I have talked with many different groups about the end of life—health professionals, church and civic groups, ministers and chaplains, adult continuing education groups, AARP chapters, and college students. I talk a little about the traditional fear that death will come too soon. Then I ask, “How many of you are afraid that death will come too late for you?” The result is always the same: about half the audience members raise their hands. Obviously, this fear is widespread and close to the surface. Subsequent discussion reveals that for many of them, too late is not restricted to conditions of chronic or terminal illness, but also can include situations where they are lucid and free of significant pain or illness, yet nevertheless believe they have reached a good time to die. This article is an attempt to give voice to their conviction that death may often be worth pursuing—a conviction that I share.

**Our New Kind of Death**

Historically, most people died in childbirth or war, of accidents or infectious diseases. These deaths were usually quick—a matter of a few hours or days between the onset of a terminal condition and the arrival of death, or at least delirious noncomprehension. They also almost always came too soon, before one had a chance to live a full life, raise a family, complete life-defining projects, or make the contribution one had hoped to make. And those who
managed to avoid an early death did not have to contemplate the threat of being debilitated and bedridden for years. Old people who became bedridden usually developed pneumonia, the “old man’s friend.” Since pneumonia could not be treated, they died and were thereby delivered from the peril of a long period of debility at the end of life.

But we have killed the old man’s friend. With better public health measures and the development of medical technology since World War II, we now find ourselves facing a very different kind of death. This new technology has given us better health and longer lives. But it has also given us more debility, dementia, and protracted chronic and terminal illnesses. Joanne Lynn has said that the average American male now is debilitated for five years before he dies, and the average American female for eight years. These numbers will probably grow larger by the time we reach the century mark. These numbers will probably grow larger by the time we reach the century mark.

None of this is news. It is what has been called the epidemiologic transition. But the epidemiologic transition has been called the fourth stage of the epidemiologic transition. But the retrospective cohort analyses of deaths in the United States have shown a striking increase in deaths from chronic and terminal illnesses. But these analyses have also shown a striking increase in deaths from chronic and terminal illnesses. But these analyses have also shown a striking increase in deaths from chronic and terminal illnesses.

Most members of the generation that is dying now were caught off-guard by this new kind of death. They had little or no firsthand experience of long, drawn-out deaths until they came to their own. My mother watched her mother die “a beautiful death” lasting only a few minutes. My grandmother sat down in her rocking chair one night after doing the dinner dishes. She sat there a few minutes, then turned to my mother and said, “Oh, Olga, my whole body feels so light—just as light as a feather.” Then she died. But my mother waited for death for years. She sat in despair at the side of her nursing home bed, repeatedly saying, “Why does this have to take so long? I’m ready to go. I’ve been ready for years. Why does this have to take so long?” Throughout most of her miserable stay in a very nice nursing home, she had little physical pain and no terminal illness. She felt stuck—there was nothing for her to do but wait for death to show up.

We are different. We should not be caught off-guard, for we know what to expect. Almost all of us carry personal horror stories about relatives who lingered on in a frail or demented state, or with chronic or terminal illnesses that lasted a frighteningly long time. These wrenching personal experiences anchor the fear that death will come far too slowly and too late.

This new kind of death has been around only about sixty years, which is a very short time in the evolution of a culture—too short for the changes in the way we die to be thoroughly discussed, much less assimilated. Our institutions—our law, our medicine, our customs and traditions, our ethics, our religions—are all designed to respond to the older kinds of death. They are not well suited to the tasks that confront those of us coming to the end of our lives in the early part of the twenty-first century. Some are beginning to think about how our institutions can be reformed to give us better and more timely deaths, but those reforms are not yet in place, or even on the horizon. Those of us coming to the end of our lives in the next couple of decades will probably have to die without much assistance from health care professionals or institutions, which still concentrate on prolonging life. In this context, we each need to think about steps we can take ourselves, without much support from others. Accordingly, the focus in this article is on the person approaching the end of life. The implications for doctors, nurses, chaplains, gerontologists, and health care reformers will come later, if the task of going to meet death becomes more widely acknowledged and accepted.

