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Care of the dying in sixteenth- and seventeenth-century England: opportunity for reflection in modern day practice

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Keywords: bereavement, death attitudes, hope, meaning in life, spirituality

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THE CARE OF DYING PEOPLE IN SIXTEENTH-AND SEVENTEENTH CENTURY ENGLAND

Abstract

Between the years 1500 and 1700, mortality was higher and exposure to death greater than in the modern day. Through analysis of primary texts from the chosen period, we explored the principles behind the care of the dying in the context of medicine, spirituality and society. Results showed that a ‘holy death’ was a cultural norm and medicine was subsidiary: hope was for the salvation of the soul, not the body. This was part of an approach that focussed on symptom relief, irrespective of disease classification, demonstrating an early holistic approach to death and dying.

Keywords: bereavement, death attitudes, hope, meaning in life, spirituality

The progress of medicine in the 20th century is largely in terms of curative medicine. The development of antibiotics and the polio vaccine are just two of numerous developments that helped to decrease morbidity and mortality globally. Nevertheless, where cure failed, the customs around accepting and dignifying death evolved; a process pioneered by Cicely Saunders, a physician, and the foundation of the hospice movement (Baines, 2011). Mr Norman Barrett, a surgeon, stated the following to Saunders: “go and read medicine, it’s the doctors who desert the dying” (Saunders, 2000, p. 9). She did so, and her belief in regular opiate analgesia for the terminally ill revolutionised the care of these patients.

Nevertheless, this model of care assumed a focus primarily on cancer pain, and has been recognised as failing to address the needs of those dying from other illnesses (Seymour, 2012). In the United Kingdom in 2013, cardiovascular disease constituted 28% of deaths, respiratory disease 14%, and cancer 29%. Despite this, 88% of palliative care inpatients had a diagnosis of cancer: a clear inconsistency with the leading causes of death (Dixon, King, Matosevic, Clark, & Knapp, 2015). This discrepancy between palliative care patients and the distribution of terminal diagnoses is improving, however; 20% of patients referred to palliative medicine had a non-cancer diagnosis in 2013, up from 12% in 2008 (Dixon et al., 2015).

Ultimately, beginning to address these inequities represents the ongoing endeavour to facilitate a good death wherever possible. The definition of a good death varies from individual to individual, and relates to the wider cultural context within which one lives. Cipolletta & Oprandi (2014) suggest that integral features are the control of pain and unpleasant symptoms, and passing with dignity. Steinhauser et al. (2000) reached more detailed conclusions, identifying a sense of completion and affirmation of the whole person as vital in preparation for and acceptance of death. These themes are set against the wider cultural context; factors such as class, socioeconomics, gender, race, ethnicity and religion all

influence one's experiences and values, building and adapting throughout, and at the end of, life (Thompson et al., 2016).

Thus, medicine is continually looking to improve palliative and end-of-life care, in order to ease the emotional and physical experiences of dying people and their families. One strategy for this is the analysis of past customs, yet, the evidence of such happenings are sparse; palliative care was not, prior to Saunders' work, a discipline in itself. Therefore, for this research we have analysed the process of palliation and end-of-life care in a time pre-dating Saunders: sixteenth- and seventeenth-century, or early modern, England, when medical care was less formalised, culturally unalike, and death more visibly present. This period also witnessed the Reformation, which saw the end of charitable, early "hospices" that sought "to carry the burden of the sick, poor and countless pilgrims and crusaders throughout the Middle Ages" (Saunders, 2000, p. 8): values that Saunders drew upon in her own, ground-breaking work.

Firstly, we examined: the dominant medical theory of the time – Galenicism – and competing ideas; the early modern connotations of "cure" and "palliation", to make clear the boundaries of non-curative care; the role of Galenicism in palliative and end-of-life care in order to gauge the influence of medical perspectives in these processes. We then built upon these areas to explore the care of dying people, including both medical and spiritual perspectives, in early modern England. It is timely for us to explore the early nature of the care of dying people, with a view to understanding where we truly came from and what can be learnt.

