

Shaped by lament and hope

by [L. Gregory Jones](#) in the [April 14, 1999](#) issue

Let's face it," my clergy friend said to me. "We clergy are much better with people after they are dead than when they are dying. We know how to do funerals. But we find it very difficult to be present with and to care for people at the end of life."

My friend spoke these words as we discussed what a divinity school might do to begin focusing more clearly on caring for people as they face death. Because of broad changes in medical care and in our culture, more and more people are reaching adulthood without ever having been present when someone has died. I asked a group of 60 undergraduates how many of them had watched someone die or been present shortly thereafter. These students would have a sensory appreciation of the reality of death. Only one student raised her hand.

Yet it has not always been that way. In earlier periods and in other cultures, care for the dying has been a ritual focus for families, friends and other loved ones in a community. Stories and paintings dramatically portray the presence of a community caring for the dying. By contrast to earlier periods, where paintings depict a dying person surrounded by close friends, a typical contemporary portrait would have the dying person surrounded by medical equipment.

What has occasioned this difference? In part, it is a result of the widespread denial and evasion of death in our culture. This has been exacerbated by a youth-oriented culture of progress in which any sign of aging or decay is seen as a threat to be avoided.

Further, contemporary medicine has been focused more on curing than on caring. Indeed, too many doctors see a patient's death as a sign of failure. Recently, as a dying patient was moved from the hospital into a hospice, a resident asked the attending physician: "Why are we giving up?" The resident believed that the physicians should have remained optimistic that they could cure the patient, despite the fact that it was clear the patient was dying.

Our dominant cultural and medical approaches to suffering and death are characterized by complaint and optimism. People tend to be optimistic that any illness or wound can be treated and cured. If for some reason that does not seem possible, we shift into a mode of complaint--complaint about the pain being endured, complaint that medical technology has not progressed rapidly enough, complaint that we are not devoting enough resources to saving the lives of those we care about.

As a result, our medical practice, our cultural expectations and even our training as clergy converge so that we continually intervene to try to cure people all the way to their dying breath. It is no wonder, then, that such a disproportionate percentage of our medical resources is spent on people during the last six months of their lives. Nor is it any wonder that, despite its horrific ethical and theological implications, physician-assisted suicide has begun to attract sympathetic attention. We somehow fear that the only alternatives we have are either costly intervention up to the point of death, or a seemingly compassionate physician-assisted suicide. If those are the only options, then it should not surprise us that Jack Kevorkian could appear to some to be a sympathetic hero.

Fortunately, there are alternatives for those who want to provide better care for the dying. In *Practicing Our Faith*, Amy Platinga Pauw notes that the Christian practice of dying well should be shaped not by complaint and optimism, but by lament and hope. We can draw on centuries of Christian wisdom and faithful practice to nourish a commitment to dying well and caring for the dying.

In addition to alternative practices of caring for the dying, Christians can also draw on alternative institutional contexts. Hospice care has emerged in recent decades as an important movement offering first-rate medical, nursing and pastoral care for the dying. More and more patients and families are receiving the gift of competent, thoughtful care from both in-patient and home health-care hospices. The poignant stories of families who have received effective and compassionate care for their dying loved ones offer a compelling contrast to the tragedies of lonely patients dying surrounded by machines, and the horrors of people dying at the hands of Kevorkian and other well-intentioned but ultimately misguided physicians.

We face significant medical, ecclesial and cultural obstacles to recovering the practice of dying well. In 1997, only about 400,000 dying people received hospice care out of almost 1.6 million people who would have been appropriate candidates.

The median stay for people in hospice was less than three weeks, even though hospices are equipped to provide as much as six months' worth of care. Almost 40 percent of those people who did enter hospice had still not been told they were dying at the time they were admitted. More broadly, churches and families are less directly involved in the care of the dying than they have been in previous generations.

Recovering the practice of dying well will require attention to cultural, economic, theological, ethical and policy issues. It will also involve reshaping our theological, medical and nursing education, drawing on Christian wisdom and insights to provide better care for dying persons and their families.

Christians are called to reclaim and sustain practices of caring as well as curing, of being present with the dying at the bedside even when we know that the news we bring is not what the patient wants to hear. We are called to be people of lament and hope rather than complaint and optimism. And, above all, Christian clergy ought to be as gifted in caring for the dying as in providing funerals for the dead.