The Art of Dying

When death came unforeseen and fairly quickly, there was little or no art of dying. Death just happened to you, often striking completely out of the blue, and your life was over. Little discernment, skill, or wisdom were required to die well—it was mostly a matter of summoning courage for a few hours or days in the face of the inevitable. But a good death now is only partly a matter of good fortune. It is increasingly a work of art. If we are to avoid a death that comes too slowly and too late, we will usually have to do something. It will be up to us to plan to die—to discern the right time, to arrange and prepare for it, and then to do it, or at least to permit it to occur. And since death is something many of us will have to accomplish or arrange for, we can do it well or badly. Dying well today requires wisdom, skill, and prudential virtues. If we lack or fail to exercise these at the appropriate time, we will probably die poorly, too slowly, and too late. (Let me hasten to add that our new kind of death also requires us to master a troubling new ethics; but that is a story for another occasion. Accordingly, I leave to the side as much as possible the harms to others from deaths that come too late. The focus here is on the art rather than the
ethics, deeply intertwined though the two often are.)

There is, of course, a deeply personal element in dying well; a good death cannot involve a violation of one’s own beliefs and values. Moreover, our commitment to patient autonomy ends up effectively requiring each of us to develop this art for ourselves. If we make unwise decisions at the end of life, our doctors may shake their heads at the folly of those choices. They may try gently and briefly to dissuade us. But most will feel that they must manage our care on the basis of our expressed wishes, even if they know—from their clinical experience and from talking with us—that there could be a much better ending to our lives than the one we are choosing.

The deeply personal nature of dying well does not, then, mean that it is simply a matter of individual taste. Grave mistakes are possible and even likely—we are all inexperienced at dying and reluctant even to think about the end of our lives. Moreover, the scripts we have been given for dying well were written for very different scenarios. As one of Lynn’s patients put it, “Nobody in the Bible died like this.” Some people hold beliefs and values that virtually guarantee a bad death. (There are imprudent beliefs and values about life’s end, just as there are about its other important aspects.) The task of providing guidance for confronting our new kind of death is, then, an enormous one.

Acknowledging Life’s Trajectory

Going to meet death requires, first, an honest acknowledgment of where one is on life’s trajectory. I cannot prepare myself, make plans to avoid a death that comes too late, or help ready my loved ones if I cannot even admit that I am coming to the end. At age sixty-nine, I should be aware that I am now approaching the end. I am now too old for the fear that death will come too soon to be a reasonable one. Moreover, at my age I should be ready to die. It’s not that there is nothing more I could accomplish or enjoy, nor that my death is impending. I might live another twenty-five years, and for most of that time may even be in relatively good health. But I should realize that I have already had a full life, complete with the opportunity for many of the good things in life. If I am not yet ready to die, something is deeply amiss in my outlook on life. My basic beliefs and values need revision, for they will not sustain me through the decline that likely awaits me. There is no disrespect or devaluing of the elderly in this. It is simple acknowledgment of the implications of being alive, and aware that we are alive. After old age comes death. I must have known that; I should have been prepared.

Beliefs and values that will sustain us through the decline should enable us to face old age and the end of life without bitterness, self-deception, remorse, or anger. The prospect that my life is just about over should not bring on immense suffering. If the initial shock of a terminal diagnosis does cause me to suffer, I should soon be able to overcome it. The fact that I must die should not strike me as tragic or unendurable. I should be able to come to terms with the fact that my life is concluding. Such an orientation should involve the ability to wrap up, say goodbye, and then leave, all with grace, good humor, and serenity. If I cannot do that, surely my orientation to life is unsustainable in some deeply personal sense.

