (1989).

turn her attention to what matters to her at the end of their life, such as spending time with family and friends. Fourth, one should be given the opportunity to exercise her virtues; that is, one should be given room to exercise her excellences according to the degree that she is able.

Notice that each of Dugdale's pieces of practical advice, but especially the third and fourth, is something that the patient herself must *do*. According to the *ars moriendi*, a good death is not passive. Dying well requires both that the patient plays a role in her passing and that the patient's passing is a community affair. The patient, supported by her community, sets her life in order and prepares for her own passing. As Curlin writes, "Dying well is, in Ramsey's terms, both 'a gift and a task.' To be aware of the gift and to engage in the task, patients must be conscious of themselves, which means they will be conscious both of their symptoms and of their mortal condition" (Curlin, 2015, 48). The *ars moriendi* emphasizes the patient's agency and focuses on her "dying role": one's ability to intentionally guide the final days of her life. In their final days, "People want to share memories, pass on wisdom and keepsakes, settle relationships, establish their legacies, make peace with God, and ensure that those who are left behind will be okay" (Gawande, 2015, 249). Dying well requires one's active involvement in her own life, if possible, up until the very end: "If the *ars moriendi* teaches us anything," Dugdale writes, "it's that the work of living well is what enables us to die well" (Dugdale, 2020, 180).

The *ars moriendi* flourished for hundreds of years. It was not until the 1920s, when medicine progressed to the point where it seemed that we might be able to eventually cheat death altogether, that the notion of a good death seemed antiquated. However, even though most people report that they would rather die at home, most in the U.S. die in hospitals. Most would rather die in a familiar setting surrounded by their family and friends, yet most die confused and surrounded by strangers. Why the disparity? Latham suggests that "[w]hat has happened is that death has been medicalized ... and this medicalization ... is interfering with people's abilities to experience deaths that permit

them to demonstrate or experience higher values—love of family, rootedness, closure, religious enlightenment, and so on” (Latham, 2015, 43). We seem to die in places that we would rather not and in ways that are often, with enough foresight, avoidable.

Many in medicine have recognized this problem and opted for a less-medicalized approach, which is what the HPM was originally meant to be. But as Curlin (2015) points out, some current HPM practices seem to fall into some of the same trappings of a medicalized death. It is not uncommon for providers to treat dying patients’ distressing symptoms but with little thought to how this will affect their ability to exercise their agency. To be clear, addressing the patient’s symptoms is a central part of HPM’s role, but doing so without keeping the downsides of these treatments in mind is problematic. These practices often result in diminishing the consciousness necessary for one to engage in her own death. In focusing solely on relieving a patient’s suffering, HPM can end up diminishing her consciousness, one of the very capacities necessary to die well. “Such consciousness,” Curlin writes, “invariably includes some degree of suffering. When practitioners of HPM too quickly sacrifice consciousness in order to end suffering, they frustrate the possibility of dying well” (Curlin, 2015, 48). Additionally, when HPM seeks to alleviate every aspect of a dying patient’s suffering—physical, psychological, social, and spiritual suffering—HPM can usurp the patient’s role in her own death. According to the *ars moriendi*, the patient herself must play the key role in preparing for death. If HPM seeks to alleviate all forms of suffering, it runs the risk of diminishing the patient’s role: it can overstep into the realm that the patient herself should oversee.¹² On the view that HPM aims at health, it promotes the dying patient’s ability to participate in the goods that are important to her. The patient’s own activity is paramount.

¹² Again, this presupposes a certain level of cognitive capacity that might be absent in some patients.

If medicine aims at health, and if HPM is a sub-discipline of medicine, HPM also aims at health. This means that HPM aims to palliate a patient only insofar as it is conducive to her health. And if health refers to the well-working of a whole organism, it follows that HPM should palliate a patient only insofar as it promotes or preserves her health overall. By not seeking to address the other aspects of the dying patient's suffering, HPM creates space for the patient, supported by her community, to exercise her agency and play the dying role by pursuing the goods that are the most important at the end of one's life.

