Ethos, Mythos, and Thanatos: Spirituality and Ethics at the End of Life

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Abstract

Every ethos implies a mythos in the sense that every systematic approach to ethics is inevitably based on some fundamental religious or religion-like story that gives answers to questions such as: Where did I come from? Where am I going? How am I to live? These narratives generally lay hidden beneath the plane of the interpersonal interactions that characterize all clinical encounters, but caring for patients who are approaching death brings them closer to the surface. For many patients and practitioners, these narratives will be expressed in explicitly religious language; others may invoke a sense of “immanent transcendence” that affords a spiritual perspective without requiring theism or notions of eternity. In caring for patients at the end of life, practitioners should strive to be more conscious of the narratives that undergird their own spiritual and ethical positions as well as seek to understand those of the patients they serve.

Key Words

Spirituality, ethics, religion, hospice, palliative care, physicians, nurses

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express these fundamental beliefs, even if not religious, must be considered at least religion-like in their character. The story of Adam and Eve in the Garden of Eden, for instance, is one such story. Just so, however, is the story of the “Original Position” as told by the philosopher John Rawls, a story that is full of assumptions about who the people are in this mythical original position, standing behind the mythical “Veil of Ignorance,” and choosing what their society will be like.3 Secular bioethics is full of such mythical stories, replete with built-in assumptions about the answers to the most basic questions facing humankind, even before one begins to draw out the bioethical implications of these stories. For another example, think of the bioethics of an author such as H. Tristram Engelhardt. His libertarian bioethics is founded on some very foundational commitments that find expression in stories. Sometimes, one must dig deeply into what seem like purely rational philosophical musings to find the stories, but they are there. I have called the myth that undergirds Engelhardt’s libertarian bioethics, with its emphasis on individuals and their liberty, “The Myth of the American Frontier.”2 As he explains it in a footnote in one of his books:

This description somewhat foreshadows the American frontiersmen who moved on further when the smoke from too many neighbors’ houses could be seen, or the old Texas view that “your neighbors are too damn close when you can’t shoot in all directions without fear of hitting someone.”4

The bioethics that flows from such a mythos will be shaped by it.

Charles Taylor has written in secular philosophical terms about the fundamental, self-identifying, and morally originating commitments on which various systems of ethics are based.5 He argues that each and every system of ethics requires answers to such questions before it can get off the ground. He calls these “strong evaluations.” There is no ethics from nowhere. Even if these self-identifying and morally originating commitments are not religious, these comprehensive sets of assumptions are really sets of religion-like beliefs. As the saying goes, it takes a lot of faith to be an atheist. The answer to the question of whether there is a deity will require just as much or as little faith if one answers the question in the negative as in the affirmative. And it will require equal amounts of courage to live one’s life in accordance with the fundamental moral commitments that flow from one’s answers to such questions.

In thinking about the ethics of caring for patients at the end of life, then, it pays to attend to the mythos that undergirds any ethical position that may be proposed, whether that mythos is religious or secular. In thinking about addressing the spiritual and existential needs of patients at the end of life, it pays to attend to the mythos in which such needs are framed. Every mythos about care at the end of life concerns itself, implicitly or explicitly, with an account of Thanatos (the Greek demiurge of death). That is to say, there is no spirituality of care at the end of life and no ethics of care at the end of life that does not presuppose some account of death that comes from a faith-like set of beliefs, often embodied in narrative, beyond the reach of bare reason or brute fact.

Care at the End of Life and the Big Questions

The profound questions that one confronts in all of medicine are brought into sharp focus when caring for patients at the end of life. Superficially, one faces questions such as whether to use oxycodone or morphine to treat a patient’s pain; whether intravenous hydration helps or hinders a patient’s quality of life in the last hours or days. But underneath the clinical and scientific questions lurk the very deepest questions that religions and philosophers have long sought to answer, questions about the origin of life and of death; how to define joy; whether physical suffering can have a purpose; about the scope of freedom and the place of responsibility; about the power of love, the necessity of contrition, and the role of reconciliation; about the nature of good and whether there is such a thing as evil; about the relationship between the finite and the infinite; and many more. The answers we give to these questions—as practitioners, as patients, and as a society—form the moral and spiritual infrastructure on which hospice and palliative medicine are founded. Because the clinical practice of hospice and palliative care often
lays these very powerful questions bare, many health care professionals shy away from this area of medicine. This is understandable. Most people do not want such questions thrust in their faces on a daily basis. Thankfully, however, others are drawn to care for patients at the end of life, whether consciously or unconsciously, precisely because this area of specialization forces them to confront these questions.

**The Spiritual Roots of Palliative Care**

Because of this, it should come as no surprise that the roots of contemporary hospice and palliative care have been religious and spiritual. Some of the earliest hospices in the modern era, such as St. Vincent’s in Dublin (1834), St. Rose’s (1899), and Calvary (1899) in New York, were founded by religious sisters specifically to provide comfort care for the dying indigent. It is well known that the deep Anglican faith of Dame Cicely Saunders was instrumental in her founding of St. Christopher’s Hospice in London in 1967 and in her shaping of the contemporary hospice movement. More recent leaders in hospice and palliative care such as Michael Kearney continue to give voice to a profoundly, if broadly conceived, spiritual inspiration for the field. Although it is true that the field has been in many ways secularized, it remains the case nonetheless that many of those working in hospice and palliative care today are drawn to that work for spiritual reasons.