Methods

We used a humanities methodology to examine palliative care in the sixteenth and seventeenth centuries, a time of development and progression in the sciences, medicine and

philosophy, including Harvey's discovery of the blood circulation and Bacon's scientific method (Slack, 1971). These developments embodied a new mentality of scepticism about the established theories, which their contemporaries questioned, and sometimes, disproved. This shift towards challenging, rather than accepting, the status quo directly applied to medicine; new theories, such as the Paracelsan, began to emerge, as we will discuss.

We examined primarily medical or surgical vernacular texts to capture the disseminated knowledge of the period. Authors constructed many of their texts as treatises, mostly with a motive that, at least in part, included the altruistic notion of educating those who could not afford a physician, so that people could treat themselves (Slack, 1979). We also studied fictional dialogues, in which authors use imagined conversation between two or more characters to illustrate medical principles.

In addition, we studied personal diaries and physicians' casebooks that were not written for publication at the time, selected to span the greatest possible section of the period under study. Such material allowed the period to come alive by reliving the day-to-day events experienced by the individuals who wrote them, providing personal and largely non-medical perspectives on dying.

We viewed each primary medical text, with the exception of the diaries, on Early English Books Online (EEBO); we analysed the diaries in their twentieth-century editions.

Dominant Medical Theories

In this section, we will discuss in greater depth the landscape of medical theory and practice in early modern England. The discussion will then build to define the boundaries of curative and palliative care, as well as analyse the role of learned medical theory in the latter area.

Firstly, Galenicism was the dominant form of medical thought in early modern England. This medical framework, named after its founder, Galen (129-210 CE), is largely based on Hippocratic medicine, which is described as “patient-oriented, focusing on ‘dis-ease’ rather than disease understood as ontological entities” (Porter, 1997, p. 60). This notion of disease as a deviation from the norm stemmed from their belief that ill health resulted from an imbalance in the four bodily humours: yellow bile, phlegm, black bile and blood. Re-establishment of this equilibrium was key to recovery (Porter, 1997). Galen’s theoretical framework was also tied to the four elements, each of which were associated with two characteristics: earth is cold and dry; air is hot and wet; wind is cold and wet; fire is hot and dry (Wear, 2000). Each individual had their position in this schema, and were assigned a characteristic: choleric, sanguine, melancholic, or phlegmatic.

One would endeavour to maintain their health through the careful balance of the humours, embodied by regulation of one’s diet according to the individual’s dominant humour. The Galenic ‘diet’ encompassed one’s entire lifestyle: food, drink, exercise, sleep and the environment (Nutton, 2005). This concept of opposites also formed the basis of Galenic therapeutics. The characteristic of the patient’s illness was determined, and a remedy with the opposing characteristic was administered; ‘hot’ illnesses were treated with ‘cold’ remedies (Porter, 1997).

Despite the learned physicians’ and the governing Royal College’s advocacy of Galenic medicine, Paracelsian and Helmontian medicine challenged this theoretical model. These eponymous and related medical movements, named after Paracelsus and Joan Baptista von Helmont, arose from mainland Europe. Paracelsus was a Swiss Physician, and von Helmont his most ardent advocate. However, it was their remedies, rather than their theories, that influenced medicine. The late sixteenth century saw medical practitioners use metals and minerals such as mercury, antimony and arsenic, as medicines (Porter, 1997; Wear, 2000).

Disseminated across Europe by religion and war, these ideas spread to England during the late sixteenth century (Trevor Roper, 1990).

When seeking medical care, the university-educated physicians, who were usually learned in Galenic theory, were the most senior practitioners. Inferior in status were the surgeons, known as chirurgions, and apothecaries, the latter akin to the modern day pharmacist. Chirurgions mainly treated external ailments: they lanced boils, pulled teeth, let blood; apothecaries prepared the physician’s prescriptions. Chirurgions and apothecaries trained by apprenticeship, rather than academic learning (Porter, 1995).

