

ARTICLE



Spiritual Care and the Artes Moriendi

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Abstract

Modern palliative care is holistic in its approach, aiming to assuage both the physical and emotional pain of the dying. Drawing on Dame Cicely Saunders's concept of "total pain," the NHS identifies four modalities of care: physical, social, psychological and spiritual. Of these, spiritual care poses a particular challenge. The bounds of spirituality are difficult to define in the modern world and it is well documented that healthcare workers are often reluctant to engage with patients on this level. This article draws on both medical and historical perspectives to see whether the historical literature of the *Artes Moriendi* (the Art of Dying) can furnish useful tools or frameworks for modern palliative medicine. Drawing on a selection of English examples from this tradition (mostly from the fifteenth and early-sixteenth centuries), it is suggested here that texts in this tradition often divided spiritual care into two, starting with a more palliative component, in which the fear of death itself was addressed, before moving on to a second, more positively religious stage, in which rituals and professions of faith were used to prepare the dying for their end. This, we suggest, may prove a useful distinction for modern medicine, helping to overcome reticence and clarifying the roles of different members of the care team in administering spiritual care.

Introduction

Acutely aware of their mortality, a “good death” has been the aspiration of humans throughout history. And it is no less the object of palliative care within the modern National Health Service. UK palliative care guidelines identify four areas of treatment central to obtaining the best possible result: physical, social, psychological, and spiritual (Department of Health 2008, 7). Of these, spiritual care remains one of the most challenging to administer. Uncertainty in the definition of spirituality in a multicultural society and uncertainty respecting the responsibilities of different members of care teams has led to patchy administration of such care, as revealed by the *National Audit of Care at the End of Life* (NHS Benchmarking Network 2019, 49). This article offers some tentative suggestions based on an examination of how spiritual care was practiced in the past, specifically as articulated in some English examples of the late medieval literature of *Ars Moriendi* (the art of dying).¹ Examining these texts within the framework and through the objectives of modern palliative care, we suggest that a two-stage approach to spiritual care was a common feature of several medieval texts instructing readers on dying well. The first stage was a palliation of spiritual distress, which was a prerequisite for more specifically religious ministrations. This palliative stage made fewer religious demands of the dying, often drawing themes and material from classical and philosophical writing. This article makes the case that this two-stage or two-tier structure may help to clarify the role of healthcare operatives and facilitate more consistent coverage overall.

Though conceived of before the Covid-19 pandemic, this project gains urgency from the crisis within which it was written. *Prima facie*, a reflection on individual spiritual care in the midst of a crisis, the grievousness of which is conventionally expressed in terms of the mass of infections, recoveries, and deaths, may seem incongruous. At the time of writing, there have been, in the UK, 2,382,865 confirmed cases and 71,560 associated deaths (UK Government 2020). Yet, the scale of mortality combined with the exigencies of lockdown have led to a corresponding re-evaluation of how spiritual care

¹ For the purposes of this article, we will use the singular *Ars Moriendi* to refer to the tradition as a whole and the plural *Artes* to refer to the texts within it.

is provided. So many of the keystones of spiritual care, such as close contact with family and with chaplains are now highly restricted owing to the risks of infection transmission. In some cases, the disease has also required the adaptation of liturgy to the requirements of disease control; extreme unction must now be practiced with a cotton bud rather than a thumb (Mulgrew 2020).² With infectious disease opening up a gulf between the dying and the normal social avenues of spiritual care, and given the NHS commitment to providing spiritual palliation to the dying, it is more important than ever to reconsider the role of health-care providers and clinicians in its administration. This paper is emphatically not about spiritual care responses to the pandemic. However, it would be crass not to acknowledge the conditions under which such care must now (and almost certainly for many years hence) be practiced. The Covid-19 pandemic underlines the fact that spiritual care plans, like all forms of care, must be flexible and imaginative if they are to be effective.

There is a well-documented reticence among healthcare teams around exploring and engaging with patients' spiritual care (Department of Health 2008, 77). Spiritual care itself became part of the NHS's mission through the influence of the hospice movement, initiated in the 1960s by Cicely Saunders (1918–2005). Taking her inspiration from a religious institution, St Joseph's Hospice in Hackney, at which she worked in the 1950s and 60s, Saunders became convinced that hospitals could not provide the best end of life care. Since treatment and healing were at the core of hospital philosophy, the inevitability of death was frequently not accepted. Furthermore, the NHS, designed to deliver mass healthcare, was not set up to address the very individual spiritual and psychological suffering of the dying (Saunders 1963, 1346; Saunders 1964).³ As such, her idea, which took hold in the 1960s, was to move terminal care to a different setting, the hospice, where treatment was built upon the pillars of the acceptance of death and

² This reworking of death liturgies recalls earlier reworkings of the last rites to manage the effects of disease. During the Black Death of 1348–50, the Avignon pope, Clement VI (1291–1352), granted remission of sins to all who died of plague, consecrated the river Rhone so that it could be considered holy ground (meaning, therefore, that bodies could be disposed of in it), and permitted confessions of the dying to be heard by laymen and women if a priest could not be found.

³ Owing to the exigencies of lockdown, we were unable to secure a paper copy of this book. All references to articles in Cicely Saunders, *Dame Cicely Saunders: Selected Writings* (Oxford: Oxford University Press, 2006) provide the 'location' number in the Kindle edition.

community support for the individual (Saunders 1965, 1700; Saunders 1967). Founding St Christopher's Hospice in 1967, Saunders revolutionised palliative care in the UK and the influence of her theories on the holistic diagnosis and relief of a patient's "total pain" is now felt throughout Europe and the world. Although the hospice movement, reacting against the depersonalising effects of modern medicine, initially broke away from the NHS, from the 1970s onward, the health service began to absorb hospice institutions and integrate the hospice movement's ethics into their own practice. By 1987, palliative care became a fully accredited speciality within the NHS (Lawton 2000, 17-18). The quadripartite definition of palliative care mentioned in the introduction—physical, social, psychological, and spiritual—was intended to summarise Saunders's own concept of 'total pain' (Saunders 1978). However, studies of patients and their families and anecdotal evidence tends to agree that while the first three modalities of care are well catered for, spiritual care is less clearly meeting patients' requirements. Surveys conducted as part of the first round of the government's *National Audit of Care at the End of Life* show that of all patient needs, spiritual and cultural wants were least well satisfied. A case note review of individual end of life care plans showed that spiritual needs were assessed only in 47% of cases, with 37% not assessed and 16% deemed not applicable for such assessment. Only 34% of respondents to the quality survey reported satisfaction with spiritual care.⁴ The survey of terminal patients' families revealed a further gap in end of life care provision in the UK, with only 34% responding that their spiritual needs were taken into consideration (NHS Benchmarking Network, 2019, 43 and 49).