When it comes to leaving, timing is everything. Since a good death is in large part a matter of avoiding one that happens too soon or too late, it must be brought about at the right time. There are grave perils in tarrying, in procrastinating, in postponing ended up with a long stretch of perfectly lucid and pain-free though meaningless and purposeless days, and they found that unbearable. They could not abide struggling each day to distract or amuse themselves—to somehow fill the long, dull parade of hours. For these women, life simply is not about trying to keep yourself amused, much less comfortable. Their problem was compounded by the absence of any terminal illness—there was no end in sight. I’m not there yet, and I may surprise myself. But for me now, happiness, a deep joy in living, and even basic satisfaction all depend more on a sense of meaning or purpose than on pleasure or having fun. If even pleasure is not enough for me, a string of pleasant days will certainly not be, to say nothing of a string of merely pain-free days.

Some features of the right time to die obviously depend on our internal resources for keeping ourselves meaningfully occupied or simply entertained. My aunt would have done better as a ninety-year-old bedridden and nearly blind nursing home resident if she had had a deeper apprecia-

Learning how to go to meet death is, I believe, one of the basic tasks of our time.
tion of music and more interest in the world of books on tape. I like books and music a lot, but could I happily do nothing but listen to music and books for twelve or fourteen hours a day? Every day? For years? Should I wait and see? It might be wise for me to give nursing home life a try to see what I could make of it. Perhaps I can develop the skills and virtues needed to make that life rewarding. But I should try this only if the exit remained clearly visible and within reach. It would be both foolish and arrogant, I think, to assume that I have or can develop the personal skills and capabilities to do much better with nursing home life than many of the current residents of such facilities.

For most of us, there will not be a bright line separating a life of acceptable quality from one of unacceptable quality. We will not wake up one morning to find that life is much, much worse than it was the night before. Yet at some point we would be wise to draw a line. Those who are not granted an obvious place to do this must exercise discernment, self-awareness, and wisdom in order to make a very difficult judgment. But this is easier said than done. We know that if we do not step up and find a place in our declines to call a halt, death will likely come too late and take too long. But how can we summon the wisdom to draw this line in a good place?

Our medical conditions can, of course, provide relevant information. Progressive diseases can be calculated. Treatment can be tried and its efficaciousness assessed. Also relevant is whether one has a condition that might well precipitate sudden incompetence. We can no longer rely on the inexorable progress of a chronic or terminal illness or the limitations of our medical technology to define the endpoint for us. Waiting for a terminal diagnosis is, we know, dangerous—that’s no way to draw the line. There may or may not be any medical treatment to be discontinued. The right time to die may also not be marked by pain or even the exhaustion of combating a chronic illness. Indeed, there may well be no medical marker at all for the right time to die.

Thus, we face the task of discerning—sometimes without the aid of medical indicators—a good time to die. Deep questions about what life is all about must be faced and resolved in order to draw the line appropriately. These deep concerns are not new, of course—they are central to what makes us human. What is new is that the advances of medicine thrust basic questions about the purpose and meaning of life into our faces: What do I now want to use more life for? What will it enable me still to do or to enjoy? And what risks do I undertake if I choose to live on? Even if I have the health, do I have the will and the energy to undertake new initiatives? If I have recently suffered major losses, do I still have the will, the ability, and the self-confidence to be reborn as a new self with new projects or new sources of meaning? If I could still do that, is there value on balance in doing so? Or would doing so undermine values to which I have long been committed and thus threaten my personal integrity and the coherence of my life? We will have to find—or define, or become aware of—our answers to such questions, and then embrace the answers with enough conviction to use them to discern when our time has come.10

The Doctor, the Family, and the Priest

The kind of questions that can help us draw a line do not fall within the purview of medicine, and this marks a basic change. When death was likely to come too soon, the doctor was the pivotal figure and the hospital the favored place for it once they had proven that they could prolong life. Accordingly, when illness threatened life, the family and the spiritual counselor11—whom I will call the priest here—were displaced from the center to the periphery. Staying at home became an unwise decision for the ill—much better to call 911 and then press for admission to an intensive care unit. That was only sensible. And once the sick person had entered a hospital, the family and the priest were irrelevant at best, and at worst, in the way—they might inadvertently interfere with the attempt to save the patient’s life. As a result, they were relegated to the corner of the hospital room, where they watched anxiously and ineffectively.