Especially at the end of our lives, our relationships with our family members and friends provide us with some of our greatest goods.¹³ As noted earlier, much of the research on people's priorities later in life supports this claim.¹⁴ According to Aristotle, friends are second selves. We are, by nature, social animals; we need one another to flourish. As Dugdale writes, "Aristotle was correct when he said that no one flourishes in isolation ... [W]e are relational beings, and dying is a community affair. It takes a village to flourish while dying" (Dugdale, 2020, 205). These goods—nurturing and strengthening our relationships with our family, friends, and community at large—are those that, when HPM is at its best, enables patients to pursue.

One might object here that if HPM enables patients to pursue other goods, then it is no longer aiming at promoting *health*. And if that is right, we are back to a more expansive view of HPM where all aspects of the patient's life, such as her spiritual or social well-being, are within HPM's proper domain. HPM no longer aims at health like other branches of medicine. One might thus be

¹³ See Shea (2019) for a recent philosophical defense of the importance of friendships as a primary good in the context of healthcare.

¹⁴ In addition to the studies listed earlier, a recent Pew Research Center (2017) survey of Americans found that people are the most likely to say that family provides the most meaning in their lives, and friends ranked only a little farther behind this.

tempted to conclude that the *ars moriendi* in fact supports the view that HPM should aim at addressing every domain of the dying patient's life, not only promoting her health.¹⁵

This objection highlights a subtle but important point. If HPM aims at promoting the dying patient's health, HPM promotes other goods only *indirectly*. Restoring the patient's health as much as possible provides the precondition for her to live well by enabling her to pursue other goods. HPM can promote these goods by seeking to relieve the symptoms that hinder a patient from engaging with her family and community. These symptoms might include things like nausea, constipation, insomnia, and debilitating pain. If HPM can do this, it has succeeded in promoting the patient's health and ability to die well. The *ars moriendi* rarely requires that a person perform great physical feats, but, as Curlin (2015) notes, it does require that a person be attentive—that she directs her mind outside of herself and becomes relationally present to her family and community, often involving some kind of writing or oral communication. Performing these tasks is nearly impossible when one is plagued by symptoms like excruciating pain, breathlessness, vomiting, constipation, insomnia, and delirium. “By treating and relieving these disabling symptoms,” Curlin writes, “palliative medicine helps to restore the measure of health that a patient needs in order to participate actively in the task of dying well” (Curlin, 2015, 55). On this view, HPM enables a patient to die a good death when it assists her in exercising her ability to participate in various goods by promoting her health.

It is worth emphasizing that if dying well is both a gift and a task, the patient must take it up voluntarily. It cannot be forced. HPM can only promote these goods indirectly. If a patient has no interest in engaging with their community, no interest in passing on wisdom, and no interest in actively engaging with their own death more broadly—or even if they would rather not pursue these

¹⁵ I thank an anonymous referee for raising this objection.

goods at the cost of enduring more pain—there is nothing that HPM can do to coerce them. The *ars moriendi* requires that patients choose to exercise the excellences available to them at the end of their life. As we have discussed, studies suggest that most patients prefer to meaningfully engage with their community and loved ones. But for those who choose not to and would rather only be made “comfortable,” HPM should certainly honor her wishes. This is already what the American Academy of Hospice and Palliative Medicine advocates. It says,

When the [patient’s] goals have been established, providers should review the patient’s current medical treatments (eg, medications, tests, monitoring) and potential planned interventions (eg, CPR intubation, dialysis, hospitalization) and decide which will help the patient achieve his or her goals based on treatment philosophy and clinical condition (Periyakoil et al., 2019, 188).

The standard of care is to ask a patient what is most important to her and seek to provide treatment that allows her to achieve her goals.¹⁶ The *ars moriendi* tells us what some of the dying patient’s goals should be as a general rule; but because it emphasizes the patient’s agency and role in her own death, if a given patient’s goals differ from pursuing the goods that the *ars moriendi* prescribes, HPM practitioners ought to respect her decision.

With both the *ars moriendi* and the kinds of goods that are typically of the utmost importance at the end of one’s life in mind, let us look at a couple of cases to see how they would go differently if a patient were palliated with the intention of improving her health versus the intention of only relieving her suffering.

IV. APPLICATION OF THE *ARS MORIENDI*

Consider the following case.

