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Dying Virtues: Medical Doctors’ Epidictic Rhetoric of How to Die

Karen Kopelson

This essay takes the recent popularity of medical doctors’ narrative writings about the dying process as its cultural exigence, analyzing these alongside an earlier wave of such writings as epidictic rhetorics that function to reshape cultural values surrounding the “good death” by reconstituting our notions of virtuous dying conduct. Although the texts analyzed have many admirable and comforting qualities, encouraging us to face death with realism and assuring us that there are aspects of the way we die which are within our control, the virtues and modes of conduct they promote and exalt around a controlled death are available only to the privileged subject.

KEYWORDS: death and dying, epidictic rhetoric, virtues, agency, subjectivity

“Is she dying?” one of the sisters asked me.

I didn’t know how to answer the question. I wasn’t even sure what the word ‘dying’ meant anymore. In the past few decades, medical science has rendered obsolete centuries of experience, tradition, and language about our mortality and created a new difficulty for mankind: how to die.

—Atul Gawande, M.D. (2014)

January of 2016 saw the posthumous publication of Dr. Paul Kalanithi’s book, *When Breath Becomes Air*, the wrenching, yet soaring, first-person

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account of the 37-year-old neurosurgeon's dying (and living) process in the face of metastatic lung cancer. In an interview with the *New York Times*, Kalanithi's wife, Dr. Lucy Kalanithi, who completed the book's manuscript after her husband's death, recalled asking their literary agent how she thought the book would fare and being told, "Well, it's either going to do very well or it won't do well at all. It kind of just depends whether people want to read a book about dying, by a man who has died" (Hafner, 2016, para 2). *When Breath Becomes Air* became an instant best seller.

Preceding the publication of Kalanithi's book by just 15 months was renowned surgeon-writer Atul Gawande's (2014) book, *Being Mortal: Illness, Medicine, and What Matters in the End*, another medical doctor's narrative about dying, which became an instant best seller in the fall of 2014 (and has perennially returned to the *New York Times* best sellers list in the five years since its publication). Similar to Kalanithi's agent, Gawande's publisher expressed concern about *Being Mortal*'s potential for success, wondering if anyone "would want to read a book about dying," especially "during the holiday season" (McHugh, 2016, para. 1). Again, it turned out that not only did people want to read such a book, they were purchasing multiple copies to give as holiday gifts (McHugh, 2016, para. 2). At year's end, the *Washington Post* declared 2014, "The year we finally learned how to talk seriously about dying" and credited Gawande's book as the culminating contribution to this cultural-conversational "turning point" (Millman, 2014, para. 4).

As the word "finally" in the *Washington Post* headline attests, this recent purported "turn" in the way we talk about dying has been both long awaited and preceded by other periods of intense effort to facilitate similar discursive shifts. The 1990s were another decade marked by what Judy Segal (2000) has termed a "proximity" of discourse about death and dying, and one in which medical doctors' narrative writings for large public audiences played a large role (p. 29). 1993 marked the publication of the late Dr. Sherwin B. Nuland's best-selling, National Book Award-winning *How We Die*, a now legendary text in death and dying literature. Nuland's famed work was soon joined by other books about dying written by doctors who were then, and who remain, influential voices in medical and broader cultural discussions about how we (should) die in the contemporary United States. These included Dr. Timothy Quill's (1996) book, *A Midwife through the Dying Process*, and Dr. Ira Byock's (1997) book, *Dying Well*, which followed a year later. All three books continue to sell consistently today.

Fully accounting for these two (if they are discrete) waves of “death talk” (Segal, 2000, p. 29) is beyond the scope of this paper, but one can speculate on contributing factors. One factor may simply be generational cycling (see Solomon, 2016; Tedeschi, 2017). Reviewing five books on death and dying all released within weeks of each other in the winter of 2016 (of which Kalanithi’s was one), Andrew Solomon (2016) wrote simply but eloquently in the *New York Times Book Review* that “Death goes in and out of fashion. The topic lingers behind euphemisms for a few years, and then someone calls it forth again” (para. 1). Solomon goes on to list a number of influential authors and books that have called death forth over the last several decades, beginning with Elisabeth Kübler-Ross’s (2014) revolutionary *On Death and Dying* in 1969. With regard to factors beyond cycles of “fashion,” and with respect to the vociferous calling forth of death in the 1990s, Segal (2000) attributed that decade’s proliferation of death and dying talk to “the aging of baby boomers” and to the AIDS epidemic (p. 31). Further, whether as cause or consequence of broader cultural discourse, we can observe that the 1990s was a decade ushered in and shot through by significant legal activity concerning the right to die. 1990 marked the death of Jack Kevorkian’s first patient, for example (Kevorkian’s deeds would consume the public imagination until his conviction in 1999), as well as the landmark U.S. Supreme Court decision sentencing Nancy Cruzan to continued life support, and the beginning of the even more infamous legal case of Terri Schiavo, which would persist for 15 years.¹ The ongoing discursive wave of death talk is surely linked to the continual aging of the population and continuous dramatic increases to the human life span. Though commonly heralded as one of modern medicine’s greatest achievements, the fact of humans living longer has led to a “rampant institutionalization of death” (Warraich, 2017, p. 46); that is, to greater numbers of us dying (often slowly and alone) in hospitals or nursing homes, despite inroads made by hospice and related forms of healthcare which allow people to die at home (Warraich, 2017, pp. 45, 51; see also Volandes, 2015, p. 4).

¹These are just three of the most culturally renowned legal battles around the right to die that occurred in the 1990s. For a comprehensive overview of cases, and of the evolution of the right-to-die movement in the U.S. more generally, see Childress (2012). For rhetorical analyses of the right-to-die movement and key figures, such as Kevorkian and Schiavo, see Hyde and McSpirit (2007), Kenny (2000), and McDorman (2005).

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Certainly, the above-named factors all offer plausible explanations for the waves of discourse on death and dying in the 1990s and again today. What is telling for my purposes, however, is that doctors who wrote about dying in the 1990s, such as Nuland (1995), Byock (1997), and Quill (1996), and those writing today, such as Gawande (2014) and Kalanithi (2016), articulate much the same exigence for their work. All are seeking, first, to extricate the inevitable and organic processes of dying, both figuratively and literally, from medical and scientific “advances” and mandates to aggressive treatments, which have rendered dying inaccessible to understanding and, were it not for death’s insistence, almost impossible to achieve. Next, they are seeking to instruct us in how to die “better” within and against these mandates—with less suffering, and more autonomy and control, than modern medicine allows.²

Writing in introduction to Marilyn Webb’s Pulitzer Prize-nominated study, *The Good Death: The New American Search to Reshape the End of Life* (published at the height of the 1990s wave of death and dying discourse), palliative care specialist Dr. Joanne Lynn (1997) asserted that the best way to (re)gain a cultural familiarity with the dying process and with modes of living possible during it is through narrative. She stated: “We are a nation that desperately needs stories . . . about dying to provide some guides to appropriate roles and worthy behavior” (pp. xvii–xvix). Books by Lynn’s contemporaries Nuland (1995), Byock (1997), and Quill (1996), and by their successors Gawande (2014) and Kalanithi (2016), provide those stories and become those guides. In so doing, these books function as exemplary instantiations of epideictic rhetoric for our time.

²Though either slightly more specific or more expansive in focus than the texts of my study, three more recent doctors’ books about dying have continued this general trend (some of which have already been cited above). Angelo Volandes’s (2015), *The Conversation: A Revolutionary Plan for End of Life Care*, seeks to demonstrate, and to help rectify, the commonality of “horrible deaths” which result, in his view, from depersonalized scientific medicine and doctors’ failure to discuss options with critically ill patients (p. 26). Jessica Nutik Zitter’s (2017) *Extreme Measures: Finding a Better Path to the End of Life*, critiques what she terms the “end-of-life conveyor belt” leading to so many of us dying highly technologized and often brutalizing deaths in intensive care units. Haider Warraich’s (2017) *Modern Death: How Medicine Changed the End of Life* provides a history of dying over the last century, focusing on end-of-life changes wrought by medical technology. It is worth noting that concern over “a changing [increasingly technologized and depersonalized] field of medicine,” more invested in “prolonging life rather than diminishing suffering,” was an exigence for Kübler-Ross’s 1969 work as well (Kübler-Ross, 1969/2014, p. 11).