The reasons for this deficiency are manifold and mutually reinforcing. In the first case there is an inherent tension in integrating the highly individualised imperatives borrowed from the hospice movement with those of mass healthcare. In the UK, in 2016, only 5.7% of deaths occurred in a hospice setting compared to 46.9% in hospital; of the remainder, 23.5% took place at home and 21.8% in care homes (UK Government 2018). In spite of heroic efforts to do so, it is simply not possible to recreate the

⁴ When asked whether "staff took into account his/her beliefs, hopes, traditions, religion and spirituality" 10% reported various degrees of patchy care, 8% none at all, 33% reported that the question was not applicable, and 14% responded that they were not sure.

conditions of hospice care where patient loads are so high (Lawton 2000, 20ff). Moreover, defining spiritual care is inherently difficult, as no uniform idea of its content exists, and the tendency to identify spirituality with religion frequently means that, apart from the chaplaincy team, most caregivers feel ill-prepared to administer spiritual care. Unlike physical care, which is methodical and follows established protocols, spiritual care and discussion is personal and fraught with uncertainty (O'Brien, Kinloch, Groves, and Jack 2019; Gijsberts, Liefbroer, Otten, and Olsman 2019). Furthermore, this type of care generally has less visibility than others—chaplains do not often work alongside the rest of the team in an integrated manner but instead operate in parallel with medical structures (Gijsberts, Liefbroer, Otten, and Olsman 2019, 13). Though it is widely accepted that nurses and healthcare assistants do much to spiritually support patients (by being present at the bedside, conversing about loved ones, expressing empathy) without their work being recognised as spiritual care *per se*, the lack of systematisation means that there remain gaps to be filled (Donesky, Sprague, and Joseph 2020).

The Ars Moriendi

In drawing on medieval and early modern literature, the so-called *Artes Moriendi*, for ideas about care of the dying, this article makes, emphatically, no claims about the relative merits of late medieval western Christianity as a system of belief. Nor does it subscribe to the nostalgia for premodern “tame death”, as the French historian Philippe Ariès famously described it in his seminal 1977 work *L'Homme devant la mort*, translated into English under the title *The Hour of our Death*. For Ariès, in the medieval regime of “tame death”, dying and burial were public and visible, eschatology, ritual and imagery combined to reconcile individuals with their mortality, and post-mortem rites of remembrance provided mortals with insurances against damnation (Ariès 1981). Ultimately, Ariès’s judgement on the effectiveness of this “tame death” in taking away the fear and psychological stress of dying is more ambivalent than his critics have given him credit for. The association of death with original sin and divine judgement, he argued, meant that it:

is never experienced [in the Middle Ages] as a neutral phenomenon... Resignation is not, therefore a submission to a benevolent nature of a biological necessity as it is today...rather it is the recognition of an evil inseparable from man (Aries 1981, 605).

Yet, his work is often taken as emblematic of an anti-modern longing for a golden era of safe or familiar mortality (e.g. Whaley 1981, 8). This nostalgic tone is certainly present in twentieth century efforts to reform palliative care. Elisabeth Kübler-Ross, whose seminal work at the University of Chicago has informed palliative practice around the world, famously began her *On Death and Dying* with a childhood recollection of a farmer whose very traditionally managed death, surrounded by family and the village community, represented something of an idyll (Kübler-Ross 2019, 190ff).⁵ Cicely Saunders likewise appropriated Ariès's work in support of the hospice movement (Saunders 1984, 3742ff). However, looking back on the medieval and early modern periods as eras of peaceful dying is misguided. There is plenty of evidence that efforts to subdue death through community involvement and religious ritual could result in a death that was anything but peaceful (Wunderli and Broce 1989, 268–9). Having a rigidly clear definition of the “good death” could be as painful and destructive as having none. The *Artes Moriendi*, therefore, are useful, not because they are exemplars of a period when death was disarmed but precisely because death was then (as now) perceived as frightening, difficult, and requiring coherent strategies to mitigate its most terrifying features. Though these strategies can never be reproduced in the present, they can, nevertheless provide points of departure and tools for reflecting on and informing modern practice.

Conventionally, *Ars Moriendi* or “the art of dying,” refers to a loosely defined corpus of writings that instructed a reader on how to die well (see Beatty 1970; Atkinson 1992; Ruys 2014; Appleford 2015). The name itself probably derives from the title of the third part of the *Opusculum Tripartitum de praeceptis decalogi, de confessione et*

⁵ References are to Elisabeth Kübler-Ross, *On Death and Dying* (New York: Scribner, 2019) Kindle edition location number.

de arte moriendi, written in the first decade of the fifteenth century by Jean Gerson (1363–1429), chancellor of the University of Paris (Rainer 1957, 65). This proved the inspiration for the anonymous Latin *Tractatus Artis Bene Moriendi*, compiled in the first quarter of the fifteenth century, which became one of the tradition’s most popular and influential entries, and which was translated into English shortly after as *The Craft of Dying* (O’Connor 1942, 41ff; Comper 1917, 1–47). This was a text for those entrusted with the care of souls; it was essentially a commentary on the *Ordo ad Visitandum Infirmum* (the order for the visiting of the sick), a liturgy to be performed by a priest at the bedside of the dying (Duffy 2005, 313; Henderson 1874, 44* ff).⁶ But *Artes Moriendi* are very diverse. Even among English examples, they range from texts closely linked to the formal worship of the church, like the *The Craft of Dying*, to manuals of private devotion like the *A Dayly Exercyse and Experyence of Dethe*, written by the Bridgettine monk Richard Whitford (c.1543). *Artes Moriendi* encompass a vast range of text genres, including, for example, dramatic dialogues set at the deathbed like the “dialogue with the vision of death” section, extracted from Henry Suso’s (1295–1366) *Orologium Sapientiae*, and the anonymous English *Lamentation of the Dying Creature*, and epistles, such as Thomas Lupset’s (c.1495–1530) *The Treatise of Dying Well*, ostensibly a letter written to his friend John Walker (Comper 1917, 105–124, 137–169; Lupset 1534).⁷ Though the heyday of such writing was the fifteenth century, new *Artes* continued to be written well into the seventeenth century and beyond. Even the Reformation did not diminish the perceived utility of such manuals (Atkinson 1982). Protestant *Artes Moriendi*, such as William Perkins’s (1558–1602) *A Salve for a Sicke Man* and Jeremy Taylor’s (1613–1667) *The Rule and Exercises for Holy Dying*, continued to draw on the repertory of ideas established by the Catholic tradition even as they supplanted it in those areas where reform took hold (Perkins 1595; Taylor 1651). The longevity of some

⁶ There were various forms of this service. The Surtees edition reproduces in its appendix the form that was current in most of the province of Canterbury during the fifteenth and early sixteenth centuries, which was printed in the 1506 edition of the Sarum *Manuale* (a handbook of services to be performed by priests).

⁷ Lupset, incidentally, penned this letter just eleven months before his death from tuberculosis.

entries in the tradition was astonishing, with Christopher Sutton's *Disce Mori = Learn to Die*, originally published in 1600, reprinted as late as 1839 (Sutton 1839).