Subordinate to chirugions and the apothecaries were the unlicensed, and in some cases amateur practitioners. Unlicensed practitioners included quacks, mountebanks, bone-setters and blood-letters. Many would practise as a career, whereas the amateurs often practised altruistically: Ladies of the Manor often served the surrounding community by providing basic medical care for those in need. The unlicensed practitioners were not considered part of the medical profession (Porter, 1995).

Overall, the environment within which university-trained practitioners operated, both professionally and epistemologically, was a competitive one. The dominance of Galenicism was rivalled by novel theories from mainland Europe, as well as the ad-hoc care of those without accredited training; medical care in early modern England was complex and multi-faceted. Thus, with this understanding of the medicine of the period, we can now define and explore curative and palliative care, with particular focus on the latter.

Cure and Palliation

In order to understand the early modern concept of palliative and end-of-life care, it is important for us define ‘cure’ and ‘palliation’. Firstly, physicians believed that for them to facilitate recovery from illness, it was necessary to understand “all the causes, rules and

sedes, wherof […] sicknes doth growe" (Bullein, 1564b, p. 19). Should this not be feasible, however, any "cure will be but palliative" (Andrewes, 1603, p. 3). This would suggest that in early modern English, "cure" referred to the treatment process, rather than an intervention that leads to complete recovery. On the other hand, palliation was the treatment of a disease where the cause was unknown and, consequently, complete resolution of any ailment deemed unlikely: when "[a tumour] becomes cancerous" and "an Absolute Cure will never succeed", only "Palliative cures" remain (Salmon, 1698, p. 578).

Assuaging symptoms when recovery is unlikely, as presented above, is similar to the modern concept of palliation. It invokes the image of life-limiting or -ending illnesses, where treatment aims to increase quality of life and comfort. However, despite the familiarity, we must nuance the modern and early modern meanings of 'palliation': it was a broader concept in the early modern period. Not just a term denoting symptom alleviation in life-limiting and -ending illnesses, 'palliation' also encompassed any treatment deemed inadequate to address the root cause, irrespective of illness severity. For example, fistulae - "long narrow, suppurating canal of morbid origin in some part of the body" – are often not fatal. Some cases heal naturally: "they doe good, therefore heale them not". For others, "there is hope" (Cooke, 1648, pp. 39–40). Nevertheless, if treatment does not address the root cause, it will be "fictitious, false and palliative" (Bonet, 1686, p. 126).

Thus, the early modern concept of "palliation" shares similarities with the modern day, only with a broader scope; this label was also given to any treatment not addressing the root cause, regardless of severity.

The Role of Galenicism in Palliation and Death

By building upon the previous analysis, we can now explore the role of medical perspectives in early modern palliative and end-of-life care. Authors of vernacular medical literature addressed these areas to varying extents. Firstly, some physicians do not address the specifics of treating incurable ailments: "if the place be pricked and will not bleede, the Morphewe is not curable […] curable [morphews] do bleede' (Boorde, 1547b, pp. 73, 84); only a brief, almost dismissive statement is made about the incurable. Additionally, the casebook *Select Observations* alludes to failure of treatment just once in one hundred accounts: "being not wholly freed from [a grievous cough, Mr Queeny] fell into it again the next year, and all Remedies proving successless, […] died" (Hall, 1657, p. 33).

Despite the reluctance from these Galenists, other physicians and chirugions did illustrate the place of Galenicism in palliative treatments. On "cancer of the eye", a "palliative cure" involves "a cooling and moistning Course of Diet […], afterwards Blood must be drawn from the Part opposite to the Eye affected […] Cupping-glasses must be also applied to the Shoulders, and other sorts of Revulsions must be used" (Pechey, 1695, p. 31). The palliative treatments suggested here – diet, blood-letting and cupping glasses – are practices synonymous with Galenicism. Medical practitioners also incorporated Paracelsan remedies: "a Plate of Lead besmeared with Quicksilver [and] triple quantity of Mercury" is used in the palliative treatment of tumours (Salmon, 1698, p. 333).