Epideictic rhetoric—most simply, the rhetoric of praise and blame³—“constitutes [what is] admirable in . . . human conduct” (Walker, 2000, p. 9). Though some scholars would contest the categorization, the Greek funeral oration has come down to us, largely via Aristotle, as epideictic rhetoric’s “exemplary genre” and original form (Segal, 2005, p. 61),⁴ the purpose of which was to “[call] on auditors to imitate the virtues of the deceased” (Sullivan, 1993, p. 115). That is, quite like the stories Lynn (1997) was calling for in the 1990s, the funeral oration, through its construction of and appeals to imitable virtues, “served not only to eulogize the dead but to guide the conduct of the living” (Sheard, 1996, p. 770). Despite this originary connection with funeral oratory, and despite a “renaissance” of epideictic rhetoric scholarship occurring coevally with the 1990s wave of death talk (Hogg, 2018, pp. 425–426), epideictic rhetoric has received little attention in rhetorical scholarship on modern death and dying. (Michael J. Hyde’s [2001] work constitutes a notable exception here.) Rather, rhetoric scholarship on death and dying has tended to focus on forensic or deliberative rhetoric in high-profile public debates and specific cases associated with euthanasia, physician-assisted death, or the right to die (Hyde, 2001; Hyde & McSpirit, 2007; Foley, 2010; McDorman, 2005; Kenny 2000, 2001), or on end-of-life decision making in institutional contexts (Segal, 2000, 2005; Barton, 2005, 2007; Keränen, 2007). It remains indeterminable whether this underexploration of epideictic rhetoric is due to a contemporary discomfort with the antiquated notion of “virtue,” due to epideictic’s “narrative character” (Hauser, 1999, p. 18) and general association with the literary or poetic (Perelman & Olbrechts-Tyteca, 1969, pp. 48, 51; Sullivan, 1993, p. 116; Walker, 2000, p. 7), or due to other lingering “[p]rejudices against epideictic

³Charlotte Hogg (2018) notes that the Aristotelian “thumbnail definition” of epideictic as the rhetoric of “praise and blame” has been critiqued by rhetoric scholars as at once “too reductive” and “too malleable” (p. 426). Other common, and sometimes preferred, definitions of epideictic rhetoric arise from the etymology of *epideixis* as “showing forth,” and thus conceive of it as the rhetoric “of display, of demonstration, of making known, of shining” (Moe, 2018, p. 436; see also Walker, 2000, p. 9; Rosenfeld, 1980).

⁴In *The Invention of Athens: The Funeral Oration in the Classical City* (1986), Nicole Loraux is emphatic that the funeral oration cannot simply be collapsed under or “merge[d] . . . into the genre” of epideictic rhetoric (p. 11). She notes that “the funeral oration [was] a form existing before the full development of rhetoric” (p. 43); that it was a form with a specific “politicomilitary character,” serving more to praise Athens *as a city* with a distinct political system than to praise or eulogize its dead (pp. 11, 56). “[T]he epideictic genre” therefore, she maintains, “seems more like a neighboring genre than like [the] larger whole” that Aristotle’s classificatory system made of it (p. 225).

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discourse” as somehow less publicly relevant than the forensic or deliberative (Sheard, 1996, p. 767). What seems clear, however, is that the work done on epideictic rhetoric in our death and dying scholarship (however scant) or in closely related scholarship, such as Segal’s (2005) work on the epideictic rhetoric of illness narratives, is suggestive of future directions for inquiry *and* of the enormous cultural power of epideictic rhetoric itself.

Even when conceived in its simplest formulation as the rhetoric of “praise and blame,” epideictic rhetoric may be “a culture’s most telling rhetoric,” given that “we praise people for embodying what we value, and we blame them for embodying what we deplore” (Segal, 2005, p. 61). It may also be a culture’s most “fundamental” rhetoric (Walker, 2000, p. 9). As Jeffrey Walker (2000) explains, by asking its audience to form opinions “about what is praiseworthy” (or blameworthy), the “suasive ‘demonstration’” of epideictic “shapes and cultivates the basic codes of value and belief by which a society or culture lives” (p. 9). Epideictic rhetoric’s especial power, moreover, arises from, or perhaps inheres in, its aforementioned “narrative character.” As Segal (2005) writes, narrative is distinctly formative and constraining at once: “Narrative . . . gives us a repertoire of available responses” so that, essentially, “we live in the terms of the epideictic rhetoric of the moment” (p. 69). Hyde (2001), too, in his expansive work on rhetorics of the euthanasia debate, references epideictic rhetoric’s cultural power in its ability, as narrative, to “strike and arouse the hearts of others” (p. 146). So revelatory and emotionally evocative does he find epideictic narrative, in fact, that he intimates the euthanasia debate may well “be decided by those who end up telling the best stories” (p. 178).⁵ Perhaps the way we die in the United States will be similarly decided.

This essay analyses five narrative texts written by medical doctors seeking to instruct us in the process of dying, building from and extending the insights regarding the telling and fundamental cultural role of epideictic rhetoric. Specifically, in what follows, I elucidate how recent best-selling books about dying by Gawande (2014) and Kalanithi (2016), and key predecessors in the tradition by Nuland (1995), Byock (1997), and Quill (1996),

⁵In this passage, and throughout *The Call of Conscience: Heidegger and Levinas, Rhetoric and the Euthanasia Debate* (2001), Hyde is largely working from the etymological definition of *epideixis* (see note 2) as evocation and revelation, as a “‘showing forth’ of what is” (p. 178). For instance, in his discussion of the “epideictic discourse” of Justice Stevens’s dissenting opinion in the Cruzan case, Hyde writes, “Stevens speaks to us of persons, not abstractions. He wants to move us closer to . . . a reality of living death” (p. 201).

endeavor to reconstitute our notions of virtuous dying conduct in order to (re)shape the codes of value and belief by which we approach our deaths. I show that they do so, in part, by resurrecting ancient values and virtues, such as acceptance of and courage to submit to death, praised in Greek funeral oratory and other classical texts. More specifically still, I demonstrate how, through suasive narrative demonstrations of different dying processes, the texts disparage the deeds and character of those who die “poorly,” while they praise (in order to constitute) the virtues of those who “die well.” These five touchstone books on dying, I acknowledge, have many admirable and comforting qualities. In defining dying well as courageous yielding to death at the right moment, they encourage us to face death with realism even as they continually assure us that there are aspects of the way we die that are within our control. Ultimately I argue that it is precisely in their focus on control, and on how to (and who can) exercise it in the face of illness and death, however, that the texts raise concerns. The virtues and modes of conduct promoted and exalted in these five books as those which eventuate in a controlled (thus, good) death—among them, self-transformation, striving, and preparing and deciding for death—are those available only to the privileged subject, where “privileged” denotes both class privilege and the self-mastering, self-determining subject favored by the West. Before getting to any of this exposition and critique, however, I more thoroughly introduce my five texts and their doctor-authors. In so doing, I further explain how these texts, as paradigmatic examples, manifest epideictic rhetoric’s features and functions (not all of which are laudable), and thus its particular cultural power.

The Doctors, Their Stories, and “The Ethos of Epideictic Encounter”⁶

Though all slightly different in arrangement and style, each text examined here heeds (or presages) Lynn’s (1997) call to help bring about new modes of dying through the power of story. Nuland’s (1995) foundational text is renowned for its meticulous, unsparing displays of “the actual processes by which various diseases drain us of vitality and take away our lives” (p. xviii). Yet in Hyde’s (2001) estimation, *How We Die* is primarily driven by Nuland’s “moving stories” (p. 238)—of patients, friends, and family members as

⁶The quoted phrase is borrowed from Dale L. Sullivan’s (1993) article of the same title.