But when death comes too late, the doctor becomes much more peripheral, especially if the right time is not marked by a terminal illness or untreatable symptoms of chronic illness. The pivotal issues when death comes too late are deeply human or spiritual concerns about discerning the right time to die, wrapping up a life, preparing loved ones, and then leaving. The traditional order is thereby restored: the family and the priest again take their rightful place at the side of the one whose life is drawing to a close. The home becomes once again the right place for most of us to die, held by our loved ones, not a respirator.

Although our families and priests belong at our side when we face the end, many of them are not comfortable there. Most families cannot even begin to have honest discussions about the right time to die. The priest may feel his or her theology is deeply challenged by the idea that the right time to die may be unmarked by serious illness. Many of us cannot talk with our priests about the right time for suicide—our moral and religious codes forbid even thinking along these lines, much less discussing it. A “pro-life” priest will probably seem pathetically wrongheaded in the face of death that comes too late.

Central or not, our doctors and other health professionals could certainly help. But they, too, may be deeply troubled if we share plans with them for ending our lives, especially if we have no terminal illness that we have fought for a respectable length of time. They thus become unable or unwilling to offer even what help and
support they could. If I am planning to end my life, most doctors would probably not want to help me strategize or assist in my plans, and many would not even want to know. Death—and particularly, death that comes too late—also threatens the professional values of physicians. Will I then need to lie to my doctor? If I intend to use prescription drugs, will I need to make myself the patient of several doctors? Or make a trip to a veterinary dispensary in Mexico? If I am considering a nursing home or extended care facility, it will be much more difficult to assemble (or even to retain) the means to end my life. Knowing this, should I ask the nursing home whether they would support a competent decision to stop eating in the absence of a terminal illness? Or would that question simply horrify them and make my time there more difficult under the increased surveillance of a staff that has been warned about me?

Without a social practice or a compelling moral tradition and very often without physician, priest, or family able to understand and support an active end to life, many of us will have to do this individually, each for herself. Indeed, some of us will have to act secretly, even furiously, enacting carefully concealed plans. If so, we obviously will not be able to seek counsel in honest conversation that could help us avoid unwise choices, poor, misinformed, or depressed judgments, ineffective means, or even bad timing. And since each must take the necessary steps for herself, we will need to take them while we’re still competent and comprehending.

**Getting Stuck and Unstuck**

Those who fear that death will come too late usually also fear that they will get stuck waiting for a death that comes too late. My mother lived to regret having accepted treatment for her cancer and also a later, panicky decision to press her medical alert button. She missed her opportunity to die at the right time, and then she was stuck with no way out.

There are many ways one can get stuck, the insidious decline into incompetence being one of the most common. If we become demented, or even frail and institutionalized, we will probably fall into the hands of caring and conscientious people who will feel themselves professionally responsible or legally bound to prolong our lives—often even long after almost everyone would acknowledge that to do so is not in our interests—fully weighed. But pursuing this line of thought would take us quickly into the ethics of dying.)

One can also get stuck due to moral, social, or religious traditions. There are strong religious proscriptions against suicide and elaborate deployments of the doctrine of double effect to avoid the conclusion that someone took an innocent life. There are blanket ethical proscriptions against suicide, as well. Those who accept these prohibitions will face much more difficulty avoiding the perils of

It is now up to us to plan to die—to discern the right time, to arrange and prepare for it, and then to do it, or at least to permit it to occur.

especially if there is no medical treatment to be refused or discontinued. My blind and bedridden aunt found her way out by refusing to eat, and her nursing home supported her decision. She was lucky. Many nursing homes would have had a gastrostomy performed and then fed her, especially if her horrified family had threatened to sue.

For one’s family can also leave one stuck. They may be shocked or appalled by an act of ending one’s life, or deeply pained by a decision to forego a life-prolonging medical treatment that is very likely to be successful. One can get stuck due to unwillingness to hurt them in this way. Most of us care about the emotional baggage we may leave our partners or children, who will have to come to terms with the fact that we deliberately took steps to end our lives. One can also be stuck if family or friends would regard suicide as an act of cowardice, disgrace, or personal failure. Many of us will need to carefully weigh our ability to resist pressure from others to live on. (This is not, of course, to say that the ramifications of one’s death on loved ones should be ignored. They ought to be very carefully considered, for they will have to surmount internal barriers of ambivalence created by moral or religious self-condemnation.