To discuss the *Ars Moriendi* inevitably means discussing texts, but to think it as simply a text genre is somewhat misleading. The themes and ideas of the *Ars* (such as the shortness of life, the immanence of divine judgement, and the need for spiritual preparation) suffused late medieval and early modern culture and society (Duffy 2005, 310ff.). The pre-eminence of prayer and liturgy, particularly the mass, as tools of intercession (by which a soul in purgatory could be relieved of its pains), led to a thriving marketplace for such intercessions, formalised in the very widespread institution of the chantry, in which a priest was endowed to perform masses on the behalf of one or more deceased persons. Virtually every parish had its religious guilds, which have been characterised (with some justice) as burial clubs (Daniell 2005, 19). Every church had its Bede Roll, a list of parish benefactors, read in its entirety four times a year so that parishioners could pray for dead (Duffy 2005, 334ff). This was a reciprocal transaction: the dead were expected, in their turn, to pray for the living. Indeed, the dead, so often present in the thoughts and practices of the living, with their own distinct rights and responsibilities, have been thought of by historians as constituting more an "age group" in medieval society than the permanently departed (Davis 1972, 332). The enthusiastic uptake of the aforementioned *Tractatus* across Europe may be demonstrated by the fact that it exists in more than three hundred Latin manuscript transcriptions, was translated into several European vernaculars, and was reprinted (under many names and with various abridgements) well over a hundred times across the continent, even before the close of the fifteenth century (O'Connor 1942, 1, 113ff and 133ff). Examples could be multiplied endlessly. In many ways, *Ars Moriendi* is better characterised as a tone than a genre of texts, and writers of potentially any kind could (and did) draw upon and engage with *Ars moriendi* themes. So, while drawing on the content of individual *Artes moriendi*, we must acknowledge the broader context of these ideas in the society in which they were formulated. They made sense as part of a culture where the discussion of personal death was not taboo. If there was any unifying message to the various *Artes*

Moriendi, it was that spiritual preparation should not be left until the deathbed. Borrowing from these texts with an eye to the care at the time of death alone means borrowing in quite a limited way. They were texts, in the main, for the living, rather than the dying.

The breadth of the *Ars moriendi* theme has a further consequence for this article: scale. There is simply too much and too varied literature for this short study to embrace it all. As sharp-eyed readers may already have guessed from the examples hitherto cited, our conclusions rest on a limited case study of English examples from the fifteenth and sixteenth centuries and will, therefore, reflect the particular inflections of the genre within the Anglophone world. This keeps the source base manageable, while still allowing us to identify patterns in the development of a particular branch of the tradition. While our conclusions may with further analysis prove true of other European *Artes moriendi* literatures, they cannot, for now, be said to be reflective of this genre *in toto*.

Modern Spiritual Care

The core questions of this study are, ultimately, shaped by a present-day imperative: Can *Artes Moriendi* offer useful frameworks for modern healthcare professionals thinking about the problem of “spiritual care”? As such, our objectives are structured by the necessarily nebulous, modern catch-all of “spiritual care.” There is, inevitably, a risk of anachronism in applying such terminology to a period of relative (though certainly not absolute) religious uniformity. This is not, in itself, more of a problem than applying any other category from modern sociology. Yet it requires a self-reflexive approach to ensure that the answers remain historically valid. The patient-centred approach to care, expounded famously by Cicely Saunders and later by Kübler-Ross means that spirituality, effectively, has no content *per se*, other than what the patient chooses to admit (Saunders 1967 II, 2220). Though some tendencies can be identified, spiritual assessment can assume nothing about the patient in question.

The emphasis on individuality in modern, institutional conceptions of spirituality has led to a tension in thinking about palliative care: how can any definition of spirituality

balance this extreme individuality with the need to establish a working definition that, in turn, will permit the development of requisite competencies in healthcare staff? In an age of globalisation and multicultural societies, spirituality in a palliative care context must embrace a vast and dazzling panoply of human values, connections, and existential questions. A comprehensive, modern definition was formulated in 2011 by the European Association of Palliative Care (EAPC), a pan-European research and lobbying group founded in 1988:

Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred (Nolan, Saltmarsh, and Leget 2011, 88).

The EAPC definition is slowly gaining traction as a European standard, appearing frequently in medical literature and being used by other medical research and policy bodies, such as the EU-funded EPICC Network, which ran from 2016 to 2019 and aimed to enhance spiritual care skills among nursing staff (See EPICC's Spiritual Care Education Standard). Yet, it is only one among many competing definitions with distinct emphases and functions. There is no space in this paper to summarise them, but a common thread running through these definitions is that spirituality must be thought to extend beyond religion to other sources of hope, values, and existential meaning. The inherent risk, however, is that a very inclusive definition of spirituality will lead to a kind of mission creep, in which spirituality becomes a catch all for everything that gives human life meaning or significance. Such a definition may prove unwieldy in practice. A 2020 EAPC white paper on multidisciplinary education for spiritual care added refinements to their model divided into existential considerations (such as questions of identity, suffering, and grief), value based considerations (the importance of family, work, nature, arts, and culture), and religious considerations (Best, Leget, Goodhead, and Paal 2020). What this reveals, perhaps more than anything else, is that modern spirituality is dynamic and cannot be thought of as fixed. It is an expanding and polymorphous arena of

discourse. The competencies, therefore, needed for spiritual care are much less prescriptive skills than they are values. As Carlo Leget (a leading member of the EAPC) argues, broad minded acceptance of diversity and acknowledgment of the multitude of imperatives structuring spiritual issues will be key to providing non-judgemental, patient-centred care (Leget 2017, 59ff).

It is ultimately, however, the integration of this theoretical work into care, as a whole, that matters. NICE (National Institute for Clinical Excellence), the public body responsible for issuing guidelines for medical practice in England and Wales, affirms the need for a “holistic needs assessment” with a spiritual component in its “End of Life Care for Adults” guidelines (NICE 2019), but no specific assessment tools or interventions are advocated. Elsewhere, there is more detail. A 2004 manual on end of life care for patients with cancer affirms the need for spiritual support in palliative care and advocates assessment of a patient’s spiritual needs at key points in their journey, affirming patient dignity and adapting care to the patient’s beliefs or philosophy. A multidisciplinary team including chaplains is recognised as being necessary to meet the breadth and complexity of spiritual requirements (NICE 2004, 95ff). Nevertheless, while objectives and responsibilities are clearly apportioned and recommended guidelines set out, the manual recognises the impossibility of completely formalizing spiritual care; much care, by its very nature, has to be informal and discursive (NICE 2004, 96). Full systematisation, the manual recognises, is neither possible, nor, in fact, desirable.