In addition to these principles, the role of opium is illustrated in a remedy for "sarcoma": "if it is Malign, it is scarcely at all to be touched, but only with Palliatives; […] Opium [and] a plate of Lead besmeared with Quicksilver" (Salmon, 1698, pp. 361–2). This illustrates the value of a powerful analgesic in the relief of symptoms, used as an adjunct to popular and learned theories.

To conclude this section, there is clear evidence that medical perspectives influenced palliative care. Galenic and Paracelsan ideas pervade these elements of vernacular medical texts, despite the varying levels to which authors address it. This amalgamation of competing medical theories reflected the composite landscape of curative medicine, suggesting palliative care – by the early modern definition – was indeed within the remit of learned practitioners and the frameworks of theory that they applied.

Care of Dying People

In the following section, we analyse the medical, spiritual and cultural aspects of care, specifically at the end of life. We discuss medical texts alongside idiosyncratic accounts of prominent lay individuals, to illustrate the acceptance of medicine's limits and the shift towards religion and the soul, as was the cultural expectation during early modern England.

Medical Perspectives

Firstly, once it was recognised, case-by-case, that the limits of medicine had been exceeded, physicians relinquished their power and, with the patient, put their faith in God. "if [it] do come by nature or kind, or by any monstrous humour there is not remedy, but onely God and pacience" (Boorde, 1547b, p. 71). The limits to the power of medicine were recognised, beyond which God's omnipotence took control.

Fictional dialogue illustrates well the shift from physician to theologian, and body to soul. *A Dialogue…against the fever pestilence* depicts the physician-patient relationship at the end of life (Boorde, 1564a). This work addresses the deaths of two people: the atheist, Antonius, and the Christian, everyman character, Civis. Firstly, the apothecary, Crispinus, asks Medicus, the physician for his opinion on Antonius' odds of survival. To which, Medicus responds with 'I have had a long talke with hym. But to bee plain with you, I think never to se hym again alive. He was paste cure or I came to hym, and he could not skape,

therefore I kepte hym with longe talke, but I spake but softly' (Bullein, 1564a, p. 49). Medicus identifies that no medicine could prove curative for Antonius' pestilence and resorted to "soft" speech in order to comfort him; the physician recognises the limits of his power, but does not resort to religion: he is implicit in defying the Christian customs of death. Later in this work, the antithesis of this atheistic death is shown in the passing of the Civis, a character who also succumbed to the pestilence. Upon recognition of his fate, Civis cries:

> Now my body is paste cure, no Phisicke can prevaile […] I might sende for some manne of God, to be my heavenlie Phisicion, teaching me the waie to the kyngdome of Christe (Bullein, 1564a, pp. 84–5).

This summoning of a theologian indicates Civis' loss of hope in medicine and awareness of the limits of medicine. He consequently focusses on his spiritual, rather than physical, health: "I am of twoo partes, bodie and soule, the one paste all cure, the other in hope of salvacion" (Bullein, 1564a, p. 87). He separates his body from his soul, resigning the former to death, whilst seeking religion to save the latter. These two deaths illustrate the line between hope and resignation, as well as the medical physician and theologian – the "heavenlie physician" – in the case of Civis; religion is viewed as the more powerful medicament for the sick, sinful soul.

Spiritual Perspectives

In addition to this fictional piece, the prominence of spirituality is evident in the real-life experiences of death, depicted in the diaries of Ralph Josselin, an Essex vicar, and Robert Hooke, the prominent engineer. In February 1647, the following experience is recorded:

> My child was ill, full of phlegme, wee sent for the physitian, he gave it syrrupe of roses: it wrought well. My wife persuaded her selfe that it would die it was a very

sicke child indeed […] god continued it to morning and it seemed to me not hopeless: lord its thine, I leave it to thy disposing. (Josselin, 1976, p. 112)

Then, four days later, the child's passing is confirmed:

This day my deare babe Ralph, quietly fell a sleepe, and is at rest with the Lord, the Lord in mercy sanctifie his hand unto mee, and doe me good by it and teach me how to walk more closely with him. (Josselin, 1976, p. 113)

This account also shows the primacy of religion in death. The line between hope and resignation to Ralph's fate is unclear, but it is clear that the physician, whom he called upon just once in this final illness, was a final attempt to restore his health, rather than easing his passing (McCray Beier, 1987). At the time of the latter, however, accepting God's will was the choice approach, rather than seeking further medical help.