Those of us who are confident in our ability to calmly end our lives when it is time to die can more safely accept medical treatments. We are less likely to get stuck. We have our ticket out of here, and we can use it at any time. Of course, this self-assessment had better be accurate. Those who believe they will be able to end their lives only to discover that they are wrong can find themselves stuck. But those who know that they are unable to commit suicide or to refuse to eat need to be much more cautious about accepting medical treatments. They lack the escape routes available to others. At the end of life, treatments should sometimes be declined precisely because they will be successful—a medical intervention that restores someone to a perfectly satisfactory state of health may also leave her stuck.

There is, however, still an element of good fortune in a good death: despite careful plans and our best efforts, we could still get irremediably stuck. Sudden incompetence—from a
massive stroke, for example—can leave a person doomed to wait life out.

**Letting Life End, and Ending Life**

Some people will find that they are granted a convenient exit—a terminal event that comes at the right time and then kills them very quickly. But it is foolish simply to hope against hope that we will die of a massive stroke or heart attack. Few of us will get a death like that. Alternatively, for those who want a little time to wrap up our lives, the most convenient exit would be a terminal illness that comes at about the right time, allows us to live a life of acceptable quality for a time, and then kills relatively quickly, but with a few weeks of warning and without much discomfort. That, too, is highly improbable—what a remarkable confluence of happenings that would take! That is not the way most of us will die. Still, these illnesses happen, and they provide a relatively easy way out.

Less convenient are terminal illnesses that we decide to allow to become terminal much more quickly than they might otherwise. Such exits require hard decisions, courage, and resoluteness, but refusing life-prolonging treatment for a terminal illness is well-charted terrain and is supported in many circles. Hospices and palliative care units stand ready to wrap up our lives, the most convenient exit would be a terminal illness that comes at about the right time, allows us to live a life of acceptable quality for a time, and then kills relatively quickly, but with a few weeks of warning and without much discomfort. That, too, is highly improbable—what a remarkable confluence of happenings that would take! That is not the way most of us will die. Still, these illnesses happen, and they provide a relatively easy way out.

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Along these lines, we could resurrect the old man’s friend. Pneumonia can be cured simply, relatively quickly, and inexpensively, without lasting side effects or a long and difficult recovery period. But at the end of life, pneumonia is a friend; it provides a timely exit. Most contemporary bioethicists find no morally compelling reason that treatment for such a disease must be accepted by a competent elderly patient. Yet many bioethicists, health care professionals, and others would find it at least mildly disconcerting that an otherwise healthy, fully competent elderly person declined treatment for a simple pneumonia solely on the grounds that it is time for her to die. That exit will probably be significantly less convenient because we still expect an untreatable or chronic illness to indicate that the time to die is at hand.

Still less convenient, perhaps, is mindfully accepting risks that might well result in death. I know of an elderly woman whose entire family converged on her home at the end of a dirt road far back in a hollow in Appalachia. “Mom,” the children pled in unison, “you’re getting tottery and frail, and you don’t even have a phone! Sooner or later, you’re going to fall and break a hip. Then you’ll lie here on the floor and die of dehydration, probably before anyone even knows that you’ve fallen.” “That’s okay,” she responded. After a long and difficult discussion, the family decided to leave her as she was, knowing that her end would likely be lying on that floor unable to get to food and water, or to summon help. Many families and physicians would find her deliberate acceptance of this risk simply unacceptable. They would push a phone and a medical alert button on her, making this exit less convenient. In fact, we now have monitoring devices that enable a family member at a computer a thousand miles away to check to see whether you’ve gotten out of bed, eaten breakfast, even taken your medicines. We have the technology to close this exit.