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they are transformed by these processes and succumb to death. Quill's (1996) and Byock's (1997) stories in *A Midwife through the Dying Process* (hereafter, *Midwife*) and *Dying Well*, respectively, share the most in common both in agenda and form. Both doctor authors have been leading voices in hospice and palliative care movements, while Quill has also been an outspoken advocate of physician-assisted death.⁷ Each book is organized by physician-told narratives of patients' dying processes, the titles of which designate an intended theme—for example, "You Promised Me I Wouldn't Die Like This" (in Quill) and "Growing within Tragedy" (in Byock). Gawande's (2014) text is organized by theme or topic (for example, "Dependence"; "Letting Go") and, like Nuland's, is driven largely by stories of patients' and family members' dying processes. Finally, Kalanithi's (2016) book is unique in narrating his own dying process (a distinction I make more of below), but also incorporates stories of patients and family.

Each doctor-author claimed or implied that it is both an intention and effect of his text to bring readers closer to the actual reality of dying through the revelation of storytelling and/or vivid rendering of bodily states (Nuland, 1995, p. xvii; Quill, 1996, p. 3; Byock, 1997, p. xiv; Gawande, 2014, p. 9; Kalanithi, 2016, p. 215).⁸ While Nuland arguably comes closest to achieving this effect, all of the doctor-authors' displays of dying, including his, are (per Walker's [2000] definition of epideictic) deeply *suasive*, serving to promote and facilitate their vision for how to die appropriately or well. Quill's and Byock's texts have been critiqued along just these lines—for being limited by the doctors' "passionate advocacy for their own styles of care" (and, to my point, styles of dying), and limited by being "told from the vantage point of the physicians themselves" (Barnard, Towers, Boston, & Lambrinidou, 2000, pp. 5–6).

Accusations of selectivity, slant, and univocality in Byock's and Quill's demonstrations of dying would apply to the texts of my other authors as well. In some circles, such features constitute methodological or narrative

⁷Though physician-assisted death has been controversial among hospice and palliative care practitioners, in 2013 Quill was nonetheless named a "Visionary" by the American Academy of Hospice and Palliative Medicine (an honor also received by Byock and Gawande) (Smith, 2013).

⁸Again, bringing readers "closer to reality" is the preeminent epideictic task when epideictic rhetoric is conceived as the rhetoric of revelation, display, making known, or shining forth. See notes three and five.

flaws.⁹ Yet these bias-features fulfill and illumine the books' functions as epideictic rhetoric. As many rhetoric scholars have observed, epideictic rhetoric is didactic—minimally, in that it is aligned with teaching, but also often in the stronger sense that it seeks to shape morality and prescribe right action (Perelman & Olbrechts-Tyteca, 1969, p. 52; Sullivan, 1993, pp. 115, 125; Hauser, 1999, pp. 17–19). The obvious narrative selectivity and slant of these doctor-authors' accounts of dying thus arise from and reflect their mission, as epideictic rhetors, to lead readers "to a common sense of the virtuous path" (Hauser, 1999, p. 17), in the form of common but specific ways to die.

The epideictic function of the narratives contained in these five texts is further enhanced and illumined by the fact that they are told by physicians (and, in some cases, surgeons), and by physicians of exceptional repute. As rhetoric scholars have again made clear, because of epideictic rhetoric's role in instilling virtues and shaping cultural values, it is essential to the epideictic encounter that the rhetor manifest cultural authority, which can be bolstered further still by individual reputation (Halloran, 1982, p. 60; Perelman & Olbrechts-Tyteca, 1969, p. 52; Sullivan, 1993, p. 126). In short, ethos, as Dale L. Sullivan (1993) has argued, "plays [an especially] important part in the effective use of the [epideictic] genre" (p. 116). Though doctors' cultural authority has diminished in recent decades, doctors remain uniquely positioned and authorized to speak, write, and teach about dying. They possess a constant, *material* awareness of death and dying that continues to set them apart from the majority of laypeople (see Charon, 2006, p. 22; Hunter, 1991, p. xviii).¹⁰ Reviewing the multiple ways expertise accrues to doctors in *Doctors' Stories: The Narrative Structure of Medical Knowledge*, Kathryn Montgomery Hunter (1991) concluded that, "Above all, they are familiar with death and [we imagine] are fearless and rational in its presence. Most of us will learn from one of them how and approximately when our lives will end" (p. xviii). It makes sense, then, that as a culture we would continue to turn to the authoritative, authorized, and authorizing accounts of doctors' stories to learn *how to die*.

⁹Scholars across medical humanities and disability studies have long expressed concern about the potentially appropriative, exploitative authority of "doctors' stories" (Hunter, 1991), and encouraged greater attentiveness to illness narratives told by laypeople (see, for example, Hunter, 1991; Frank, 2013; Couser, 2004).

¹⁰According to Rita Charon (2006), it was "this gap in laypersons' knowledge of what really happens" as we die that Nuland was seeking to fill in writing *How We Die* (p. 35, n. 10).

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With regard to individual ethos or reputation, Kalanithi and Gawande are almost surely the best known and most highly esteemed of my study's authors at the present time. After its instant ascent to best seller status, Kalanithi's (2016) text went on to become a finalist for the Pulitzer Prize (among other awards) and was named one of the best books of the year by news outlets too numerous to list here. Gawande's (2014) *Being Mortal* likewise was named a best book of the year by innumerable sources, though he accumulated a good deal of cultural clout prior to its resounding success, having authored three previous best sellers, written regularly for the popular press, and being named in 2010 as one of the world's hundred most influential thinkers by *TIME Magazine* (McHugh, 2016). As for the earlier doctor-authors, at the time of his death in spring of 2014, Nuland was the author of 12 other books beyond his legendary *How We Die* and had contributed prolifically to high profile periodicals for decades. Byock and Quill, though perhaps less widely known today than Nuland, are foundational figures to any study of death and dying discourses. At the time of *Dying Well's* publication, Byock (1997) was president of the American Academy of Hospice and Palliative Medicine, and has since held a number of similarly prestigious leadership positions in the field. He has authored or co-authored four other books on end-of-life care and also writes frequently for the popular press. Quill, whom Hyde (2001) called "a master storyteller who has achieved celebrity status" (p. 231), is best known—or was at the time of *Midwife's* 1996 publication—for his 1991 *New England Journal of Medicine* article, and fallout therefrom, in which he revealed he had prescribed a lethal dose of barbiturates to a terminal patient to assist her in dying. (The story also introduced Quill's [1993] first book, *Death and Dignity: Making Choices and Taking Charge*).¹¹ He has continued to publish widely on end-of-life decision-making and care.

Finally, the cultural authority of my study's doctor-authors is enhanced further still by their maleness. To be sure, that the doctor-authors who have achieved "celebrity status" for their writings about death and dying are men reflects the persistent sexism of U.S. society and the field of medicine—silencing sexism which resound all the more loudly when we consider that

¹¹ Quill would go on to become a lead plaintiff in *Quill v. Vacco*, another high profile 1990s legal battle over death and dying rights which reached the Supreme Court in 1997. The court upheld the New York state ban on physician-assisted suicide (see Hyde, 2001, pp. 230–33, for an overview of these events).

women have been entering the medical profession in numbers roughly equal to men for over 20 years and have most certainly contributed to U.S. cultural conversations about how we (should) die.¹² The gender of these authors not only signals and enhances their cultural and professional authority, but once again calls attention to a distinguishing if troubling feature of epideictic rhetoric. As recent attempts to “regender this persuasive category” attest (Wood, 2016, p. xviii; see also Hogg, 2018), epideictic rhetoric, in “both classical and contemporary conceptions,” has been “the exclusive province of elite male orators” (Wood, 2016, pp. 2, xii), aligned across the ages with “grand, male, public displays” (Hogg, 2018, pp. 444–445). While the authors of my study are not delivering public speeches, they are nonetheless exercising the “prerogative of powerful men” to deliver grand, public pronouncements of praise or blame (Wood, 2016, p. xi) through which they legislate public morality about a universal experience of the greatest personal and cultural significance: the ways and means of achieving a good death.