The Diary of Robert Hooke also depicts the shift from physic to religion and body to soul. The final illness of Tom, a servant, unfolded as follows: on the 9th September 1677, Dr. Diodati "judged [that Tom] had the measles" (Hooke, 1968, p. 311). Two days later, further medical attention was sought: "Gidly here refusd to let Tom Blood […] Dr Diodati here directed him to be Let Blood […] At 8, Mr. Gidly and Mr Whitchurch here, they let Tom blood" (Hooke, 1968, p. 312).

The following day, Tom's receives his prognosis, and peacefully passes away:

I spake with old Dr. King, he affirmed pissing blood in the small pox mortal, as did Dr. Mapletoft. These two with Dr. Diodati met at 9, concluded Tom irrecoverable. […] Tom spake very piously, began to grow cold, to want covering, to have little convulsive motions, and after falling into a slumber seemd a little refresht and spake

very sensibly, and heartly, but composing himself againe for a slumber he ratled in the throat and presently Dyed (Hooke, 1968, p. 312).

This passage highlights Hooke's initial hope for, and then desperation about, Tom's recovery, manifest through his consultation of numerous practitioners: Mr. Gidly, Mr. Whitchurch, Dr. Diodati, Dr. King and Dr. Mapletoft. Hope appears to be driving this search for a cure; however, once he receives the prognosis of likely death from King and Mapletoft, Hooke recognises the limit of medicine, recalibrating his focus to the salvation of Tom's soul and encouraging devout speech; soteriological confidence [on the deathbed] was "the most recognised sign of salvation" (Newton, 2012, p. 98). Moreover, the boundary between Hooke's hope and resignation appears also to be represented by a syntactical change. Initially, Hooke's frenetic consultation of multiple practitioners, as demonstrated above, is in keeping with the terse sentences used throughout his memoirs. However, the account becomes much more thoughtful and pensive when describing his peaceful decline to death. This demarcation between of the physician's limits not only represents the shift from physic to God, but also that of hope to resignation and the body to the soul.

Thus, we show that, despite the application of medical perspectives in non-curative care, spiritual health took prominence at the end-of-life. Both primary medical and idiosyncratic, private material have shown this; end-of-life care was primarily a spiritual experience in early modern England.

The Art of Dying Well

Thus far, the discussion has illustrated that the medical perspectives cede power to the spiritual when death is deemed imminent. The roots of this change are evident in the popularity of *Ars moriendi* – the Art of Dying – a popular form of treatise in medieval and early modern England that inspired hundreds of related texts (O'Connor, 1966). The original,

fifteenth-century text on *Ars moriendi* consisted of six chapters, detailing, for the lay audience, the principles of dying according to Christian ideals. We will briefly outline these, facilitated by Nancy Lee Beatty's descriptions and her use of original quotations from *Ars moriendi*, in *The Craft of Dying* (1970). The first chapter "exhorts mortal man to recognise the significance of death and apply oneself to learning the art of dying well and surely" (Beaty, 1970, p. 5). It defines what it means to die well, which is "the most prophetable of all cunnynge [for] the [perfect] christen man" (Beaty, 1970, pp. 7–8). The second chapter arms the dying man against the five temptations of the devil: unbelief, despair, impatience, spiritual pride, and avarice, none of which can prevail unless the dying man allows it (Beaty, 1970). The third chapter is a list of interrogations, questions "that shulde be asked of them that were in her deth-bed" whilst they are still able to understand and respond (Beatty, 1970, p. 5). The fourth instructs the dying man, if still conscious and aware, to 'imitate Christ on the cross, who "prayed, cried out, wept, committed his soul to his father, and gave up the ghost willingly" (Beaty, 1970, pp. 23). The fifth chapter depicts the role of the bystander in death, which was to "'help the dying follow the instructions lain down so far" (Beatty, p. 26) and to avoid giving "false hopes of recovery through 'friendly' hypocrisy and blindness" (Beaty, 1970, p. 26). The sixth and final chapter outlines prayers for the attendants to say in the final moments of life, "[restating] the clichés of Christian gospel" (Beatty, 1970, pp. 31–35).