There is, moreover, a structural cause for variations in palliative care services. As mentioned, palliative care is itself a comparatively new speciality within the NHS. Though now made available to patients nationally (be it through community services, hospital specialists or hospices) palliative care services are (of necessity) not fully integrated into the health service. Death takes place in a variety of settings (hospice, hospital, care home or in the community). The health service, therefore, has only a limited capacity to prescribe or standardise its service provision in this area. Hospices, though relatively few people die in them, are a good example. Some are entirely funded by the NHS and integrated with other healthcare services, while others are partially or

fully charitably funded, allowing for some independence in their management. As such, though NHS palliative care aims to be standardised and able to provide for patients of all cultures and religious or secular backgrounds, more independent hospices may have a particular religious focus.

Creating tailored spiritual care packages requires spiritual assessment. Tools have been developed for use by medical practitioners. Two of the best known are the HOPE and FICA tools, both used in the NHS (Anandrajah 2001; Borneman, Ferrell, and Puchalski 2010). HOPE explores sources of hope, engagement with organised religion, personal spirituality or practices, and the effect of these beliefs on the individual's care or medical decisions. FICA is similar, exploring the individual's faith or beliefs, its importance or influence in daily life, involvement in spiritual communities, and preferences for how these beliefs should be addressed by the healthcare team. Both tools were developed for the teaching of medical students or training doctors with the aim of integrating the taking of a "spiritual history" which would fit alongside clinicians' other information gathering tools. They prioritise the information deemed important for the care of a patient and provide a route into a discussion about support systems. However, such tools are more commonly used in research than practice and there is some scepticism amongst UK physicians about their use with patients (Holloway, Adamson, McSherry, and Swinton 2011). Some of this resistance stems from concerns that spirituality is being 'medicalised' or boxed into categories, ignoring the importance of human connection between patient and carer in true spiritual care. This is indeed a challenge when aiming to deliver adequate spiritual care on a large scale alongside other health services. However, proponents would argue that the delivery of assessments through simple tools reduces the reticence of healthcare professionals and promotes widespread, standardised use by the whole team to ensure that patients have the opportunity to signpost their needs.

Fundamentally, however it is delivered, it is widely recognised that spiritual care must be responsive to patients' distress or their articulated needs and it must adapt to their particular backgrounds or beliefs. It cannot set out a "spiritual ideal" to guide

patients towards or a set of imperatives. Significantly, such treatment must be directed at the current episode of care. It does not attempt to advise individuals at any time prior to the palliative stage on how to optimise their “spiritual health” or to relate current practices to considerations of dying and the afterlife.

Modern Reinterpretation of the *Artes Moriendi*

Offering spiritual care in fifteenth and sixteenth century England, by contrast, meant something very different. The context for the care of the dying was not medical but religious. The role of the “carer,” who might be a clergyman or a layperson, was to assist the dying person (or *moriens*) to fulfil their obligations, as mandated by ecclesiastical doctrine. These included practices such as the disposal of their estate, making peace with neighbours and family, performing a final confession of faith and receiving the last rites. Though such actions might take place in instances of modern spiritual care, the context was radically different. While *moriens* himself had some leeway in accepting or resisting certain aspects of the practice, the criteria for a good death were, notionally at least, fixed by ecclesiastical authority. This is not to say that there were no exceptions or that what we read about in the *Artes* accurately represents medieval and early modern dying. There is considerable evidence that popular opinions about death did not always match (and often conflicted) with those expressed in the *Artes* (Wunderli and Broce 1981). It is, rather, to say that the *Artes Moriendi* cannot speak directly to the universalism of spiritual care practiced by modern healthcare providers. They were rhetorical and instructional works in service of a particular theological system, with its own internal logic. Nevertheless, palliative care theorists have already begun to explore the possibilities of particular *Artes Moriendi* as a template for spiritual care and have already run up against this very problem (for a review of the literature, see Espi Forcén and Espi Forcén 2016). These explorations have, thus far, been few and tentative. Yet, some have shown promise, pointing the way to positive adaptations of palliative practice. Since 2003, Carlo Leget has developed what has become known as the AMM (Ars Moriendi Method) of spiritual assessment (Leget 2010 and 2017). This is based on a very popular abridged

version of the original *Tractatus Artis bene Moriendi*, which consisted mainly of its second chapter, on the temptations that afflict the dying (The first printed edition of this shorter version is reproduced in Rylands 1871). Rather than offering a framework of questions designed to elicit information on a patient's spiritual background, as is the case with most conventional assessment methods, the AMM method is looser, offering, primarily, a method for conceptualising spirituality and structuring a more spontaneous style of conversation. It envisages spiritual problems within a framework of five tension fields. These are autonomy, pain control, attachment and relations, guilt and evil, and the meaning of life (Leget 2010, 315-16). These Leget developed (and reordered) from the temptations (and the corresponding virtues needed to mitigate them) of the second chapter of the *Tractatus* (being the choice between doubt and faith, despair and hope, impatience and patience, complaisance and humility, and between avarice and charity). The aim is to develop an idea of an individual's spiritual landscape, which can provide directions for future care. Trialled in the Netherlands, the method has proven useful in overcoming healthcare professionals' reticence over provision of spiritual care; however, so far, trials have been limited and evidence of the method's effectiveness remains anecdotal rather than statistical (Vermandere, Warmenhoven, van Severen and de Lepeleire 2015, 299-300; Leget 2017, 191ff).

Leget's interest in the *Ars Moriendi* is structural, rather than contentual. For him, the strength of the *Tractatus* is the succinct clarity with which it pinpoints the themes of spiritual distress, reduced to five dyads within which *moriens's* suffering is to be managed (Leget 2017, 43). Yet, in the *Tractatus* and its English translation, *The Craft of Dying*, each of those dyads is predicated on medieval soteriology. Take, for example, the third of the *The Craft of Dying's* temptations, impatience, which may be thought of as the least theologically determined of the five, arising as it does from the pain of dying: "For they that be in sickness in their death bed suffer passingly great pain and sorrow and woe" (Comper 1917, 15). The author characterised *moriens's* grudging of his suffering as a rejection of charity, which, as a theological virtue (as distinct from the practice of charitable giving), might best be characterised as the human reflection of God's

unconditional love. Impatience, here, is unwillingness to accept the theological necessity of suffering. Individual suffering was, in the end, God's will: whoever suffered willingly signalled his acceptance of divine judgement. The text's author, referencing an *exemplum* (a story used in sermons to illustrate a theological point) attributed to the thirteenth century friar, Albert the Great (c.1200–1280), states that “sickness before death is as a purgatory.”⁸ So, whereas modern palliative care is, above all, an exercise in controlling or, more exactly, mitigating suffering in this world, fifteenth and sixteenth century *Artes Moriendi*, dealt primarily with suffering in the next world. Physical and psychological pain at the end of life was not merely regarded as unavoidable, but in some instances, was represented as actually salutary. Thus, in separating the *Tractatus*'s themes (faith, hope, patience, humility, and charity) from their soteriological object, Leget is forced to de-contextualise them. He must extrapolate very abstract themes of spiritual care, based on modern spirituality and only remotely connected with those of the original text.