**Belief and Medical Action**

The central thesis of this essay is that our fundamental self-identifying and morally originating commitments regarding the most profound questions that all human beings must face—questions that lurk always beneath the surface of medical practice—inform our attitudes and shape our actions in the work we do in caring for those who are dying. For instance, Curlin et al. have shown that while 69% of U.S. physicians are opposed to physician-assisted suicide, 84% of highly religious physicians are opposed. Whether one acknowledges it or not, the big ethical questions have a spiritual as well as a moral character. So, for example, if the self-identifying and morally originating mythos that informs one’s life is the story of human progress, then death will remain a perpetual enemy and one will pursue biomedical research with a spiritual zeal; regenerative medicine and transhumanist ambitions will be seen as instantiating human excellence rather than as pursuits to be viewed with caution or suspicion. If, in accord with the tenets of one’s underlying mythos, death is utter annihilation and physical suffering is pointless, then it is difficult to see how one could be opposed to the legalization of euthanasia and assisted suicide on any grounds other than fear that these practices will be abused.

**Religion, Spirituality, and Ethics**

Religions also have answers for these sorts of questions and are often much more explicit about the stories that express the fundamental self-identifying and morally originating commitments of those that profess the religion. Religion and medicine meet at the same junctures in human life, and both have a great deal to say about the most significant aspects of human existence, such as birth, sexuality, the raising of children, sickness, suffering, and death.

In caring for patients at the end of life, suffering and death are the main concerns. To illustrate how religious content can influence the ethical decisions and the spiritual and religious concerns of dying patients, consider the following two passages, one from Hinduism and one from Christianity.

In the *Bhagavad Gita* (8.6), one reads the reply of the god Krishna to the inquiries of Arjuna who is facing the prospect of death on the battlefield: “On whatever sphere of being the mind of a man may be intent at the time of death, thither will he go.” Stories such as this one have deep resonances for Hindus, helping to explain, for instance, why a Hindu might be reluctant to treat pain with opioids. Consciousness at the time of death is of great value, allowing preparation for one’s death and, in part, determining one’s fate in the afterlife. Hindus typically also place great value on dying at home, and may not wish to stay in the hospital or a nursing home or even an inpatient hospice as they approach death, because the familiarity of family and home also can prepare them mentally for death.
Such stories can even resonate across religions. Buddhism, which owes a great debt to Hinduism, has similar teachings about consciousness and death. And the great Christian poet, T.S. Eliot, also approvingly incorporates this verse from the Bhagavad Gita into his poem, “Four Quartets.”

The Christian saint, Francis of Assisi, includes a verse praising God for death in his poem called “The Canticle of Creatures,” in which he praises God for the wonder of the created world, calling the sun, the moon, fire, water, the wind, and plants his brothers and sisters. Finishing this poem and adding this final verse on his deathbed, Francis writes:

Praise be you, my Lord, through our sister Bodily Death,

From whom no mortal being can escape...

Blessed are those whom death will find in Your most holy will,

For the second death shall do them no harm.

This poem suggests that death is not an enemy and would fortify a believer to face death as inevitable. Like the Bhagavad Gita, it also speaks of the afterlife but emphasizes having lived a life in accordance with God’s will rather than emphasizing consciousness at the moment of death. Thus, for a Christian, the risk of diminished consciousness should not be an absolute barrier to taking opioid analgesics or other potentially sedating drugs at the end of life. Catholic Christians, like Francis of Assisi, also would want to be sure they stood in right relationship with God before death and would seek the Sacraments of the Sick, Reconciliation, and Communion before death. To try to escape from the inevitability of death by means of euthanasia or assisted suicide would be considered ironic attempts to assert control in the face of what “no mortal being can escape” and would be considered practices outside the “most holy will” of God.

Conclusion

From these arguments and brief examples, it should be clear that the underlying mythos of a person says a great deal about his or her ethos in the face of death, partly determining that person’s spiritual and existential needs and partly determining his or her moral acts. Conversely, I have argued that every person’s spiritual and existential needs and moral convictions surrounding death depend on some sort of story that embodies the person’s needs and convictions and partly determines them, whether that story is explicit or not. These stories need not be religious, nor does a person’s spirituality need to be religious. Whereas spirituality invokes the transcendent, Charles Taylor has described a common contemporary Western belief that he calls “immanent transcendence”—a belief in something that transcends the person and his or her needs and preferences but is circumscribed by the bounds of society or humankind or the world or the universe and is not “supernatural” in the sense of being beyond nature. Death becomes, in this secular spiritual view, “the paradigm gathering point for life.” Fundamental self-identifying and moral commitments based on some version of “immanent transcendence” can (and often do) undergird the spirituality of patients and practitioners.

Every ethos implies a mythos. Where did I come from? Where am I going? How am I to live? Every physician, nurse, and patient, whether consciously or not, is committed to some sort of story that answers these questions, whether expressed in the language of the Big Bang or of the Exodus of Israel from Egypt. Careful, mindful practitioners will understand this and will reflect on their own deepest self-identifying and morally formative convictions and work to understand, as best they can, those of the patients they serve. The implication, frightening as it may be, is that the work of health care is itself more profound (perhaps even sacred) than we usually recognize, an awareness that the approach of death will often make manifest in mysterious and myriad ways.

References