The *Ars moriendi* was the beginning of a tradition relating to death literature, and addresses the primary concern of the dying person: salvation of the soul (Beatty, 1970). Despite this, it appears that medical perspectives did have place at the side of the dying patient. This is evident in Jeremy Taylor's *Rule and Exercises of Holy Dying* described as the "artistic climax" of literature on *Ars moriendi* (Beaty, 1970, p. 197). In Section three, the "constituent or integrall parts of patience", Taylor advises to oppose "peevishnesse" with

"obedience, tractability, easinesse of persuasion, aptnesse to take Counsel. [One must be civil] to his Physitians and servants" (p. 41). He adds that dying people must "be obedient unto [their] Physitian in those things that concern him, if he be a person fit to minster unto thee; God is he onely that needs no help; and God hath created the Physitian for thine" (p. 111). These citations, in combination with the previous analysis, have shown that the role of the medical perspectives in death was auxiliary to the spiritual, but relevant nonetheless.

Furthermore, the tradition that developed around death literature suggests that the principles therein were generally accepted in early modern English society. Additionally, fragments of evidence suggest that medical authors did also gave prominence to *Ars moriendi* and its principles. Boorde (1547a) states that "good kepers must be diligent, should not [weep] and wayle about the sick man. […] Make every thynge evyn betwixt god and the worlde & his conscience" (pp. 53–4). Boorde is aware of the role of the bystanders, as in chapter five of *Tractatus artis bene moriendi* and Taylor's *Holy Dying*, "of visitation of the sick", where he outlines "[a] short exercise, to be used for the curing the temptation to direct despair, in case that the hope and faith of good men be assaulted in the day of their calamity" (pp. 150, 175).

Furthermore, Robert Hooke's account of his servant's death shows alignment with chapter three of *Ars moriendi*: the interrogation of the dying individual. Hooke's account of his servant's pious and sensible speech shows a satisfaction of the previously discussed soteriological confidence near death (Newton, 2012, p.98). Moreover, Ralph Josselin (1976) provides similar example of this confidence upon the death of his daughter, Mary, where notes the following:

> I rest confident of [Mary's] glory […] the soberness, towardlines in obedience spiritualnes of her conversacon for a child, argued the reall impression of the image of god upon her (pp. 203–4).

This quotation exemplifies how parents guided their children; they "helped their children to prepare for death […] by asking them if they were ready to die […]. Young children as well as older children, and girls as well as boys, were questioned in this way" (Newton, 2012, pp. 98–99).

One further example of the acceptance of *Ars moriendi* comes in Bullein's *Dialogue*, where the unscrupulous physician, Medicus, provides Antonius with false hope in the latter's battle with the pestilence, contrary to chapter five of the treatise. As we saw earlier, Medicus promises cure to Antonius: "I will declare thee, the beste defence I can, I will hide nothing", before declaring him "paste cure" in discussion with his colleague (pp. 34, 45). Before answering Antonius' questions about his treatment. Medicus, contrary to the custom of the time, placated Antonius' fears despite his true opinion, facilitating an ungodly death. Medicus' immoral practice is the antithesis to a good death in the early modern, allowing inference as to the expected standards.

Overall, this section has explored the roots of end-of-life care in the early modern period. Sacrificing the physical body to achieve holy salvation, once death was deemed imminent, was the accepted way to die well. This was set within a monotheistic, Christian society, showing the importance of culture and ideology on the expectations around the dying person. The documentation of both medical practitioners and lay individuals showed awareness of these ideals; the accepted norms around death were powerful, permeating medicine, literature and popular thinking.