Yet, Leget perceptively identified that palliation, of a kind, absolutely is a component of these historic texts, albeit one that was instrumental rather than an end in itself. The *Artes Moriendi* were, fundamentally, rhetorical texts. Since there were few means of mitigating physical suffering, the only palliation that anyone could prescribe was attitudinal, convincing *moriens* to interpret their pain within a theological framework. Several authors of *Artes* examined in the course of this study, in fact, recognised and lamented the difficulty of even convincing people to start preparing for death (e.g. Comper 1917, 32–33; Whitford 1537, A3r; Lupset 1534, 13vff). Some, like the *Lamentation of the Dying Creature*, even dramatized the perilous results of this reluctance (Comper 1917, 137–168). Though perhaps more alert to the need to prepare for their dying, medieval readers did not necessarily find such preparations much less uncomfortable than their modern counterparts. As such, most *Artes* approached their theme accepting, as part of their task, the need to convince their readers both of the need

⁸ In the exemplum referred to by Albert's colleague Thomas of Cantimpré (1201–1272) in his *Bonum Universale de Proprietatibus Apum*, a man is offered a choice between one year of sickness or three days of purgatory; upon choosing the latter, he very swiftly regretted his decision.

to consider their own death and, more pertinently to this article's theme, to accept and interpret their distress in a soteriologically salutary way. They had to write persuasively, that is to say rhetorically.

Rhetoric and Palliation

In Classical forensic rhetoric, i.e. legal rhetoric from which the subsequent medieval tradition derived, the orator's first task was to render his audience (usually a judge) apt to receive his arguments; the practice was called *captatio benevolentiae*, the seizing of good-will (see Cicero, *De Inventione*, I.15). The authors of the *Artes Moriendi* were manifestly not writing forensic orations, but they did envisage a similar initial stage, for spiritual ministrations. Before *moriens* could receive religious care, their spiritual distress had to be attended to: before a person could die well, they must first be taught to die freely.

The terminology this article uses, distinguishing between “dying freely” and “dying well,” is derived from *Artes Moriendi* and from Seneca's *Epistle LXI*: “to die well is to die freely...he who takes his orders freely escapes the bitterest part of slavery, having to do what he does not want to do” (Seneca, *Ad Lucilium Epistulae Morales*, 61.3). While it is not a terminology that these authors generally use, it describes a structure common to many of the *Artes*.⁹ In essence, free dying was a philosophical acceptance of the fact of death and its attendant sufferings. Dying well entailed observance of religious rites and obligations. Since dying freely was not necessarily grounded in the religious comforts of the Church, it was, in fact, a highly syncretic virtue. As averred, authors frequently borrowed from the classical texts in their cultivation of free dying.¹⁰ Some authors freely acknowledged that it was perfectly possible for non-Christians to die bravely or dispassionately (i.e. freely), even if dying well was particular to Christians, who alone could benefit from the Christ's sacrifice and the intercession of the Church (this is

⁹ Lupset, taking his cue from Seneca, does use the terminology “dying gladly” (Lupset 1534, 12v).

¹⁰ Seneca was among the more widely cited classical authorities, hence the use of his terminology in our article.

implied in the *Craft of Dying*, Comper 1917, 7, but is fairly explicit in the work of Lupset, 7vff, and Whitford 1537, B1r-v).¹¹

It is in such a context, then, that the first two chapters of the *Tractatus* and its English translation, *The Craft of Dying*, should be understood. As mentioned, the text is an appendage to and commentary on the *Ordo ad Visitandum infirmum*. The emphasis on first palliating *moriens's* emotional distress may in fact have been borrowed from the *Ordo*, where among the first things the priest is required to do is set up a crucifix in the sight of the dying (Henderson 1874, 44*).¹² Subsequently, the *Ordo* invites *moriens* to make a declaration of faith, which was then followed by shriving, a confession and absolution of sins (Henderson 1874, 45*ff). The *Ordo* underlines the importance of a good will. In the normal course of a confession (i.e. one performed during the years of health), a penitent would be assigned penitential activities (such as fasting) to perform in return for absolution (or forgiveness) of their sins. Since *moriens* could do no such penance, their unfeigned sorrow and honest willingness to perform penances, were they able to, was the only basis for the priest to pronounce absolution. As the *Ordo* put it: “without charity [i.e. loving acceptance of God’s will], faith will gain you nothing” (Henderson 1874, 47*). The subsequent oration, which functions as a preparative to the confession of sins, covers many of the same themes contained in chapter II of *The Craft of Dying*, for example hope and despair, humility and charity. The palliative sections of *The Craft of Dying* mirror the preparatory sections of the *Ordo*, in function if not in ordering, and build from palliation to a declaration of faith and penitence in its third chapter.

¹¹ Even this was not a hard and fast rule. Occasionally pagans had the benefit of this. The pagan emperor Trajan, for example, was widely believed to have been saved from hell by the intercession of St Gregory the Great (540-604). In his *Comedia* Dante Alighieri (1265-1321) added the Roman, Cato, and the Trojan, Ripheus, to the number of Pagans in Heaven. Alexander of Hales (1185-1245) went so far as to argue that it would be inconsistent with the mercy of God to bar virtuous pagans, who had no knowledge of Christ’s teaching, from Heaven. William Langland clearly held open the possibility of pagan salvation. Some otherwise fairly orthodox religious figures, such as the anchoress Julian of Norwich, evidently believed in the salvation of all virtuous souls, Christian or otherwise.

¹² That this was meant to comfort *moriens* may be illustrated by the mystic Julian of Norwich’s account of her own near death, where she recalls the parson’s words to her: “Daughter, I have brought you the image of your saviour. Look upon it and be comforted, in reverence to him that died for you and me” (Julian 1998, 5).

Whether in its full length or its abridged form, the *Tractatus Artis bene Moriendi* did not represent, by itself, all that was needed for a good death. The spiritual state of one who died having only observed the prescriptions of the abridgment would be doubtful. The purpose, therefore, of these early chapters was to bring *moriens* to a state where their spiritual distresses, their doubt, despair, impatience avarice or pride would not mitigate the salutariness of religious rituals to their soul either by diminishing the genuineness of their performance or increasing *moriens's* burden of sin.

Several English *Artes Moriendi*, though generally more removed from the liturgical components of the good death, nonetheless, employed a similar structure. Both Lupset and Whitford affirmed that the fear of death and the love of life were natural, if immature, responses to one's mortality (Lupset 1534, 14rff; Whitford 1537 A2rff). Consequently, dying "freely", at least insofar as they presented it in the introductory passages of their texts, was much less about averting sin on the deathbed than it was averting this fear and ensuring one's own well-being. As Renaissance humanists (i.e. those trained in the classical humanities), the Classical world was a natural place to seek examples of fortitude in the face of death.

