ARS AMANDI – ARS MORIENDI

"The art of loving intimately impacts on the art of dying in the field of Palliative Care."

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A GOOD DEATH
"A good death is to die loving and being loved"
Gerard Manion OAM

LOVE
"Love is the active care and concern for the growth to wholeness of the person."
C.B. Keogh

Is there any more dignified way to die?

ABSTRACT

Years ago Michael Kearney urged us to consider the risk of Palliative Medicine becoming "just another specialty." The aim of the very different practice of Palliative Care is certainly unique in its calling for the practitioners to be a people of compassion towards the dying person.

The very notion of care summons up the reality of love which is the essence of compassion.

This call for compassion summons all involved in that care to love the dying patient to the point of identifying with the person's experience. Our concern must be for addressing the most intimate needs of the whole person.

The word care is part of any definition of love. Love needs to be understood as a function of the will, defined as "The active care and concern for the welfare and growth to wholeness of the person." (Keogh 1975) or "The will to extend oneself for the purpose of nurturing one's own or another's spiritual growth." (M. Scott Peck).

Palliative care means far more than the management of the patient's physical pain and comfort.

This is an extraordinary call to all those people comprising the palliative care team. Death is the most profound of mysteries. There are no experts from whom to learn. The experts have gone beyond the experience, and are no longer available.

Our work with terminally ill patients over forty years required that we look to finding a way to answer that call by daring to venture into the realm of the transcendent, risking the uncertain. The practice of the art of loving belongs, of course, in the realm of mystery.

The dignity of the dying person urges us to compassion and to the enhancement of the nobility of the role of palliative care.

THE ANATOMY OF COMPASSION

Compassion is the evident recognition of the dignity and preciousness of the suffering person being cared for.
Consequently indispensable to the practice of palliative care! Its *sine qua non*.
Compassion is the fruit of mindfulness.
Compassion relies on imagination, as does all art.
Sir William Osler asserts medicine is an **art**.
Compassion is the art of loving. It animates science.
It addresses the whole person, not just the body.
It can elicit communing, not merely communication.

What does compassion look like?
Unhurried presence, warm, relaxed, intimate, calm, gentle, caring, personal, listening, consistent, unconditional.
Compassion equates with love, mercy, magnanimity.
"Twice blest. It blesseth him that gives, and him that takes."
Compassion is **not** cold, abrupt, symptom-focused, clinical, shy. self-conscious, mean, faint-spirited, selective, conditional.
Not to be sacrificed for efficiency. They are not mutually exclusive.
Compassionate practitioners don't DO compassion.
They become compassionate.

HOW CAN PALLIATIVE CARE ENABLE THIS?

Only with compassion! The dying person **needs to know** he/she is loved.

As healers who claim to care for those who are suffering and dying we need to recognise the paramount importance of compassion. It is the *sine qua non* to the practice of palliative care, whatever our own self-image. We need to embrace the meaning of love as including care. Compassion is about otherness, selflessness. It calls for boldness and even a readiness to risk misinterpretation. It is about magnanimity.

The compassionate are not timorous. The dying person needs to know he or she is loved in order to die loving, so compassion must be evident. We need to make it obvious. Spend the time, make it warm, loving, personal. No way is it unprofessional. It is no longer a time to cure. It's a time of healing. The ultimate going away present.

References
Hutchinson, Tom A. (2011) Whole Person Care, Springer.
Kearsley, John H. (2011) " In the nighttime of your fear: the anatomy of compassion in the healing of the sick." Palliative and Supportive Care, Vol 9, 215-221.
Kellehear, A. (2005) Compassionate Cities, Routledge.
Manion, H-A., Manion, G. Dansie, K. (2011) " Discovering Options." International Perspectives on Public Health and Palliative Care, Routledge, pp 139-155
Roy, David J. (2011) " Words for Hard truths" Journal of Palliative Care, 27;1 Spring, pp. 3-4.

COMPASSIONATE CARE BY FAMILY, FRIENDS AND NEIGHBOURS

THE DYING AT HOME PROGRAM – 32 YEARS ON.
www.dyingathome.org

Over thirty years ago a dying cancer patient wanted to know if he could remain at home to die. He wanted to die with his family and his friends gathered around him. We enabled him to do just that.

Then, every time it happened it created a love story affecting everyone involved. It brings together family, friends and neighbours as they journey together in this precious time of life.

Experiencing this with thousands of families has helped us to develop our DYING AT HOME Program. This is now available, as always, free of charge, on the web for developing and developed worlds.

DYING AT HOME
Dying should be a social event, not just a medical illness.