Forecasting Death

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Recently someone told me of an expression that the Swedish people have: “There is no such thing as bad weather, only bad clothing.” Given the geographical realities of these northern peoples, I trust the tried truth of their wisdom.

May I paraphrase this quite adaptable wisdom saying? “There is no such thing as a bad death, only bad surroundings.”

Oh, there are easier and there are more difficult deaths. Some deaths are longer, some are more painful, some carry a greater accumulation of losses, some have less reconciliation and final resolutions. But is death itself bad? Is it not rather the environment—material, social and transcendent—that is either “bad” or “good”? In other words, is it not the presence, or lack of, physical comfort, emotional care, or spiritual resting, that either protects the dying sojourner or leaves him or her exposed to the raw, and should we say, inhumane elements?

I harken back to an interview I conducted a little over five years ago with Dr. Ned Cassem, MD, Chief of Psychiatry at Massachusetts General Hospital, on the care of dying persons. A highly recognized and respected clinician (as well as a Jesuit priest), he emphatically said that there was almost no reason why a person should suffer intractable pain when she or he is terminally ill or dying. Some extreme cases may necessitate some creative mixture of pharmaceuticals and some decisions on degree of alertness, but science and, most importantly, her practitioners have the ability to manage pain today.

First, as any patient will tell us, physical comfort begins in a more basic and simple manner on the other end of the continuum from the complexity of pharmaceutical engineering of drug composition. The “good” death includes the physical comfort resultant from the attention to the details of hygiene, nutrition, body position, clothing, furniture, room temperature, personal belongings, and access of some sort to the outside world.

An all or nothing technological approach to physical care leaves us with terrible expressions such as “pulling the plug,” as if once the technology is not working, the only other option is pulling the plug on a lamp and going into the next room. Or, perhaps worse yet, as in the case of feeding tubes, putting in the plug and letting the lamp burn day and night until the bulb wears out. This is physical mechanics not
physical care.

Hallways and hallways of long-term care facilities attest to this physical maintenance lacking physical care. Where the machines stop, perhaps the hands and wet cloths can begin.

Second, the “good” death always involves the presence of the network of human relationships. Whether that of the faithful spouse and primary caregiver of 50 years, or the new face and name of the attending nurse, emotional care is as essential as physical comfort. A kind smile or a sobbing embrace is often as pain relieving as any drug or surgical procedure, depending upon the degree of emotional distress affecting the physical well being of a person.

Recently I visited a man on a ventilator and I observed the others who were coming into visit with me. They were anxious, not knowing what to say, standing back from the bed, saying they just wanted to say “hello,” and further indicating that they wouldn’t stay because they knew he must be tired.

Thankfully, his son interjected that Dad loves the company and that he likes to watch and listen to the conversation. And so we stayed and conversed, and he looked thoroughly pleased even though he was often on the side watching intently the interchanges.

People in our culture are so afraid of illness, especially terminal illness, and even more so being with persons who are dying. But their avoidance and denial shuts people out in an isolation that contributes to a “bad” death.

We are social to the core even when we actively shut people out. How many of our patients feel chained in their sick beds with little or no control of their environment and yet will passionately communicate their desire not to communicate by turning their heads or closing their eyes. But they are communicating, and sometimes, like all of us, the behaviors are simply not what we are really trying to say.

Third, the “good” death, it seems, needs a place of spiritual resting. In other words, a “good” death transcends more than the failing body, or the fading relationships. In so doing, the person reaches out beyond the tangible body and touchable heart to a greater concern or a greater connection with meaning, values, purpose, amendment, conviction.

For so many of us, this is God. For some of us, this may be the summary desires of a life lived. If I lived for fly fishing, and no desire comes near this reality, then perhaps I will die as a fly fisherman or
woman. And there I can rest or there I can search before resting, just as the lifetime believer in God can search and search before hopefully resting in a “good” death.

You and I, as ministers, and particularly as ministers in health care or other crisis settings, know the above realities that contribute to a “good” death or diminish the possibilities of a “good” death. But as study after study indicates, most Americans are not aware of their ability to surround dying in a good and beneficial way.

In January, I attended a reception for Bill and Judith Moyers in Washington D.C., to promote their upcoming series, “On Our Own Terms: Moyers on Dying in America.” This series premieres Sunday, September 10, and will air consecutive nights through Wednesday, September 13, from 9 p.m. to 10:30 p.m., eastern time, on PBS. At the reception, Bill Moyers spoke movingly of the dying persons that he interviewed for this series. He began one year before (January 1999) and has 36 hours of taping which will be edited down to six hours for this special.

At the reception, we watched six minutes of the taping and it was very moving. Bill noted that every single one of the people he interviewed (the people we would see in a few moments) had died except one man, who, ironically, Bill had just received word was now critical and would probably die in the next few days. We had the opportunity to ask questions about the series, and both he and Judith were both candid about the powerful message contained in this project, not only for the American people, but for themselves.

This presents a unique opportunity, it seems to me, for chaplains to take a leadership role in a major public interest project. We know firsthand the “good” and “bad” environments surrounding the death experience. We know firsthand the “dos” and “don’ts” in practical terms. We know firsthand the neglect in helping patients and families to explore the place of spiritual resting, or the neglect of emotional care, or even the neglect of physical comfort for these our patients.

And as Roman Catholics particularly, though not exclusively, we know that there is no need to slide the ethical ruler toward killing if we create environments that allow persons to die with the dignity of reasonable physical comfort, emotional care, and a place of spiritual resting. Life is sacred, but can appear less so when neglect and abuse give rise to the cries of so called “mercy killing.”

We have five months to prepare. How can we take our rightful leadership in educating the public to the care of dying persons? If we don’t act, then we will not have a voice, a much needed voice, in
helping to better the care of the dying person and her or his family.

How about leading brief discussion groups following each night’s presentation? What if we worked with our local churches and within our own settings to get the word out and to arrange for a place with a large screen television to view the series? Following the particular evening’s show, the chaplain-leader (perhaps in collaboration with other health care leaders) could break up the group into smaller groups with discussion and then a brief return to the larger group? A process of this sort could be focused with specific questions for discussion and done in an hour.

This national focus could be the meeting ground for lots of cooperation and collaboration between health care institutions and local congregations, networked through dioceses, clergy associations, and ecumenical dialogues. The reality is that on this issue most people agree: we need vast improvement in the way people die in America. With that kind of agreement, and the proven success of the Moyers’ PBS specials, we have a wonderful opportunity not only as a society, but as chaplains who are the spiritual care providers for many people who are facing a terminal illness.

If you have creative ideas as you mull over these possibilities, why don’t you share them as you begin implementing them in your own settings? We will publish your suggestions in Vision so that we may learn from each other.

It’s time to wrap death up warmly in good surroundings. ✡