I make so much of my authors’ cultural authority—as highly reputed, elite, male doctors and authors—because the *additional* authority of reputation, masculinity, and, in Kalanithi’s (2016) case, of embodied experience, may prove necessary not only for the authors’ most effective use of epideictic rhetoric generally, but in their efforts to write about dying specifically. Despite their obvious and distinctive purview over death and dying, doctors nonetheless have been trained to view death as a “technical defeat” or “medical failure” (Charon, 2006, p. 22; Quill, 1996, p. 1), and thus to stave it off and save us from it at all costs, literal and figurative. Their frank discussions of the dying process thus risk being perceived, both in and outside of medicine, as a betrayal of this training and of the public’s trust—surely a truer assessment and greater rhetorical and professional risk for pioneering doctors writing in the 1990s than for those today. But even more recently, Gawande (2014) acknowledged this reality in *Being Mortal*’s introduction, stating simply, “Some will be alarmed by the prospect of a doctor’s writing

¹² As a recent article in *The Guardian* points out, while U.S. women have been *entering* medicine in numbers roughly equal to men for two decades, they are “systematically disadvantage[d] . . . at every stage of their careers, causing many to leave” (Poorman, 2018). Further, top leadership positions continue to be dominated by men, and the accomplishments of women physicians overlooked (Poorman, 2018). These factors, coupled with epideictic rhetoric’s historical masculinity and concomitant exclusion of women (Wood, 2016, p.2), would account for female doctors’ underrepresentation as “celebrity” epideictic rhetors on death and dying even as women (doctors, nurses, journalists and others) have contributed to our cultural conversations on death and dying in other genres and forms.

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about the inevitability of decline and death” (pp. 9–10). In sum, to write about the dying process, a doctor-author must *write against the ethos of medicine* and its life-prolonging logic of technological interventionism. Individual reputation (and surely the privilege of masculinity) helps mitigate some of this risk. Yet it remains the case that when “mak[ing] statements contrary to received opinion,” even extra-authoritative and authorized epideictic rhetors “are in danger of undermining their authority unless they are able to associate the statements with some other generally accepted value and to show that value’s superiority” (Sullivan, 1993, p. 124). This is precisely the tack we see doctor-authors taking as they write against their field’s highly influential values of techno-scientific interventionism by appealing to the U.S. culture’s widely shared values of choice, autonomy, and control in their constructions of virtuous (and non-virtuous) dying conduct.

Fighting for the Bad Death and Never Letting Go

As stated, a primary task of each text studied here is to instruct us in dying *better*. Indeed, Byock’s (1997) text, as its title suggests, is composed almost exclusively of hopeful narratives of patients “dying well.” This is not to suggest, however, that doctor-authors shy away or shield us from displays of intense suffering. Rather, the display of suffering, and of entirely “bad deaths,” becomes an integral and highly efficacious element of their epideictic instruction in achieving the best death possible.

Readers may come away from Nuland’s (1995) text, in fact, with the sense that there is only “bad death,” as it reads, “In dying . . . there is only the affliction” (Nuland, 1995, p. 268) and, as noted above, spares no detail in conveying the myriad ways in which dying is suffused with and even constituted by suffering. In a chapter on heart disease, for example (Nuland’s chapters are organized by disease), Nuland explains how “acute pulmonary edema,” or fluid in the lungs, becomes a “frequent final event” for sufferers, essentially causing death by drowning: “[E]xcessive fluid volume dams up and floods the lungs. Severe air hunger rapidly supervenes, the gurgling, wheezing respirations begin . . . there is no return” (p. 30). In a chapter on AIDS, Nuland describes the “torment of the final months” of this disease, detailing its fevers, night sweats, “uncontrollable watery diarrhea,” “running sores,” and dementia (pp. 190, 188). In a chapter about Alzheimer’s, Nuland’s late-stage patient, Phil, is pronounced to be “profaned” by the disease, which leaves him sitting obliviously in urine-soaked clothes and “sometimes

smear[ed] with his feces" (p. 100–101). Though these passages are frightening, Nuland clarifies repeatedly that his "intention is not to depict [dying] as a horror-filled sequence of painful and disgusting degradations," but to educate us in "what dying is like" so that we might "make choices that are most likely to avert the worst of it" (pp. xvii, 143). Nuland hopes we will make choices that ensure "the end can be managed with the greatest degree of control allowed by the pathological process that kills us," rather than those which "propel the dying person . . . into a series of worsening miseries from which from which there is no extrication" (pp. 268, 143). The displays of suffering and bad deaths in other doctor-authors' accounts of dying prove didactic as well, but in the stronger, moral sense. Beyond the educative purpose of giving us "[a]ccurate knowledge of how a disease kills" to inform sound decision-making (Nuland, 1995, p. 143), other doctors display suffering to instruct the public in right attitudes and right (dying) conduct.

As indicated, Quill's (1996) epideictic demonstrations of the dying process are especially suasive in serving to evidence the ethics and necessity of physician-assisted death. *Midwife* tells numerous stories of patients who, despite having made the types of choices for which Nuland advocates, were eventually experiencing such bad deaths that they preferred to die. *Midwife's* opening narrative, for example, tells the story of Cynthia, a young woman dying from gastric cancer, who—once she chose to stop invasive treatments and receive palliative care at home—was initially dying well: she was "say[ing] what needed to be said" to friends and family, giving "favorite possessions to special people in her life," in short, "preparing for death" (Quill, 1996, p. 20). Yet soon "the extraordinary process of her saying goodbye" was overtaken and displaced by physical symptoms of implacable nausea and vomiting, and then by "relentless dry heaves, retching, and hiccoughs" (pp. 21–22). Additionally, an "open wound filled with cancer which was growing on [Cynthia's] abdomen" (p. 21) was causing her humiliation because of its foul smell. Cynthia "had done the hard work of preparing to die" and had said her goodbyes, Quill reemphasizes; now she was only suffering and "ready to die" (p. 22).

A stated objective of narratives like Cynthia's, which Quill (1996) foregrounds in *Midwife's* introduction, is to combat "[t]he notion that all requests to physicians for assisted death stem from undertreated pain, unrecognized depression, or some kind of character flaw" (p. 4). Yet, a related, more pernicious notion Quill seems to be contesting—strenuously, given his insistent praise of Cynthia's (and others') hard work—is that *bad deaths*

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themselves result from “some kind of character flaw.” Representative accounts of bad deaths from Gawande (2014) and Byock (1997) attest to the urgent need for Quill’s preemptive intervention. While Quill attempts to influence attitudes and conduct through character defense of patients like Cynthia, Gawande’s and Byock’s displays of bad deaths work to shape morality and action by disparaging the character, behaviors, and, especially, the choices of individuals who die “poorly.”

Gawande (2014), like Nuland (1995), emphasizes the values of choice and control in facing death, explaining in *Being Mortal*’s last chapter that though he is “leery of suggesting . . . that endings are controllable,” he wants to stress that “we are not helpless either” and “have room to act” (p. 243). Like Nuland, he strives to demonstrate that if we can resist “the seemingly unstoppable momentum of medical treatment,” and “make the choices that [mean] the most to [us],” we may even be able “to end [our] stories on [our] own terms” (pp. 165, 242, 249). The display of bad death is once again crucial to his overarching rhetorical-pedagogical task.

Gawande (2014) displays *Being Mortal*’s most wrenching death in its chapter titled “Letting Go,” which features a young woman unable to do just that. Diagnosed with stage IV lung cancer at 34 years old, Sara Monopoli, who is “unready to confront the reality of her disease,” pursues various futile and “debilitating” treatments, thus sacrificing her “opportunity to prepare for the inevitable” (pp. 167, 170). Gawande apportions some blame to Sara’s medical team, as well as to her family, both of whom also “remained in battle mode” (p. 170). Yet Sara’s individual failure (and flaw) is that she had not “learned how to achieve her goal” of avoiding “hospitals or ICUs [intensive care units] at the end” (p. 188). Instead, Sara dies in the hospital, her treatment stopped only when she slipped into unconsciousness and her family refused to put her on a ventilator. Gawande characterizes Sara’s death as “a modern-day tragedy” that is nevertheless a collective modern-day dream: “to fight, to die with chemo in our veins or a tube in our throats or fresh sutures in our flesh,” all the while “shortening or worsening the time we have left” (p. 173).