Lupset's *Treatyse* begins by addressing himself to his friend, John Walker, and, in a very traditional rhetorical move, he demonstrates his humility (and therefore his merits as a speaker) by protesting his unsuitability to tackle the matter of how "to lerne the way of dyenge well" (Lupset 1534, 3r). Listing authorities who might speak better on the subject (at the same time displaying his erudition), he at once points out that a pagan can never "declare thys thynges so trewly and effectually, as may he that is exercised in Christes philosophye." Yet, though he extols the learning of "Charterhouse monks" on the subject, he actually begins his oration with a narration of the death of the Roman aristocrat, Julius Canius, executed by the emperor Caligula in A.D. 40 (Lupset 1534, 5r-7v). This account he lifted virtually wholesale from Seneca's *De Tranquillitate Animi*, a letter in which Seneca tries to cure his friend Anneus Serenus of anxiety and worry (Seneca, *De Tranquillitate*, 14). Lupset presents Canius as a man who "playde with death", showing how it is possible, even without the comfort of Christian salvation, to

reconcile one's self with one's end (Lupset 1534, 7v). Though he goes on to predicate good death, unambiguously on Christian faith and the hope of salvation, his exordium emphasised that unsalutary and unreasonable fear must be rationally deconstructed before one can gain the full benefits of religious faith.

In his *Exercyse*, Whitford actually follows rhetorical (or Ciceronian) best practice almost to the letter (See Cicero, *De Inventione*, I.15-16). Addressing himself to “the judge”, so to speak, in this case the abbess of Syon Abbey, where Whitford lived and worked (Bridgettine monasteries were double houses, with monks and nuns), he briefly sets out his theme, taking the Doctor of the Church, Augustine, for his authority: “the best meane to dye well: is well to lyve.” In the best tradition of *captatio benevolentiae*, he humbly praises his reader (“that lesson [i.e. to live well] can you teche me better tha[n] I you.”) He then establishes that the first thing to do in learning to die is to “avoyde, exclude, exyle and put ferre away: that chyldyssh vayne and folyssh feare and drede of deth” (Whitford 1537, A2v). In a move particularly reminiscent of classical, forensic rhetoric, he then moves to bring his opponent “into hatred, or into unpopularity, or into contempt” (Cicero, *De Inventione*, I.16), in this case an imagined interlocutor, defending the “fear of death”. “Dethe,” Whitford answers, “is terryble & fearefull...unto them alone...that doubt of any other lyfe after this present lyfe.” Yet Whitford's authority is for this statement not the Bible but Aristotle, and the argument that follows, that death is natural, uses not a religious theme, but compares human life to the ripening of a fruit, dropping (and dying) in due time (Whitford 1537, A3r). In the rest of his prefatory argument, the Bridgettine monk intersperses excerpts drawn from various sources, both Classical (mostly Cicero's *Tusculan Disputations*) and patristic (mostly from St Ambrose's *De Bono Mortis*). However, his thrust balances both the hope of salvation and resurrection, with a more stoic observation that to fear what cannot be escaped is irrational.

In essence, the writers of these *Artes* shared the premise that “spiritual care” of the dying was two-stage. There should be an initial, palliative stage in which the unserviceable fear of death should be addressed so that *moriens* could subsequently

benefit from more explicitly religious devotional and sacramental assistance (Ruys 2014). Crucially, while this palliative stage often included religious statements and arguments, it did not have to be religiously premised. This structure continued to be accepted even by much later writers, such as the Protestant clergyman, Christopher Sutton (1565–1629), whose *Disce Mori* expressed its rhetorical intent by taking a form reminiscent of a commonplace book (a collection of edifying excerpts grouped under thematic headings, which a reader might then use for personal edification or deploy in their own orations). Writing for a later and a Protestant culture that emphasised the importance of personal acquaintance with Scripture, Sutton’s excerpts are, for the most part, Biblical. Yet, he reveals his adherence to a gradated approach to the good death by including a series of chapters containing arguments by which a dying person’s indifference to or fear of death may be overcome. For example, the title of chapter XV is “How the sick, when sickness more and more increaseth may be moved to constancy and perseverance,” and that of chapter XVI, “How they may be advertised [warned], who seem unwilling to depart the world” (Sutton 1839, 206 and 214).

The point to be made here is emphatically not that the arguments such as may be found in *The Craft of Dying*, Lupset’s *Treatise*, Whitford’s *Exercyse* or Sutton’s *Disce Mori* should be used by modern healthcare professionals (though a more general review of the rhetoric used in the *Artes Moriendi* is among the future lines of research we hope to follow). The considerable perdurance of such ideas may suggest that they were as effective as any other line of argument, but the case to be made here is rather for the two-tier definition of good death: dying freely and dying well.

Modern Applications

The standard methods of spiritual assessment (the HOPE or FICA systems) start by approaching spirituality in terms of the quest for meaning. This is done, to begin with, by establishing what religious or philosophical system the dying belong to. While such an approach is a logical response to the imperative to care for an individual in a multicultural society, it is equally a potential source of alienation between the patient and

the caregiver, who is not a specialist in spiritual affairs. The ideal spiritual care is based on a human relationship between patient and carer (Mauksch 1975, 20). It is not hard to see that predicating spiritual care, in a medical context, on religious principles with which a carer is unfamiliar, might make that relationship harder, rather than easier to establish. Fundamentally, such religiously predicated care would implicitly represent the preserve of the chaplaincy team. It is, therefore, worth asking whether spiritual care can be administered on a basis that is less religiously determined so that healthcare professionals feel more able to participate in this important component of palliation.

The argument that basic spiritual needs must be met in order to make possible deeper or more specialised spiritual exploration is echoed elsewhere in psychology theory. Maslow's theory of the hierarchy of needs has been applied to various healthcare settings to optimise patient care (Maslow 1943). In palliative care, Maslow's theory is used as a framework for organizing and prioritising the needs which emerge at the end of life so as to help the patient to transcend their illness and attain self-actualisation and a 'good death' (Zalenski and Raspa 2006). In Maslow's theory, human motivation is expressed as a pyramid, with core survival needs (food, water) at its foundation, progressing through safety, love and belonging, and esteem before reaching self-actualisation at its pinnacle. He argues that basic needs must be satisfied before ascending to the higher needs. In palliative care, it is clearly important to address firstly a patient's pain or symptoms before addressing their anxiety or fears about death. Further up the pyramid are relationships with family and friends, and the extent to which the patient can feel valued by and able to communicate with them. The top of the pyramid, self-actualisation, is the potential to develop identity, explore existential considerations and to reach self-acceptance. Exploration of the *Ars Moriendi* in a palliative context echoes these human needs and their prioritisation. By accompanying the patient as they face their fears around dying, perhaps anxieties about the physical experience or worries about a situation they are leaving behind, spiritual caregivers can help the patient to "die freely", removing impediments to self-actualisation at the end of life. As such, palliative care steps closer to its initial aim as voiced by Dame Cicely Saunders: "We will do all we

can not only to help you die peacefully, but also to live until you die” (Saunders 1976, 2698).

