Editorial

Recovering an *Ars Moriendi*

JOHN M. TRAVALINE AND JAMES S. POWERS

In this special issue of *The Linacre Quarterly* we are pleased to present several articles which touch upon two increasingly important areas of clinical medicine and for which morally perilous circumstances exist. The two areas are geriatrics, the subspecialty focused in the medical care of the elderly, and care at the end of life. The former, in light of the aging of society, is forcing us to examine our attitudes toward the elderly. End-of-life care too, in part because of an increased number of elderly, but also because (as one of us, JMT, unimaginatively reminds his students), “humanity is associated with 100% mortality,” will always remain of great relevance to physicians. Physicians whose practice involves either area are served well by maintaining a clear view of the multiple dimensions and complexities sometimes attending the dying person, and of death itself. This may be especially important when there appears to be a perverted view of death and dying as exists within a “culture of death,” (the term coined by Blessed John Paul II in his 1995 encyclical *Evangelium vitae*). In many ways today, the dying process has become impersonal and disconnected from transcendent and spiritual realities. The art of dying, prominent in past times, and useful by helping individuals understand and even appreciate dying as a part of living, has been lost. We propose for consideration, the need to recover an *ars moriendi*: to re-capture and enhance an ethos of end-of-life care intended to recast the dying process in a way that offsets, if not frankly impedes a death culture agenda.

The *Ars moriendi*, the art of dying, is most commonly recognized as a medieval Catholic tradition which found its expression initially in two forms. One was textual, emanating from Church hierarchy and purposed for priests attending to the care and spiritual welfare of persons at the time of dying and death. A second form was an artful compilation of images depicting the spiritual and moral struggles between good and evil, virtue and vice, thought to be experienced commonly by the dying person. Over centuries, these expressions of an *ars moriendi* which grew up in a faith-based Catholic culture, evolved into a tradition contextually situated in Protestant reform and Christian humanism. Gradually the intensity, cultural prominence, and emphasis on death and dying in the collective consciousness of societies diminished, such that an *ars moriendi* over the past century or so endures only in an attenuated form residing now in some books of prayer and liturgical sacramental rites for the sick and dying.

The loss of an *ars moriendi* in the present culture is most likely due to a perceived lack of need for it, especially if it contains any religious or spiritual qualities. Certainly an *ars moriendi* resembling its early formulations, with such richly explicit Catholic theology and tradition, would be rejected in today’s pluralistic culture. It seems that any attention to death and dying in a spiritual, moral or religious context, in any substantial way is viewed as insignificant. This appears to be particularly the case in American culture.
where death seems to have become in large part a choice, orchestrated, scripted, and demystified. There is no doubt that an *ars moriendi* as popularized in its medieval formulations is irrelevant for society today. However to the extent that dying and death can be achieved well, an *ars moriendi*, for the collective consciousness of a society at large, is timeless. We have lost a sense of the art of dying. It is time to recover an *ars moriendi*.

A great deal is happening in American healthcare today and perhaps more than at any other time in American history, the economic and financial considerations attending healthcare are pervasive. Cost consciousness among insurers, and institutional providers of health care, governmental agencies and individual physician providers of care is normative, and almost no consideration of health care occurs without serious attention given to cost, cost-efficacy, and cost-benefit-risk ratios, all of which are closely tied with quality of life analyses. Many unsettled problems in clinical medicine, and new iterations of old medical ethical dilemmas, situated in a broader social context of relativistic secularism are found at the intersection of end-of-life care and various economic forces at play in American healthcare. It is at this intersection that this issue of the Quarterly offers observations.

The essays on the following pages provide the reader with various perspectives of end-of-life care. Doctor Callahan in a letter to the editor touches upon ageism recounting a personal experience and he shares his insights on the thoughtful application of treatments tailored to the individual. Bobby Schindler also offers a personal experience reflection on diagnosing a state of minimal consciousness and his sister’s untimely death from the court-ordered discontinuation of medically assisted nutrition and hydration, popularized in the media in the early part of this decade. Doctor Fosarelli shares her reflections on Catholic social teaching and bioethics principles in the care of children and adolescents who are dying.

Doctor Kay and colleagues offer an ethical analysis involving the withdraw of cardiovascular implantable electronic devices. Doctor Morrow and co-authors remind us of the proper construction of a living will which accords with Catholic teaching, and which also serves as an evangelization tool. Doctor Buckley provides theological foundations to palliative care principles and shares a Catholic perspective of death. Mr. Way more explicitly urges an engagement with the culture of death through lived Catholic faith. Doctor Powers discusses practical applications of Catholic principles addressing fears, hopes, and best practices of palliative care. While Buckley, Way, and Powers in their respective articles offer ways of recovering an *ars moriendi*, Nichols in his paper reveals evidence for its loss. He draws attention to sentimentalism which often accompanies a sincere desire to aid some one who is suffering, but cautions that love and compassion for the sufferer be carefully understood and not confused as actions at the service of sentimentalism.

In the case report section, an interestingly unusual case of severe anorexia nervosa is presented by Doctor Scolan and colleagues to highlight end-of-life ethical dilemmas which are often the result of conflicting goods. Medical student Mark Kissler provides a thoughtful analysis of a provocative book, *The Anticipatory Corpse* in which its author argues for realigning medicine’s focus from death to a grounding in life.

It is our hope that pondering the content of this issue will yield insights into the care of older persons, and care of persons at the end of their life. Insights which may help us re-capture an *ars moriendi*. It is also our hope that this issue will spark interest, raise
awareness and engender greater discussion among colleagues in the clinics and hospitals, among loved ones in families, among caretakers, within churches and civic groups, and perhaps even on a larger societal scale where authentically good principles for our well being, found in Catholic moral teachings, can be made known and practiced. After all, it is a matter of death and life.