Byock (1997) displays one extremely bad death (out of over a dozen patient narratives) in *Dying Well*—so bad that the narrative’s first sentence warns us it will be difficult to read. And, like Gawande’s (2014) discussion of Sara, this narrative features and faults a young woman who is unable or unwilling to make choices that would facilitate “letting go.” According to Byock, the dying process of Terry Matthews, a 31-year-old mother with

kidney cancer, culminates in “a crescendo of agony” (p. 193). With pervasive metastatic disease that had become “impervious to the usual [and then to less usual] pain medications,” Terry was “trapped by her pain . . . as if she had been cornered by wildfire”; her “intermittent shrieks [of] ‘I’m on fire! It’s burning me up!’ . . . could be heard on the street” (pp. 214, 204, 206–207). Finally, a barbiturate drip is used to sedate Terry into unconsciousness until she dies—palliative medicine’s last resort for pain relief (p. 208). Terry, Byock (under)states, “did not ‘die well’ in the usual sense of the term” (p. 212).

It may be possible to read Byock’s (1997) display of Terry’s agonizing death as a concession to his “critics who say that in focusing on dying well [he is] sugarcoating the dying experience” (p. 218). To do so, however, would be to sugarcoat Byock’s readily apparent intentions. Though Byock states that Terry “remained true to her spirit and true to her values,” and in that sense “died well because she died her way” (p. 193), it quickly becomes clear that Terry’s “way” is not an equally valid alternate route to death but the road to her suffering. Like Gawande’s (2014) Sara, Terry had “fought [her] disease every step of the way” (p. 197), “seeking every life prolonging option” (p. 214) available, and living “in a state of emotional defiance of what was happening to her” (p. 200). “Fueled by a superstitious hope” that she had more time than she did, Terry failed to complete the parting gifts she was crafting for her children, and thus to properly say goodbye to them (pp. 198–199). In sum, Terry “never did let go” (p. 212). While Byock reiterates at her narrative’s end that Terry’s fight was true to her spirit and arose from love of family (p. 212), the seeds of disparagement have obviously been sown, to take root, ultimately, in outright blame: Terry’s physical pain was “enormous,” Byock acknowledges, “as bad as it gets,” as bad as he’s seen, but he “[has] no doubt” that Terry’s inability to face death “contributed to her pain” (p. 214). Terry “refused to adjust to her illness,” choosing instead “to claw at every possible route to survival,” Byock reminds us, “and for this she paid the price of extreme physical distress” (pp. 214–215). In case readers somehow miss the moral of Terry’s story, Byock follows her tragic cautionary tale with a floridly encomiastic narrative of his patient Maureen Riley who, in her dying, “epitomized a blessedness that comes with letting go” (p. 217).

Disparagement and at times flagrant blame function powerfully in Terry’s and Sara’s stories to illumine that a most significant—and significantly new—character flaw emerging within late modern rhetorics of dying is

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“being a fighter.” Sociologist Clive Seale (1995) affirmed the early stirrings of this shift in the mid-1990s (when Nuland, Quill, and Byock were writing), noting that the long-heralded ideal of “fighting” or “battling” against disease and death seemed to be lessening in esteem, to be replaced by acceptance and related virtues such as the wisdom and courage to adjust oneself to illness and discontinue treatment (p. 604).¹³ These virtues are illumined by Quill’s (1996) defensive praise of Cynthia and refracted by disparagement of Byock’s (1997) Terry and Gawande’s (2014) Sara, who, in (what is portrayed as) their failure to choose “wisely,” and their abdication of autonomy and control, serve as powerfully instructive anti-models for how (not) to die. Yet this point might be made more effectively through positive modeling. Rather than being shamed, blamed or scared into “right” action, people could be presented with laudable qualities and deeds to emulate, arguably the pre-eminent task of epideictic rhetoric (see Hauser, 1999, p. 17; Sullivan, 1993, p. 118; Sheard, 1996, p. 779). Epideictic rhetoric, as Gerald Hauser (1999) has memorably stated, “constructs accounts of nobility worthy of mimesis” (p. 18). His oft-quoted phrase captures perfectly the motives and effects of doctor-authors celebratory narrative accounts of those who die well—narratives which attest to and construct the personal attributes and behaviors that are coming to constitute virtuous dying conduct in the contemporary period.

Dying Virtues: All Roads Lead from Acceptance

Acceptance may be understood as a cardinal virtue of the person who dies well, in the sense that it is foundational and that other virtues depend upon and flourish from it. For instance, in Gawande’s (2014) story of his own

¹³ Seale (1995) based this observation on his study analyzing 250 lay accounts of the death of a loved one where participants expressed “ambiguous” valuations of “attempts to fight.” While in some cases such attempts remained associated with “admired” qualities (virtues) such as bravery and strong will, “fight [was also] associated with less admirable qualities” such as “obstinacy” and “meaningless” effort. “Acceptance,” Seale wrote, “represented for many the goal of the struggle . . .” (p. 604). More recent research suggests that the growth and influence of the palliative care and right-to-die movements have now made qualities such as “accept[ance] [of] the timing of one’s death” and “preparing for departure” dominant “attributes of the good death” among “the majority of people,” but have also created difficulty and conflict for those who resist the new norm and choose to fight (Granda-Cameron & Houldin, 2012, pp. 635, 637-38). As the authors of a recent “concept analysis of good death” concluded, “the definition of good death is subjective, and it may vary from person to person[;] . . . fighting until the end for some could be another attribute of a good death as well” (Granda-Cameron & Houldin, 2012, p. 638).

surgeon-father's processes of living with and then dying from a slow-growing spinal tumor, his father's acceptance of "the finitude of [his] time" at first begets ordinary end-of-life deeds such as making more time for family and travel (p. 209). Acceptance eventuates, however, in an extraordinary willingness and ability to wholly transfigure the self. When Gawande's father is forced at last by creeping paralysis in his hands to retire from surgery, Gawande writes that the family "braced for the worst." Surgery had been his father's "calling," his "purpose and meaning in life" (p. 210). Yet, rather than falling into despair over loss of self and vocation, Gawande's father manifested "an altogether unexpected transformation. He threw himself into his work as Rotary district governor" (a position he had assumed some months earlier), even "chang[ing] his e-mail signature from 'Atmaram Gawande, M.D.' to 'Atmaram Gawande, D.G.'." "Somehow," Gawande concludes, "instead of holding on to the lifelong identity that was slipping away from him, he managed to redefine it" (p. 210).

Seale (1995) has explained that dying during the late modern period is expected to be "incorporated into the process of reflexive formation of self-identity" (p. 598). Quill (1996) and Byock (1997) share and promote this view, which is characteristic of the hospice ideology of end-of-life care (see Banerjee, 2005), that even as dying "threatens the integrity of the person," it presents ample "opportunities for personal growth" (Quill, p. 136), which the person who dies well is able to take advantage of (for example, Quill, p. 136; Byock, p. 186). But the virtue being celebrated by Gawande is something akin to a heroic capacity for self-refashioning—full self-*transformation*, not merely growth or continued self-formation—in the face of death. Kalanithi (2016), then, becomes our supremely imitable model of this virtue.

Rather than trying to hold on to or "rebuild [his] old life," Kalanithi (2016), like Gawande's (2014) father, discovers an "ability to forge a new [identity]"—primarily as a father and writer—as he struggles with terminal illness (pp. 166, 139). While Kalanithi credits his oncologist for having "protected" this ability in him (p. 166), the real praise, as that phrasing suggests, is in this moment and throughout the entirety of the text primarily of his own dying conduct and *of the self*. As observed briefly earlier, Kalanithi's book's status as end-of-life memoir, and thus its self-focus, is what distinguishes his from the other doctors' accounts of dying. This feature is also, however, what distinguishes Kalanithi's narrative as an under-examined mode of epideictic rhetoric, which, as theorized by Robert

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Danisch (2006), “celebrat[es] the self” as a way to produce “new possibilities for everyday lived experience” and “new forms of agency” (p. 301). The new possibility for everyday experience which Kalanithi’s rhetoric seeks to model and produce is that of a *dying* experience wherein one’s capacity for agentive activity itself is preserved or even enhanced—an experience embodied, reflected, and achieved in Kalanithi’s account through the virtue of “striving.” Invoking Darwin and Nietzsche, Kalanithi concludes that since “the defining characteristic of the organism is striving,” he will “carry on living instead of dying” (pp. 143–144). Surely, striving is necessary to transfigure the self and recast one’s life in new terms, but in Kalanithi’s case the virtue literally begets new life. Because of his resolve to carry on living while dying, Kalanithi and his wife Lucy decide to have a child, knowing that Kalanithi would likely die during her infancy (he died eight months after his daughter’s birth). When Lucy asks him, “Don’t you think saying goodbye to your child will make your death *more* painful?” Kalanithi responds, “Wouldn’t it be great if it did?,” explaining to readers that neither he nor Lucy “felt that life [was] about avoiding suffering” (p.143, original emphasis).