Some can go no further than this. Life-prolonging treatments can be refused, risks can be consciously accepted, but that’s all. More active steps are forbidden or simply too forbidding. Yet a few months ago, within the space of a single week, four completely healthy friends mentioned their plans to commit suicide when they get old and feeble. Four in one week! Although these friends know that I write about end-of-life issues, their statements were not responses to anything I had said. They brought it up completely out of the blue. Two are especially memorable, one because it was between sets of a singles tennis match. I have no idea what made my tennis partner think of suicide at that time. (He was not playing poorly.) Another was at 7:30 a.m., interjected into small talk over a cup of coffee. That friend went on to say that she is already talking with her children about her plans, “trying to normalize it within my family so that no one will be surprised, shocked, or upset when I end my life. When I end my life, it will be something my family will have been expecting for a long time.” We looked at each other with a flicker of recognition.

Avoiding a death that comes too late certainly does not always involve suicide. But often, I think it does. Suicide is sometimes perfectly fitting and morally acceptable—sometimes even morally praiseworthy. I believe that suicide is morally very different when your life is all but over than when it is just beginning or somewhere midstream, while there is still time and strength to turn a life around. In any case, if one can truly make one’s peace with it, suicide can clearly give one a much better death than most alternatives. That much must be obvious in an age where even some hospices—precisely because they aim to provide a good death—are using terminal sedation, sometimes on a large percentage of their patients.

If suicide is unacceptable, there is the informed choice to stop eating. This is in some ways harder. It is perhaps also safer, with time for second thoughts and reconsideration. Some people believe that death due to starvation is one of the worst deaths possible. But those who have fasted for long periods report that the hunger goes away after a day or so. After that, one feels a lack of energy and drowsiness. If so, that’s not so bad. And hospice nurses—who should know a good death when they see one—rate death due to a deliberate decision to...
refuse food and fluids as a very good death: a nine on a scale of ten.15 We know that we have a widely accepted right to refuse medically supplied nutrition and hydration. But first, medically-supplied food or fluids must be necessary. We may need to get to that by choosing not to eat.16

If suicide is not an option and the will to stop eating is not strong enough, then many of us will get stuck with a death that comes too late. This is simply the flip side of the fact that there may be no lifesaving medical treatments to be discontinued at the right time to die.

Bringing a Life to a Close

Having discerned a good time to die, strategized about how my life can best end, and made plans and preparations, what remains is to bring my life to a close, both within myself and also with family and friends.

Bringing life to a close involves recognizing that my life is over in some deeply human sense—my biography is now largely complete. Not complete, obviously, in the sense of having done everything I hoped to do and seen everything I wanted to experience. Biographies can never be complete in that sense; no life is extensive enough to encompass all goods. But as my energy fades and my time horizon closes in, surely I must recognize that I will not be able to accomplish these goals. Even if I live on, there is no longer much I can add to my story, and my part in the ongoing drama of my community and even in the unfolding lives of my loved ones is pretty much over. I then need the wisdom to acknowledge “this is enough,” or “I’ve done what I can do.”

There will inevitably be many things that I wish I had done and experiences that I wish I had had. There will also be many things that I wish I had not done but that I no longer have the strength, the energy, the time, or the wit to alter. Moreover, many things cannot now be undone—choices have been made for a very long time now that inevitably leave roads forever not traveled, harms unalterably done, and ill will irretrievably sown. I must not, then, succumb to the temptation to tarry because I wish things had been different or find things I wish I had done. If there are still a few important things I can accomplish, I must hasten to do them.

Having recognized that I am in the end game and having tied up what loose ends I can, I need to evaluate and come to accept the life I have lived, or failing that, at least acknowledge that it is now beyond my strength to significantly alter the course of my life. Some measure of self-forgiveness will be required.

For those who have not outlived their loved ones, there will also be interpersonal dimensions of bringing a life to a close. I should have passed the torch to others, wished them well, and left them free of heavy burdens of guilt, anger, and opportunities I have destroyed. If I have loved ones who will survive me, I should have tried to heal broken relationships. If I have a partner, I should have prepared her to go on, and helped her to know that she can be whole and her life full and rich without me. My sons and daughters should have received my blessing. I should have done what I can to ensure that they face at least the same range of opportunities for a good life as I have enjoyed. Hopefully, I will have helped them to become stronger, more capable, more joyful, and saner than I. Hopefully, they will do better, and their lives will be better, than mine.