Though holistic spiritual care remains the object of palliation, clarifying the responsibilities of health professionals as opposed to chaplains would be invaluable. As mentioned, it is understood that doctors, nurses, and healthcare assistants should aim to address spiritual distress in a general sense—perhaps through discussions about what brings patients meaning or hope in their suffering, using assessment protocols like the HOPE or FICA questions and referring patients with more complex spiritual needs to the chaplaincy team. Assigning to clinicians a more specific role in a graduated system, meeting spiritual “deficiency needs,” could do much to obviate anxieties arising from the need to provide spiritual care. Distinctions of this kind do already exist within the health services, but they are not yet a formal part of departmental organization or teaching (NICE 2004, 101). Yet, a more formal circumscription of palliative, spiritual care objectives and coordination with the chaplaincy services could embolden care providers to draw on their experiences and engage with patients.

What might such generalist spiritual care look like in practice? A recent collaboration between nursing and chaplaincy professionals has highlighted a set of what are called “spiritual interventions”. These have been grouped as primary (suitable for generalists) or specialist (to be carried out by the chaplaincy team) (Donesky 2020). Primary interventions include support while the patient is alone, affirmation of worth and values, supportive listening, and referring on to specialist teams. Specialist interventions include spiritual or theological reflection, offering legacy activities, or the provision of religious resources. There is, of course, overlap in some of these roles. A systematic review of the literature identifies the importance of self-reflection of caregivers in developing any spiritual competency: “being present” with patients is the most effective way of acquiring the experience necessary to perform this work. The same review also identifies European research suggesting the benefits of healthcare workers being familiar with religious ritual and the use of silence in spiritual interventions (Gijssberts, Liefbroer, Otten and Olsman 2019, 14). Simple practices by healthcare professionals such as those

outlined above are, for the most part, already carried out on a regular basis but perhaps not recognised as spiritual care. Highlighting their function as possible spiritual interventions in education and training of professionals would likely increase confidence and understanding of this field of care. Moreover, reflection on the medieval literature highlights another possible avenue of spiritual care. Much of what the medieval writers sought to do was to reconcile the dying with pain and suffering, since these things could not be medicated. Though modern physicians can now manage the pain of dying more effectively, the physicality of death, not only in terms of pain but also physical degeneration remains an inescapable part of the patient's experience of self. Julia Lawton points out that the inability to mitigate this remains an absolute impediment to the hospice movement's objective to help people "live until they die" (Lawton 2000). Healthcare workers and particularly doctors, with their specialist understanding of symptom care, may, in fact, also be best placed to address any spiritual crises arising from physical causes. Yet, this must remain, for now, a pointer for future research.

Conclusion

The aim of modern palliative care is, ultimately, not just to mitigate pain, but also to maximise personal agency on the deathbed, enabling the patient to feel that they can still make decisions about subjects that matter (Kubler Ross 2019, 126). Decisions, for example, about preferred place of death (whether at home or in a hospice), how much they want to know about the course of their illness, and how involved, or otherwise, they would like their loved ones to be in personal caregiving are given much weight in palliative care policy, research, and in practice. The selection of *Artes Moriendi* examined here sought to do a similar thing, albeit in an expressly religious mould. With their unserviceable fear of death assuaged, the *moriens* was enabled to carry out the pre-mortem procedures required by their beliefs. By incorporating the parallel care directed at both non-prescriptive free dying and more religiously conditioned dying well into palliative practice, it may be possible to address a widely accepted difficulty by better defining and integrating pastoral roles and practices across the care team. Yet, for all this,

it should not be forgotten that the spiritual component of palliative care is essentially grounded in a relationship between carer and patient. Though education and training in such interventions would benefit both professionals and patients, “spiritual competency” cannot be taught with protocols or curricula. Our abilities to recognise and act on spiritual needs depend both on the training given within a professional domain and on life experiences, our social connectedness, society, culture, and much more. There is a danger that promoting spiritual care interventions within existing healthcare structures simply squeezes it into the system, treating this domain as an add-on. As averred above, it must be considered part of the care of the whole person and be integrated with the treatment of physical symptoms. Above all, good spiritual care depends on broader societal engagement with end of life issues and with the values that enable individuals to find meaning as they die.

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Bibliography

Appleford, Amy. 2015. *Learning to Die in London, 1380-1540*. Philadelphia: University of Pennsylvania Press.

Anandrajah, Gowri. 2001. "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment." *American Family Physician* 63 (1): 81-89.

Atkinson, David. 1982. "The English Ars Moriendi: its Protestant Transformation." *Renaissance and Reformation/Renaissance et Réforme* 6 (1): 1-10.

Best, Megan, Carlo Leget, Andrew Goodhead, and Piret Paal. 2020. "An EAPC white paper on multi-disciplinary education for spiritual care in palliative care." *BMC Palliative Care* 19. doi.org/10.1186/s12904-019-0508-4

Borneman, Tami, Betty Ferrell, and Christina Puchalski. 2010. "Evaluation of the FICA Tool for Spiritual Assessment." *Journal of Pain Symptom Management* 40 (2): 163-173. doi.org/10.1016/j.jpainsymman.2009.12.019

Cicero. *De Inventione* in *Rhetorici Libri duo qui vocantur de inventione*. Edited by Eduard Stroebel. Leipzig: B.G. Teubner. Accessed September 28, 2020. <http://www.perseus.tufts.edu/hopper/text?doc=Perseus%3atext%3a2008.01.0683>

Comper, Frances, ed. 1917. *The Book of the Craft of Dying*. London: Longmans, Green & Co.

Daniell, Christopher. 2005. *Death and Burial in Medieval England*. London: Routledge.

Department of Health. 2008. *End of life Care Strategy*. Westminster: COI. Accessed June 16, 2020. <https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life>.

Donesky, DorAnne, Emily Sprague, Denah Joseph. 2020. "A New Perspective on Spiritual Care: Collaborative Chaplaincy and Nursing Practice." *Advances in Nursing Science* 43 (2): 147-158. [doi:10.1097/ANS.0000000000000298](https://doi.org/10.1097/ANS.0000000000000298).

Duffy, Eamon. 2005. *The Stripping of the Altars*. New Haven: Yale University Press.

EPICC. n.d. "EPICC Spiritual Care Education Standard." Accessed June 25, 2020. <http://blogs.staffs.ac.uk/epicc/resources/epicc-spiritual-care-education-standard/>

Espi Forcén, Fernando and Carlos Espi Forcén. 2016. "Ars Moriendi: Coping with death in the Late Middle Ages." *Palliative and Supportive Care* 14 (5): 553-560. doi.org/10.1017/S1478951515000954.