Clearly, there is a tremendous amount of bravery or courage manifested in Kalanithi’s (2016) scenario and perhaps even something of the “battle” or “fighting courage” present in older rhetorics of dying and in traditional/classical formations of (masculine) courage, which, as Walter T. Schmid (1992) illumined, have long included “standing up to . . . fear” or to “the pain of disease” (pp. 104, 107). But while the courage that flows from acceptance still manifests in determined resolve, in striving for more and *good* life, it absolutely does not eventuate in a battle against death itself. The courage that flows from acceptance of terminal illness culminates instead in an unwavering, agentive acquiescence to death at a kairotic moment, which for Kalanithi (2016) occurs with “the prospect of losing meaning” and bodily control (p. 203): Facing a respiratory crisis that would require intubation, and with metastases now in his brain, Kalanithi tells Lucy he is “not sure [he sees] a future that includes meaningful time” (p. 208). The next morning, according to Lucy Kalanithi’s epilogue to *When Breath Becomes Air*, Kalanithi refused intubation, looked at Lucy over his oxygen mask, and in a voice “soft but unwavering” said, “I’m ready”—ready, she clarifies, to remove the mask, “to start morphine, to die” (p. 210).

While Kalanithi (2016) may serve as our paragon of resolute yielding to death, other doctor-authors reserve special commendation for their patients who exhibit this same type of courage. Nuland (1995), for instance, praises his “advanced cancer patients” who, upon learning from him the danger and probable futility of late forms of treatment, “have wisely chosen to do nothing, and found their hope in other ways” such as in living for a final Christmas with family (pp. 231, 241). Quill (1996), whose suasive narratives almost all revolve around patients who have thus “wisely” chosen, nonetheless praises one AIDS patient in particular, Robb, who chooses to stop all interventionist treatments and transition to palliative care “during his first major hospital crisis” (p. 45). Though Quill claims he was initially “shaken” by what seemed Robb’s premature decision, he came to see it as one of “clarity and courage,” affording Robb “the opportunity for a dignified exit” absent “the extremes of deterioration he had witnessed in others” (p. 45). Finally, Gawande (2014), too, praises patients who (in contrast to Sara Monopoli) refuse to submit to the “deep gouges” inflicted by aggressive medical treatment at the end of life (p. 249), and who instead, in the words of one such patient (Jewel Douglass), take “no risky chances” (p. 240). These patients, like those whom Nuland celebrates, find hope in small but realistic goals. Not (at all) incidentally, the deaths that follow from these courageous refusals of aggressive treatments are described as remarkably peaceful. Robb’s dying hours, as narrated by Quill (1996), are accompanied by the Native American drumming rituals from one of his friends, which “transported [everyone on the hospital floor] to a time, a place, and a culture in which death was accepted and sometimes even welcomed . . . [Robb] peacefully slipped into a coma and died, with drums receding in the background” (pp. 46–47). Gawande (2014) quotes a letter from Jewel Douglass’s daughter to relay that her death, likewise, “was very peaceful. My dad was alone by her side with the rest of us in the living room,” the daughter writes. “This was such a perfect ending . . .” (p. 242).

In many respects, the virtue of courage seems to be undergoing deep revisions and possibly a “feminization” in these doctors’ didactic accounts of dying conduct. Fighting, battle, and action are replaced by acquiescence, graceful (if fierce) yielding, and (voluntary, agentive) *inaction*—Nuland’s (1995) lauded “doing nothing.” Additionally, as Seale (1995) has again observed, the valuation of personal growth and reflexive self-formation in late modern discourses of dying interiorizes courage: “the

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traditional emphasis on courage in the face of external danger now becomes courage to [go inward to] explore and express the dying self,” thus valorizing what he terms a “female . . . heroics” of “emotional labour” (p. 599). Yet in other respects, or perhaps through a slightly adjusted lens, courage in the doctors’ narratives remains intriguingly traditional and masculinized. According to Schmid’s (1992) book-length analysis of Plato’s the *Laches*, *On Manly Courage*, “The willingness . . . to stand and die was for the ancient Greeks and is for all time a living symbol of manly courage and freedom and dignity . . .” (p. 105). (Quite tellingly, Gawande [2014] actually draws from the *Laches*, in a chapter entitled “Courage,” to frame and praise patient Jewel Douglass’s “prudent strength” in taking no “risky chances” [pp. 232, 240].) Though today’s brave men (and women) who die well are no longer standing in battle mode, they are no less fearless and resolute than competitive warriors. Indeed, they continue to demonstrate the ancient formation of masculine courage theorized by Schmid (1992), which “call[ed] for the . . . manly acceptance of ‘what will be’ . . . —not in the childish form of pietistic endurance, but in the vigorous manly form that accepts the [limits of action]” (p. 170). According to the doctor-authors’ narratives, today’s reward for such vigorous, manly acceptance of death is nothing less than the merciful absence of suffering while dying.

Important for inquiries into epideictic rhetoric as an evolving genre, the formation of courage praised in doctor-authors’ narratives of dying may also most closely align their contemporary epideictic rhetoric with epideictic’s original, exemplary genre, the Greek funeral oration. According to Nicole Loraux’s (1986) definitive study, *The Invention of Athens: The Funeral Oration in the Classical City*, the epitaphios commends above all else an acceptance of death that is perhaps more appropriately framed as an “active decision” or “determination to die” (p. 102). It is critical to note that being praised specifically in Athenian epitaphios was the citizen-soldier’s courageous willingness to die *for the city*—a full “abandonment of self” (p. 101) for the collective quite at odds with modern Western culture’s celebration of selfhood and individualist values (p. 105). Still, though, compelling similarities exist in contemporary doctors’ rhetoric’s and ancient epideictic’s glorifying praise of an *active submission* to dying, and of the choice, the “lucid act of will” (Loraux, 1986, p. 101), which produces it. In the final section of this essay, I analyze the (virtuous) forms of preparation for dying in which doctors instruct us so that we, too, will be able to courageously submit to death, and what we are promised in return.

"Always to be Prepared": The Privilege of Cultivating Virtue

A definitive feature of "virtues" across ancient and contemporary conceptions is that they must be cultivated; they can only be developed through instruction, experience, practice, or habituation (Duffy, 2017, pp. 234–35). Doctor-authors hold fast to this age-old understanding of virtue, propagating the idea, implicitly and often explicitly, that preparing for death, often over an entire lifetime, is fundamentally necessary (and invariably effective) for the cultivation of acceptance and related dying virtues of self-transformation, striving, and the courage to yield to death at the right moment. Doctors' narratives suggest various means of preparation. Byock (1997), for example, intimates that those who die well likely "worked hard earlier on relationships and on . . . themselves, acquiring . . . the skills necessary" to grow at the end of life and then die well (p. 218). Nuland (1995), conversely, implies that a lifelong anxious preoccupation with death can prove preparatory for dying, describing his patient Bob (another who "wisely chose" to "do nothing" when faced with terminal cancer at age 49) as "a man who lived with the constant awareness that one's existence is not only finite but always in danger of ending unexpectedly. Therein lay the seed of . . . [some] awful anxiety . . . , but therein also lay the germinal focus of his acceptance when the final illness announced itself" (p. 242).