This interpersonal dimension of going to meet death may be difficult for my family and loved ones. Simone Weil has somewhere written, “In loving, we need to learn only to let go—holding comes naturally.” My family may, then, need both permission and preparation if they are to hug me instead of calling 911. Perhaps they could even be helped to feel glad that I did not tarry. If I plan to end my life by suicide, my family and loved ones should, if possible, have been prepared and able to feel the appropriateness and deep serenity of that decision. Even the goodbyes can be said in advance. Toward the end of her life, my mother always said goodbyes with an undertone of possible finality—“I don’t know whether I’ll be here the next time you come.”

Finally, I believe there is also something to the idea of not hanging around the stage after you’ve said your final speech. The actor is supposed to exit when he no longer has a role to play in the drama unfolding around him. He is not supposed to stand—or lie in a nursing home bed—in the corner, trying to stay out of the way of the story developing around him but distorting the entire drama despite his best efforts. And honesty compels me to admit that I could one day be largely irrelevant (at best!) to the lives of even my loved ones. Would my highest virtue then be to try, quite unsuccessfully, to stay out of the way? Having reached the end of my life, wrapped it up, and concluded, it is better, I think, to leave than to wait around in some corner for the curtain to come down. To wait is also to tempt death to come too late and to risk getting stuck.

The Human Task of Dying

Something like all this is, I believe, the new art of dying. We need to learn how to go to meet death. If we do not go to meet death, our medical technology will keep death at bay.
until it is far too late. A good death is no longer primarily about good luck or about the technological brinksmanship involved in successfully navigating as close as possible to the brink without falling into the abyss. It is about the deeply human task of recognizing the right time and then bringing a life to a close.

This is something we all can do. If this is what it takes to die well, we all—barring sudden incompetence—have the wherewithal for a good death within reach. We just need the wisdom to know when, and then the virtues and skills required to step up and do it. Some people understand this art and are fully prepared to practice it. But perhaps most will find it very difficult. And once again, many of us will be completely on our own here, prey to whatever errors in judgment, misinformation, miscalculation, and distortion due to prevailing moods or mental illness that we may be subject to.

It does not have to be this way. It is possible that our difficulties with our new kind of death are all transitional. Advances in medicine have given us tremendous new powers, but we do not yet know how to use our new capabilities wisely. We do not even yet know how to think about the ways our lives now end, much less how to develop the skills we will need to bring our lives to a fitting close. But it may be that in time people will work all this out. They may look back on the difficulties we faced at the turn of the millennium and marvel at our inability to help those who are ready to die or even to call a halt to medical intervention, and distortion due to prevailing moods or mental illness that we may be subject to.

I assume for the purposes of this paper that aging and its accompanying frailty, limited mobility, and dementia will not be "cured" in our time if, indeed, they can be cured at all. It is an interesting but largely speculative question whether more life would always be a good if it were accompanied by good health and no physical or mental deterioration. I do, however, now have a few students who say they expect to live to be four hundred years old.


4. Although it should be obvious, I should state explicitly that this is not a paper about younger people. There are important differences between death in your twenties and death in your seventies or eighties. I am discussing the latter. In one sense, death can come too late for a thirty-two-year-old with a budding career and two small children. Her terminal illness may take too long to kill her, and she may justifiably take steps to shorten her dying process. But there is also a sense in which her death, unlike that of a much older person, comes too soon. As Daniel Callahan has pointed out, there is something tragic in her death that there can no longer be in that of an old person.

5. "Prudential virtues" may have an unfamiliar ring—ethicists normally associate virtues with ethics. But there clearly are prudential virtues: saving for retirement, exercising enough to maintain your health, resisting the lure of a promotion that will involve unsatisfying work. But we are tempted to go on a nice vacation instead of saving, to skip the planned workout, and to bask in the light of the more prestigious position. None of these things are immoral, but they are temptations to act imprudently. Though he did not explore this insight and most commentators also skip quickly over it, Kant clearly recognized that there are "hypothetical imperatives," and that these are genuine imperatives. Impulses and specific desires tempt us not to follow the imperatives of prudence, just as they tempt us to disobey the categorical imperative.