Case: Jasmine Claude

Jasmine Claude had already experienced tremendous suffering when she was diagnosed with lymphoma in her later thirties. A native of Haiti, she lost her husband to the Tonton-Macoutes military police and had to raise her then three-year-old son by herself. When Mrs. Claude moved to

¹⁶ See Bernacki, Hutchings, and Vick (2015) for more on the efficacy of these types of conversations.

Montreal to receive treatment, the doctors quickly realized that the disease was terminal, and her care transitioned to palliation. Her tumor eventually grew to the point where her abdomen distended as if she were in late-term pregnancy. Still, the hospital staff remarked how lucidly and kindly she was able to get her needs met: “[S]he has absolute control over her world” (Towers, 2020, 296). As Mrs. Claude's abdominal cramps became more intense, she became less resistant to taking strong painkillers, but she always remained lucid enough to maintain conversations with those closest to her. And during the two days leading up to her sudden and unexpected passing, Mrs. Claude joked with the hospital staff about how lovely the whirlpool paths are, organized her own funeral, and even contacted her brother with an obituary notice that she wrote herself. The day before she passed, Mrs. Claude changed to receiving her medication continuously through a driver syringe to better control her vomiting and allow her to have some final conversations with friends from her church community and son. “I’m satisfied with my life,” Mrs. Claude told her son, “I am going in peace.” She died the next afternoon. (Towers, 2000, 300)

Mrs. Claude's final days were, while painful, full of life. She died in the manner that she lived: organized, dignified, and in control of her own life. She set her own affairs in order and cherished her relationships with her family and community. Fulfilling these tasks gave her a sense of meaning; she died at peace. HPM allowed Mrs. Claude to control her symptoms enough to actively engage in her own death: her medications increased gradually as her pain increased; up until her last day, she was always conscious of her surroundings and actively engaged with the people around her. HPM helped her retain enough function to pursue those things that mattered most to her. This is what dying well looks like.

If Mrs. Claude's HPM practitioners would have focused on addressing all aspects of her pain and making her comfortable, her death would have been worse. Mrs. Claude consistently turned down painkillers so that she could remain more lucid. As a result, she could continue to engage in the activities that gave her meaning even at the end of her life. This would have been much more difficult, if not impossible, if she would have been on heavier medication. Moreover, Mrs. Claude's providers worked with her to understand what goods *she* wanted to pursue. The treatments did not usurp her active role in dying. HPM kept her as healthy as possible so that she could exercise her agency and address the psychological, social, and spiritual dimensions of her life with her own

community members. If HPM would have sought to address these aspects of Mrs. Claude's life, it would run the risk of rendering her a merely passive observer. Instead, her providers deftly navigated the balancing act of managing her symptoms and helping her retain enough function to meaningfully exercise her agency.

However, not all cases, at least *prima facie*, seem to support my claim that aiming at health leads to better outcomes than aiming at relieving suffering. Consider another case:

Case: Mrs. B

Mrs. B was a 49-year-old woman with widely metastatic breast cancer. She was admitted to a hospital to control her pain from bony metastases. She had already been admitted to the hospital twice in the last three weeks for this same reason. Despite her keeping up a strict regimen of celecoxib, amitriptyline, lorazepam, and very high doses of oxycodone hydrochloride and morphine sulfate, Mrs. B's pain was too severe to control at home. The situation at the hospital would be far worse. Her pain was under control on the second day, but by the third day, despite a significant increase in both the amount of medication she received and changing to a stronger medication, her pain became excruciating. By the morning of the fourth day, Mrs. B began experiencing myoclonic jerks throughout her whole body, and no dose of medication was helping. Mrs. and Mr. B consulted with the attending physician, and together they decided to initiate palliative sedation to relieve Mrs. B's suffering. They administered both a loading dose and continuous infusion of phenobarbital and later a muscle relaxant to control her myoclonus. Mrs. B passed away four hours later.

Mrs. B's pain was such that she could not function. In a later report, Mr. B says, "*My wife and I were saying goodbye to each other when suddenly she began to have spasms, whole, wracking, body spasms. Everything from her waist down would spasm every 3 to 5 seconds. After a couple of hours of this, she said, 'If anything, just let me sleep. I'm in pain, I can't die, and this is a nightmare'*" (Lo and Rubenfeld, 2005, 1811). It seems as if sedating Mrs. B was the best option available to the physicians, yet it also seems as if they were intending to only relieve her suffering and not for the sake of her health. Is this not a counterexample to my argument?