While these two modes of preparing for death—living a life of emotional labor on the self or living with a persistent sense that death is near—are praised as fruitful, both are clearly indirect or even incidental means of preparation. They are thus less amenable to the *teaching function* of epideictic rhetoric. In order to fulfill the epideictic mission of presenting us with "deeds worth imitating," doctor-authors must (and do) present us with truly imitable deeds; they must "display nobility at the level of praxis" (Hauser, 1999, pp. 17, 15). The praxis we are to imitate—the praxis in which we are instructed via suasive demonstration and direct exhortation, and in which the reading of these books forces us to engage ourselves—is that of deliberate, reflexive, *intellectual* preparation for dying. Nuland (1995) extols the benefits of this approach by invoking Montaigne's essay, "That to Study Philosophy Is to Learn to Die," writing, "Montaigne believed . . . that death is easiest for those who have given it much thought, as though always to be prepared for its imminence" (p. 88). This view is traceable far back from Montaigne, however, to still more and other ancient notions of virtuous

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dying, specifically to Plato's argument in *Phaedo* that "a man who has truly spent his life in philosophy feels confident when about to die," for he meets death with "his intellect . . . prepared" (1993, 63e, 67c).¹⁴ It is Kalanithi (2016), then (who also quotes from Montaigne's essay [p.119]), who once again becomes the absolute embodiment of—and whose entire life as rendered in his book proves an emulatable, instructive testament to—the benefits, beauty, and, importantly, the *promise*, of intellectual and experiential preparation for dying.

In the first part of *When Breath Becomes Air*, which relays portions of Kalanithi's (2016) life prior to his diagnosis, Kalanithi writes that he entered a career in medicine "in part, to pursue death: to grasp it, uncloak it, and see it eye-to-eye, unblinking", and that he was "compelled by neurosurgery" in particular because working inside the brain "seemed to present the most challenging and direct confrontation with meaning, identity, and death" (pp. 81, 71–72). In the final pages of Part I, Kalanithi elaborates further still that while "[m]ost lives are lived with a passivity toward death," he "had trained for years to actively engage with death, to grapple with it, like Jacob with the angel . . ." (p. 114). Clearly, this glorifying language of self-praise conveys that preparing for death is itself deeply virtuous. As Lucy Kalanithi confirms in her epilogue, her husband's lifelong confrontation with death, the fact that that he "examined it, wrestled with it, accepted it," as "a physician and a patient," and also as a writer and scholar, "epitomizes a fortitude we don't celebrate enough in our death-avoidant culture" (p. 215). But more so than as a virtue, preparing functions in Kalanithi's narrative as facilitator or guarantor of the kind of virtuous dying conduct lauded throughout much of the foregoing and of a "good death" itself.

Like the other doctor-authors' patients who die well—Byock's (1997) Maureen Riley, Quill's (1996) Robb, Gawande's (2014) Jewel Douglass, and Nuland's (1995) Bob—Kalanithi (2016) approached dying with acceptance, courage, and properly placed hope. "Paul faced each stage of his illness with grace," Lucy Kalanithi (2016) reminds readers in her epilogue, "not with bravado or misguided faith that he would 'overcome' or 'beat' cancer," not with hope "for an unlikely cure [,] but for days that were full of purpose and meaning (p. 219). Kalanithi's virtuous striving ensured that "[e]ven while

¹⁴In *Phaedo*, this view is based on Plato's dualistic conception of mind/body and resultant opinion that the philosopher, in his pursuit of wisdom, has spent his life "cultivating dying" by "setting [himself] at odds with the body at every point" (1993, 67e, 68a).

terminally ill,” and “despite physical collapse, he remained vigorous, open” and “fully alive” (and writing) until his last days, when he courageously refused aggressive technological interventions (p. 219). The final hours of his life, as rendered by his wife, are, as in the other narratives, incredibly peaceful: “Warm rays of evening light began to slant through the northwest-facing window of the room as Paul’s breaths grew more quiet,” Lucy Kalanithi writes of her husband’s active dying time. With all of Kalanithi’s family members, including his “beloved baby,” gathered to say goodbye, the glowing hospital room was “saturated with love,” feeling not unlike “the many holidays and weekends we had all spent together over the years” despite the sorrow. Kalanithi’s face and body are variously described as remaining “unburdened,” “serene,” “restful,” and “relaxed,” until he “inhaled and then released one last, deep, final breath” (pp. 212–214). Lucy Kalanithi concludes the book with yet one more assertive reminder that “Paul’s decision to look death in the eye was a testament not just to who he was in the final hours of his life but to who he had always been. For much of his life, Paul wondered about death—and whether he could face it with integrity. In the end, the answer was yes” (p. 225). In the end, for readers, the suggestion of cause and effect is clear: sustained wondering about and wrestling with death pays off and assures dying well.

But to whom is this form of long-term intellectual preparation for dying available? For doctors and philosophers? For those of us who study and write about death and dying? Those of us who read the *New York Times Book Review* and consume today’s endless stream of rich and challenging books on how to die well—books which then tell us that in order to do so we must devote yet more time and energy to cultivating the dispositions that will enable us to meet death with acceptance, grace, and courage, and to die in peace? Indeed, though it is well beyond the scope of this essay to pursue this point fully, one might make the provocative suggestion that the very notion of “cultivating virtue” is itself and at base an elitist enterprise, dependent upon privilege if not leisure. Within both ancient Aristotelian and contemporary virtue ethics perspectives, “virtue is something learned and developed in a sustained and continuing way from early childhood through the rest of one’s life” (Swanton, 2015, p. 111). Whether through instruction, experience, practice, habituation, or an amalgamation thereof, “virtue is something we have to acquire,” first (according to Aristotle) “through favorable upbringing and then with more focused effort as one matures” (Russell, 2015, p. 17). In sum, the cultivation of virtue takes

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repeated, focused, goal directed practice—persistent efforts at betterment (Russell, 2015, pp. 23–24)—which clearly takes and requires time and energy.

Even if we reject the idea that the cultivation of virtue is at base an elitist enterprise requiring time and a fair amount of leisure, it remains the case that many of the particular virtues propagated by doctor-authors studied here, as well as—and perhaps especially—the means of cultivating these virtues, depend upon and can flourish only in a privileged, already flourishing life. Certainly, the capacity for self-transformation in the face of death that we witness (and are implicitly instructed to emulate) in Gawande's (2014) father and Kalanithi (2016) is dependent upon already having lived a life devoted in no small measure to (successful) self-actualization, as is the more general hospice-care view, promoted by Byock (1997), that those who have been committed to personal growth and improving interpersonal relations will be more likely to die well. It would seem, then, that those who lead lives with less opportunity for self-reflexive formation of identity would in turn not have the opportunity to cultivate at least some of the virtues portrayed in and praised by these texts and authors as those most important to the attainment of a good death. And it would surely seem that the intellectual preparation for dying here propagated as the facilitator or guarantor of both of virtuous dying conduct and of a good death itself is well beyond the grasp of many. The poor and disenfranchised, the working-class family living paycheck to paycheck, likely do not regularly peruse the *New York Times* best sellers list or have their Amazon Prime notifications set to alert them to the hottest new releases in death and dying literature written by elite epideictic rhetors for an elite, highly educated audience.

Conclusion: Moments of Dis-Ease

Reviewing *When Breath Becomes Air* for the *Guardian*, Michelle Dean (2016) commented on the increasing popularity of end-of-life memoirs: "The reason this sort of writing has such a hold on us is obvious. . . . These memoirs hold out the promise that you, too, will be able to cope once the eye of Sauron falls on you"—even if "the tips [offered] are not practical in nature" (para. 7). As I hope to have demonstrated above, while perhaps not offering practical "tips," Kalanithi's (2016) self-eulogizing narrative, like the other texts I examine, is crystal clear in its epideictic guidance for the

conduct of the living *and* in its promise that we will not only be able to “cope” with dying but will be able to die with ease, grace, and control.

Indeed, despite Nuland’s (1995) unsparing focus on the grim physical realities of dying (along with his refrain that there is rarely any dignity in dying), and despite Gawande’s (2014) similar insistence that “[t]here is no prettifying death” (p. 189) and “leeriness” in suggesting endings are controllable (p. 189), the promise that an easy, peaceful, or at least reasonably controlled death is within our grasp—with proper conduct—emerges as a central motif of all of these doctors’ narrative texts. While this implicit promise is deeply problematic, it reflects the epideictic mission to offer comfort and guidance during times of cultural change. As Cynthia Sheard (1996) has written, “the epideictic ‘moment’ is one of dis-ease,” to which epideictic rhetoric responds “therapeutically,” “critically,” or in some combination, but always to offer a new communal vision for what is possible (pp. 790, 779, 770). Celeste Condit (1985) has similarly noted epideictic’s specific “function of adapting our community to new times [and] technologies” (p. 297). Authoritative epideictic rhetors such as doctors Nuland, Byock, Quill, Gawande, and Kalanithi have come forward in their respective but similarly shifting cultural moments to write against the ethos of their profession and instruct us in how to take dying back from the perilous “progress” of technology and from institutional control. But they are doing far more than this. As Gawande wrote of his epideictic moment and purpose in 2014, “A monumental transformation is occurring. In this country and across the globe, people increasingly have an alternative to withering in old age homes and dying in hospitals . . . But this is an unsettled time. We’ve begun rejecting the institutionalized version of aging and death, but we’ve not yet established a new norm” (p. 193). Working in times of crisis or change, working on and attempting to (re)shape assumptions, values, and beliefs, epideictic rhetoric seeks nothing less than the ushering in of new cultural norms.