Gijsberts, Marie-José, Anke Liefbroer, René Otten, and Erik Olsman. 2019. "Spiritual Care in Palliative Care: A Systematic Review of the Recent European Literature." *Medical Sciences* 7 (2): 1-21. doi.org/10.3390/medsci7020025.

Henderson, William, ed. 1874. *Manuale et Processionale ad usum Insignis Ecclesiae Eboracensis*. York: Surtees Society.

Holloway, Margaret, Sue Adamson, Wilf McSherry, and John Swinton. 2010. *Spiritual Care at the End of Life: A Systematic Review of the Literature*. London: Department of Health.

Lawton, Julia. 2000. *The Dying Process*. London: Routledge.

Leget, Carlo. 2007. "Retrieving the *ars moriendi* tradition." *Medicine, Health Care and Philosophy*, 10: 313–319. doi.org/10.1007/s11019-006-9045-z

———. 2017. *Art of Living, Art of Dying: Spiritual Care for a Good Death*. London: Jessica Kingsley Publishers. Kindle edition.

Kübler-Ross, Elisabeth. 2019. *On Death and Dying*. New York: Scribner. Kindle edition.

Lupset, Thomas. 1534. *A compendious and a very fruteful treatyse, teachyng the waye of dyenge well, written to a frende, by the flowre of lerned men of his tyme, Thomas Lupsete Londoner, late deceased, on whose soule Iesu haue mercy*. London: Thomas Berthelet.

Maslow, Abraham. 1943. "A Theory of Human Motivation." *Psychological Review* 50 (4): 370–396. doi.org/10.1037/h0054346.

Mauksch, Hans. 1975. "The Organizational Context of Dying." In *Death: The Final Stage of Growth*, edited by Elisabeth Kübler-Ross, 6–24. New York: Touchstone.

Mulgrew, Frankie. 2020. "A Priest's Perspective: Delivering Spiritual Care through Covid-19." Last modified April 15 2020. <https://www.dioceseofsalford.org.uk/a-priests-perspective-delivering-spiritual-care-through-covid-19/>

Murphy, James. 1974. *Rhetoric in the Middle Ages*. Berkley: University of California Press.

NHS Benchmarking Network. 2019. *National Audit of Care at the End of Life*. Manchester: Healthcare Quality Improvement Partnership. Accessed June 16, 2020. <https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-nacel-2019/#.XvliC-d7k2x>.

NICE. 2004. *Improving Supportive and Palliative Care for Adults with Cancer: the Manual*. London: NICE. Accessed June 25, 2020. <https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-pdf-773375005>

———. 2019. "End of life care for adults: service delivery - NICE guideline [NG142]" Accessed June 25, 2020. <https://www.nice.org.uk/guidance/ng142/chapter/Recommendations#assessing-holistic-needs>

Nolan, Steve, Philip Saltmarsh, and Carlo Leget. 2011. "Spiritual care in palliative care: working towards an EAPC Task Force." *European Journal of Palliative Care* 18 (2): 86-89.

O'Brien, Mary, Karen Kinloch, Karen Groves, and Barbara Jack. 2019. "Meeting patients' spiritual needs during end-of-life care: a qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training" *Journal of Clinical Nursing* 28 (1/2):182-189. doi: 10.1111/jocn.14648.

O'Connor, Mary. 1942, repr. 1966. *The Art of dying well: the development of the Ars moriendi*. New York: AMS Press.

Perkins, William. 1595. *A Salve for a Sicke Man*. Cambridge: Cambridge University Press.

Public Health England. 2018. "Statistical commentary: End of Life Care Profiles, February 2018 update." Last modified February 6, 2018. <https://www.gov.uk/government/publications/end-of-life-care-profiles-february-2018-update/statistical-commentary-end-of-life-care-profiles-february-2018-update>

Rainer, Rudolf. 1957. *Ars moriendi: von der Kunst des heilsamen Lebens und Sterbens*. Köln & Graz: Bohlau.

Ruys, Juanita. 2014. "Dying 101: Emotion, Experience, and Learning How to Die in the Late Medieval 'artes moriendi.'" *Parergon* 31 (2): 55-79. doi:[10.1353/pgn.2014.0115](https://doi.org/10.1353/pgn.2014.0115)

Rylands, William, ed. *The Ars Moriendi (Editio Princeps, circa 1450)*. London: Wyman & Sons.

Saunders, Cicely. 2006 [1962]. "Working at St Joseph's Hospice Hackney." *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1963]. "The Treatment of Intractable Pain in Terminal Cancer." *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1964]. "The Need for Institutional Care for the Patient with Advanced Cancer." *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1965]. "The Last Stages of Life." *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1967 I]. "St Christopher's Hospice." *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1967 II]. "The Management of Terminal Illness." *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1976]. “The Problem of Euthanasia (Care of the Dying - 1).” *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

———. 2006 [1978]. “The Philosophy of Terminal Care.” *Dame Cicely Saunders: Selected Writings*. Oxford: Oxford University Press. Kindle edition.

Seneca. 1920. *Epistle LXI*. in *idem. Ad Lucilium Epistulae Morales*, translated by Richard Gummere. Cambridge MA: Loeb Classical Library. Accessed September 28, 2020.

<http://www.perseus.tufts.edu/hopper/text?doc=Sen.+Ep.+61&fromdoc=Perseus%3Atext%3A2007.01.0080>

———. 1932. *Moral Essays: volume 2*, edited by John W. Basore. London and New York: Heinemann.

<http://www.perseus.tufts.edu/hopper/text?doc=Sen.+Tranq.+9.1&fromdoc=Perseus%3Atext%3A2007.01.0021>

Sutton, Christopher. 1839. *Disce Mori = Learn To Die*. Oxford: John Henry Parker.

Taylor, Jeremy. 1651. *The Rule and Exercises of Holy Dying*. London: R. Royston.

UK Government. 2020. “Coronavirus (COVID-19) in the UK.” Last modified December 29, 2020. <https://coronavirus.data.gov.uk/>

Vermandere, Mieke, Franca Warmenhoven, Evie van Severen, and Jan de Lepeleire. 2015. “The Ars Moriendi Model for Spiritual Assessment: A Mixed-Methods Evaluation.” *Oncology Nursing Forum* 42 (4): 294–301. doi: 10.1188/15.ONF.294-301.

Whaley, Joachim. 1981. “Introduction.” In *Mirrors of Mortality*, edited by Joachim Whaley, 1–15. London: Routledge.

Whitford, Richard. 1537. *A dayly exercyse and experyence of dethe*. London: Joh[a]n Waylande.

Wunderli, Richard and Gerald Broce. 1989. “The Final Moment before Death in Early Modern England.” *The Sixteenth Century Journal* 20 (2): 259–275.

Zalenski, Robert and Richard Raspa. 2006. “Maslow’s hierarchy of needs: a framework for achieving human potential in hospice.” *Journal of Palliative Medicine* 9 (5): 1120–1127. doi:10.1089/jpm.2006.9.1120