7. J. Lynn, “Living Long in Fragile Health: The New Demographics Shape End of Life Care,” Hastings Center Report Special Report 35, no. 6 (2005): S14. I also owe to Lynn the idea that many dying people are not exactly choosing what they want. Rather, they are trying to live out some model of how one is supposed to die. It is, after all, our last chance to do something well, and our one chance to make a good final impression.

8. Certainly, there are also lives that have contained few opportunities for the good things in life. As they draw to a close, part of the tragedy of such lives is that the opportunities they never had are now irretrievably lost.

9. Obviously, those who believe that "rage, rage against the dying of the light" is an appropriate attitude at any age will disagree—Dylan Thomas, for one. He famously said, "old men should rage against the dying of the light."

10. Needless to say, there are also deep existential or spiritual reasons for prolonging life indefinitely, even in the face of great pain and suffering. Some of these continue to make sense deep into dementia (to others, even if not any longer to the demented person). But exploring these reasons would be the subject of a different paper.

11. I use the word "spiritual" here to refer simply to one’s most basic beliefs, values, and attitudes—the beliefs and values that
These beliefs and values may or may not contain a religious element. Also, one’s religion may or may not provide one’s spiritual orientation.

12. For example, “professional psychiatric and psychological training reinforces the view that suicide is a manifestation of psychological disturbance. As such, mental health clinicians typically view suicide, regardless of context, as an outcome that should be prevented at all costs.” And this in an anthology about palliative care for the terminally ill! B. Rosenfeld et al., “Suicide, Assisted Suicide, and Euthanasia in the Terminally Ill,” in H.M. Chochinov and W. Breitbart, eds., Handbook of Psychiatry in Palliative Medicine (New York: Oxford University Press, 2000), 53.

13. I persist in using the word “suicide” despite pleas from some who are sympathetic to my position that I change my vocabulary. This word has overwhelmingly negative—even pejorative—connotations, and some mainstream health and medical organizations (such as the American Public Health Association and the American Academy of Hospice and Palliative Medicine) have adopted more value-neutral terminology such as “aid in dying.” Undoubtedly, this change serves their purposes well. But I think it is misleading to talk about physician “aid in dying” for someone who has no terminal illness. Although in one sense, it could still be “aid in dying,” the problem is often precisely that death has not shown up. Better, perhaps, to try to rehabilitate the once respectable way to end a life than to substitute a somewhat misleading euphemism. There are ethical and unethical suicides; prudent and foolish suicides; suicides resulting from mental illnesses and depression, and suicides resulting from wisdom and courage. Indeed, my basic thesis is that advances in medical technology require many of us to learn to end our lives. The blanket condemnation of all suicides may serve as a useful rhetorical deterrent, but it will not withstand scrutiny.

14. One study found that 52 percent of patients with metastatic cancer in home-based hospice care received terminal sedation. Another reported that 48 percent of 143 patients in a hospice received terminal sedation. A third found retrospectively that 31 percent of hospice patients had received terminal sedation. References to these and other studies can be found in P. Rousseau, “The Ethical Validity and Clinical Experience of Palliative Sedation,” Mayo Clinic Proceedings 75 (2000): 1064-69.


16. But is a deliberate decision not to eat suicide? Some would find that option morally preferable to or easier than more active forms of ending life. This issue, too, has not been worked out. Certainly if I stopped eating and drinking today, everyone would say that I committed suicide. The health care literature has developed an alternative vocabulary—“voluntarily stopping eating and drinking” (VSED)—and there is an emerging discussion of the ethics of this option. See T.E. Quill, B. Lo, and D.W. Brock, “Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia,” Journal of the American Medical Association 278 (1997): 2099-2104, and discussions referring to this article. But again, VSED is usually assumed to be limited to terminally ill patients. Why?