I think not. On the Aristotelian view, medicine aims at promoting health to the extent that, given the best practices available at the time, health is possible. The physicians did everything in their power to promote Mrs. B's health "*short of terminal sedation. Anything short of that was going to*

be preferable. It was always an option, but an option that came at the end. We got our pain consult service involved, we tried different medicines, we tried sedation, but not the idea of terminal sedation” (Ibid.). What degree of health was there left to which the physicians could aim to promote? It seems nothing beyond what Mrs. B requested: to be allowed to sleep and be free of her living nightmare. The physicians aimed at the level of health possible by ameliorating the myoclonic jerking and getting her pain under control. More specifically, they sought to *preserve* her health and did not act contrary to promoting the well-functioning of her whole organism by engaging in terminal sedation. Because Mrs. B was in so much distress, the most health that medicine had to offer her was allowing her to sleep. Enabling a patient to sleep might not seem like it promotes her health, but compared to enduring unbearable pain, it was the highest degree of health that Mrs. B’s physicians could help her attain.

In these kinds of cases, palliating a patient aiming to promote her health and palliating only to relieve suffering might look the same; there is no externally discernible difference. Patients are not always in a position to exercise their excellences to achieve other goods. Although the consciousness necessary to engage in the *ars moriendi* will invariably include some degree of suffering, the degree of suffering can reach a point where one is no longer conscious of anything other than her suffering. In these circumstances, whether one thinks that HPM is operating at its best when it aims at relieving suffering in the last few moments or when it aims at promoting health, they should recommend the same course of action. So, Mrs. B's case does not provide a counterexample to my argument but an example of how aiming at health and aiming at relieving suffering can converge.

Earlier, I claimed that if HPM were to aim primarily at mitigating suffering rather than promoting health, *some* patients would die worse deaths. Patients like Mrs. B are why it is only some. For patients like her who suffer from refractory symptoms that, whether HPM aims at promoting

health or at relieving suffering, their deaths will likely look very similar. However, for those patients like Mrs. Claude whose symptoms are easier to get under control, HPM that aims at promoting her health has the best chance of enabling her to die well; this view of HPM thus offers results that are either as good or better than the results of an HPM that aims at relieving suffering.

V. CONCLUSION

I have argued that if we think of hospice and palliative medicine as being a sub-discipline of medicine, HPM's practices will allow some patients to die better deaths than if HPM's practices aim primarily at relieving suffering. I contend that when HPM's practices aim primarily on restoring the health of the patient to the extent that health is possible, we make room to allow patients to die well, which, according to the *ars moriendi*, consists of performing various tasks that the patient herself must engage in. There may be cases where whether HPM aims at only relieving suffering or promoting health, the actions taken will look the same. But even in these cases, the results would likely be no worse if HPM's practices still aim at promoting health.

I want to conclude with an interaction between an HPM patient and a hospice nurse that beautifully captures both the tragedy and courage of a person who chooses to die well. Dave Galloway, the patient, would pass away one week later.

“How's your pain on a scale of one to ten?” Creed asked.

“A six,” he said.

“Did you hit the pump?”

He didn't answer for a moment. “I'm reluctant,” he admitted.

“Why?” Creed asked.

“It feels like defeat,” he said.

“Defeat?”

“I don't want to become a drug addict,” he explained. “I don't want to need this.”

Creed got down on her knees in front of him. “Dave, I don't know of anyone who can manage this kind of pain without medication,” she said. “It's not defeat. You've got a beautiful wife and daughter, and you're not going to be able to enjoy them with the pain.”

“You're right about that,” he said, looking at [his daughter] as she gave him a little horse. And he pressed the button (Gawande, 2014, 164).

Here we see a patient whom HPM helped die well. By addressing Dave's symptoms to restore some degree of normal functioning, the nurse encourages Dave to pursue the most important things to him: enjoying the company of his wife and daughter. HPM provided Dave health, a precondition for living a good life, to the extent that it was possible; HPM enabled him to die a good death. Dave's story exemplifies how HPM can help patients embody the spirit of the *ars moriendi*.

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