Conclusion

Overall, we have uncovered, through this exploration of early modern palliative and end-of-life care, several specific findings of interest, both historically and as tools for reflection regarding the development of modern palliative services.

Firstly, Saunders identified shortcomings in twentieth-century palliative care, but it seems that related concepts existed as early as the sixteenth and seventeenth centuries, with attention given to holistic wellbeing that the modern day is only now beginning to rediscover. Despite its absence as a discipline, palliative, end-of-life care, and dying well were still well-developed concepts during early modern England. Care was in effect multi-disciplinary, including medical, nursing and spiritual care in a holistic structure.

Furthermore, the role of the physician in sixteenth- and seventeenth-century palliation is evident as part of a holistic framework that complemented the cultural norms of the time. Saunders also pioneered the development of a modern holistic approach, despite significant changes in the conception of medicine. Firstly, the centuries between the early modern and Saunders' work saw Galenicism fall out of mainstream epistemology. Secondly, the definition of what it meant to die well had altered between the two periods. In the early modern, religion and the soul was the focus, whereas by mid-twentieth century, physical, social and emotional carried more weight alongside any spiritual needs: "total pain", this was coined (Baines, 2011). Despite the changed medical theories and cultural norms around death, Saunders inspired further evolution of what it meant to die well, whilst keeping within the deeply-rooted traditions of care at the end of life.

Moreover, there are two key aspects from this study that can be drawn upon by modern-day practitioners. Firstly, early modern end-of-life and palliative care, albeit in a differing medical landscape, purely reflected symptom and illness severity. The Galenic model discouraged focus on specific diagnoses, and consequently, the only determinant of

provision was the need of the patient. Contrastingly, modern medicine favours diagnostic labels. Thus, Saunders' pioneering work focussed on cancer care, which comprised a proportion, but not the whole, of terminal diagnoses. The challenge now, for practitioners, is to draw upon the historical principles of palliative care within a medical framework that favours labels and diagnoses, and continue the welcome, current shift of the focus towards overall need.

Secondly, as medicine advances, accepting the limits to curative treatment could become a greater challenge to patients and practitioners. Cipolletta & Oprandi (2014) cite "technological progress and increased life expectancy [that increase] faith in [modern day] medicine", culminating in a "social denial of death" that encourages the pursuit of "unnecessary life-sustaining treatment" (p. 24). Greater efficacy and number of emerging treatment options can lead to overestimation of the curative capabilities of medicine, and makes mortality more difficult to accept. Conversely, the authors of our early modern sources exhibited greater engagement with the spiritual process of living and dying well. Consequently, the limits of medicine were more readily accepted than in the modern day, facilitating the focus on spiritual wellbeing early on in the journey of dying. A contributing factor to this was, perhaps, the greater exposure to death. Mortality was much higher and death took place at home, as did pre-funerary practices; death and palliation were not sequestered away in medical institutions and funeral homes, but part of a spiritual journey for all. Thus, by appreciating the early modern principles, the diversity of practitioners involved in palliative and end-of-life care today can seek to redress any emerging imbalances between patient need and diagnoses, as well as the pursuit of survival and acceptance of mortality.

Finally, we have shown in our work that the principles of palliative and end-of-life care are rooted deeply within history; palliative care was not a distinct discipline in the early modern period, but the emphasis on one's spiritual journey allowed for the development of

clear practices at the end of life. Since this period, as medicine has evolved, both in its knowledge and philosophically, the traditions of palliative care have persisted. Observing these long-standing principles allows the diversity of professionals involved in modern day palliative care to identify shifts in ideology around death. This awareness can facilitate practitioners, patients, and families, albeit on a case-by-case basis, to address each facet of the “total pain”: physical, social, emotional and spiritual needs each weigh differently upon those facing the last months, weeks, days, and hours of their lives.

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