It is important to highlight here that some might disagree forcefully with Gawande’s (2014) assessment of a current “normlessness” around dying. As early as 1997, Webb observed in *The Good Death* that “withholding, withdrawing, or refusing treatment is the way most Americans now die, ‘letting nature take its course’ . . . [after] it becomes apparent that further medical interventions would only prolong dying” (p. 378). Ten years later, from a medical rhetoric perspective, Lisa Keränen (2007) argued that the

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prevalence of “code status discourse” and documents (Do Not Resuscitate forms and the like) “signif[ies] the abandonment of the technological fix as the preferred treatment” for dying patients and signals a “radical restructuring of deathbed subjectivity” toward “subjects who choose to die” (pp. 181, 198). Most recently, from within palliative medicine itself, MacArthur Genius Grant recipient Dr. Diane Meier stated in a 2017 interview that, while she is “not critical” of the increasing “cultural openness to [death],” she is concerned that the medical community is now verging on “saying it’s a moral obligation for people to prepare for their own death,” and that they are “braver or smarter or wiser” if they can do so. She attributes this ascendant cultural attitude (and medical practice)—as well as our larger generational cycle “where death is [again] in vogue”—partially but directly to the writings of Gawande and Kalanithi (Tedeschi, 2017, para. 6–7, 15).

Keränen (2007) acknowledged that normalizing the removal of technology at the end of life “may be a necessary development, given the potential horrors of life extended indefinitely,” yet it “must not be allowed to pass without critical interrogation” (p. 202). This article should leave no doubt that I share Keränen’s concerns regarding establishing any potentially hegemonic notions of deathbed subjectivity and Meier’s related concerns about the legislation of new moralities, or, in the terms of this article, proper deathbed conduct. This article should be similarly clear that all of the doctor-authors and texts in this study have contributed significantly to the cultural “cultivation of subjects who choose to die” (Keränen, 2007, p. 198). In so doing, they have aligned their contemporary epideictic rhetorics of dying in intriguing but disturbing ways with Greek funeral oratory and with ancient values. As Loraux (1986) clarified, the celebrated “choice of the Athenian [to die] is, in the funeral oration, determined through and through by agencies external to the subject,” who is “trained to acquiesce [to death] in the values of the city” (p. 103). While today’s dying citizens are no longer “citizen soldiers” dying for the city *per se*, their acceptance of death may nonetheless amount to what is a “personal acceptance of a *social imperative*” (Loraux, 1986, p. 102, emphasis added).

However, my remaining concern is not so much with the cultivation of subjects who choose to die but with the insinuation that those of a certain character, manifested in right action, can choose the conditions, trajectories, even the moment, of their dying. As Seale (1995) points out, “some deaths cannot be written into this script” of the controlled, autonomous,

“self-aware” death, “which is particularly well suited to deaths from cancer and AIDS” (p. 597). (Note the prevalence of cancer and AIDS narratives in my doctor-authors’ accounts.) In dying from these or other progressive diseases, a dying person is more likely to have the time and the wherewithal to come to a place of acceptance, display courage and other valued, virtuous forms of dying conduct, and then, in Loraux’s (1986) aforementioned “lucid act of will” (p. 101), make the celebrated decision to “let go” in the end. Other deaths, however, such as “sudden unexpected deaths,” or, especially, those of “the mentally confused” remain unincorporable into the coveted, heroic script of self-aware, agentive dying (Seale, 1995, p. 597), and no amount of cultural privilege, no form of conduct, no amount or form of preparation for death over the course of a lifetime will alleviate this reality.

The literal unincorporability of the mental confusion of dementia is reflected in Gawande’s (2014) refusal to mention it in the text of *Being Mortal*. When confronted with this omission in an interview in 2016, Gawande reportedly “sigh[ed]” and explained that he was “still . . . chronicling [his] own learning process,” “thinking about [the issue of dementia],” trying to find “a way in” (McHugh, 2016, para. 27). Likewise, Quill’s (1996) text contains no accounts of dementia, while Byock (1997) explores dementia in a chapter on finding dignity in death, largely to assure readers that “by the time dementia . . . is far advanced, dignity no longer has meaning for the patient” (p. 87). Only Nuland (1995) takes on dementia squarely and thoroughly in his full chapter on Alzheimer’s, wherein he describes the disease as “loathesome,” and challenges his readers to find any meaning (let alone “dignity”) in this “arbitrary act of nature” that is “an affront to the humanity of its victims” (pp. 106, 117).

Thus, with the exception of Nuland’s (1995) text, these doctors’ epidemic rhetorics of dying seem to exclude or, at minimum, occlude certain especially discomfiting modes of dying and particular deathbed (non)subjectivities. But further, they seem to occlude the very notion of arbitrariness, of meaninglessness itself. Medical sociologist Albert Banerjee (2005) has leveled this exact criticism at hospice care, writing that while it may be unrealistic to expect “a community that is primarily concerned with *improving* the care of the dying to simultaneously bear witness to meaninglessness and anguish,” it is nevertheless necessary to question the hospice care’s model’s optimistic “logic of meliorism” and the logic of mastery working within it. Narratives of “dying well,” he argues, referring to Byock directly, though clearly capturing a central message of the other texts of my study as well,

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“may . . . be viewed as a continuation of the hope that if one just approaches death in the right way, with the correct knowledge, it may be mastered” by being “made meaningful” (pp. 9–10).

Of course, death can be “made meaningful,” can *be* meaningful. And for those of us whose final affliction permits us to die the reasonably controlled, self-aware death propagated by dominant scripts, the approaches to dying advocated and *taught* by our culture’s most esteemed medical authorities’ epideictic rhetorics of dying may prove eminently instructive. For others of us (in these texts’ target audience), the shattering realism of Nuland’s (1995) account may prove preparatory somehow. As scholars of medical rhetoric, though, we can learn from the approaches to dying promoted by doctors’ epideictic rhetoric in a different way. As the rhetoric that (re)constitutes what is praiseworthy and blameworthy in human conduct to (re)shape the basic codes of value and belief by which we live, epideictic rhetoric *is* inherently normative, and its practitioners invested with special authority and influence. It thus commands our sharpest attention—and scrutiny. To be sure, there is much to celebrate in the new norms established by these five influential texts and authors, not least of which is the premier role they have played in moving our culture from being death-averse or death-avoidant to being one which has “finally learned how to talk seriously”—if now somewhat endlessly—“about dying” (Millman, 2014). Additionally, and as centrally, the texts are decisive and, I think, deeply suasive in their urgently needed efforts to move us away from what Keränen terms “the horrors of life extended indefinitely” (p. 202) toward more humane ways to die.

Yet the texts of my study provoke cause for concern as well. Though, again, I am not as concerned as is Keränen (2007) (or Meier) about the cultivation of subjects who choose to die, since I believe this concern betrays a continued presumption of the “sanctity” or given “betterness” of the living state which I do not share, I am deeply concerned by the books’ portrayal of who can cultivate dying virtues, and by their continual (re)cultivation of the Western, individualist choosing subject more generally. Though the choices advocated for and actually made in the face of terminal illness may now be more expansive, involving more varied forms of courage, the only subject celebrated across the numerous accounts of dying within my five doctor-authors’ texts is the agentive, self-aware self, master of his or her own destiny—and also master of medical technology, we might note, in that he

or she now outsmarts and dominates it through the will of refusal. Epideictic rhetoric is indeed our culture's most telling rhetoric, providing cues to what, and who, we value and to what, and who, we deplore. We must attend as closely as possible to what it is saying, including through its silences.

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