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## The Sanctity of Life Seduced: a Symposium on Medical Ethics

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# The Sanctity of Life Seduced

## A Symposium on Medical Ethics

### Daniel Callahan

Two important social forces lie behind the potentially disastrous turn of public opinion toward euthanasia and physician-assisted suicide in recent years. The necessary condition is the excessive emphasis in our culture on choice and self-determination. The sufficient condition, the triggering cause, has been the highly visible string of court cases from Quinlan in 1976 to Cruzan in 1990.

Those cases shared one important, eye-catching feature: someone in the throes of a critical illness was not being allowed to die, and it was necessary to turn to the courts to make death from natural causes possible. The American public took from these cases a threatening message: if you enter an American hospital or nursing home permanently unconscious, you are in danger of having your life extended beyond any point most people would care to endure. Moreover, the public has now been tutored to understand that medicine has become devilishly clever in its ability to keep your body going long after there is much, or any, likelihood that you retain any characteristically human capacities or potentialities.

The only way there will be any chance at all of keeping the evil of euthanasia at bay will be to recognize the moral and medical distortions that our obedience to medical technology have insinuated into how we commonly think about death and dying. Unless people can be convinced that the medical behemoth will not extend their life beyond some reasonable point, they will not be much swayed by slippery-slope arguments. For them the clear and present danger is a technologically induced bad death for themselves or their family members, not the more remote hazard of involuntary euthanasia.

A particularly frightful feature of the current drive for euthanasia is the extent to which it is a genuine grass roots movement. The Kevorkians and Humphrys and Quills have given the movement some

added impetus, but they have not created it. This drive existed well before they came along, with a strong shift in public opinion visible by the late 1970s, at which point a majority of people reported having a favorable attitude toward euthanasia. I am endlessly struck by the number of ordinary people, not caught up in the public debate, who fear a technological death and are as a consequence attracted to euthanasia or assisted suicide. The well-publicized court cases, I am convinced, have steadily inspired the worries about a bad death now being capitalized upon by the promoters of euthanasia.

How has medical technology—and, more important, its implicit ideology—led us astray? Its seduction has taken three forms. The first is that it has led us increasingly to think of death itself as accidental, a contingent event, no longer the result of natural forces but of some human decision. Nature is being increasingly banished as a cause of death. For the medical researcher, no known cause of death is acceptable, and the research enterprise carries on an endless war against all of them. As Leon R. Kass reminded us some years ago, the logic of this kind of warfare is nothing less than a search for immortality. For the doctor at the bedside, matters are not too much different: with a little more skill, a little more luck, a research breakthrough here or there, this dying patient before me might be saved. Although they know the feeling is often irrational, many doctors have accepted the imperious myth of modern medicine that somehow or other death has become their fault—even when they turn off a machine in the face of an inevitable, imminent, and unavoidable patient's demise. They think nature has been banished, that only their power over life and death now counts.

The second seduction of medical technology follows hard on the heels of the first. It is the incentive this technology provides for the erasure of the distinction between omission and commission, between

killing and allowing to die. Many philosophers and others, in their search for arguments to legitimate euthanasia, have contended that since people become dead in either case, there is no serious moral distinction to be made between turning off a respirator or pulling a feeding tube on the one hand, and giving someone a lethal injection on the other. Ironically and unhappily, many conservative thinkers—out of an apparent fear of abuse of the notion of “allowing to die”—have themselves come to act as if they also see no real moral difference between omission and commission either (even if they may still agree with the distinction in principle). It is this “as if” attitude that has inspired most of the court cases; e.g., if Nancy Cruzan is not kept alive with feeding tubes, this is tantamount to killing her, not just allowing nature to take its course.

The technological seduction behind all this is that medicine has now become omnipotent, holding life and death wholly in its hands. And we human beings, who wield this technology, have now become omniresponsible. Whether we omit treatment or kill people directly is irrelevant. What matters is that, whatever we do, death has now become our responsibility and can no longer be blamed on nature.

The third seduction is the way the ideology of medical progress and technology has managed to capture the principle of the sanctity of life and turn that principle to its own advantage. As one of the great contemporary apostles of medical progress, the lay lobbyist Mary Lasker, once revealingly put it, “I’m really opposed to heart attacks and cancer and strokes the way I’m opposed to sin.” Death by disease has, in an age that cannot accept human finitude or mortality, become the equivalent to death by malicious human intent. Correspondingly, many of those who would uphold the sanctity of life seem now to believe that they must follow technology wherever it goes so long as it preserves life. Medical technology, the child of the Enlightenment, has coopted the ancient principle of the sanctity of life and turned it into its handmaiden.

**I**s there any way to overcome this captivity to technology, to allow death to return to its natural place, the destiny of us all? I want to urge two principles that could help us toward that end. The first principle is that no one should have to die a worse death as a result of medical technology than would have been the case prior to the invention of that technology. If technology threatens to leave us worse off, and we nonetheless feel obliged to use it, we have then indeed become its slaves. The second principle is that doctors should feel as great an anxiety that a patient will die a poor death from technological excess as the present anxiety that the patient will die because there is too little technology; and these dual anxieties should remain in tension with each other, neither the one nor the other being allowed to gain the upper

hand. The moral bias now is so powerfully in the direction of using technology to preserve life that patients are put at risk of a poor death as a result. That bias needs changing.

If used properly, the traditional moral distinction between ordinary and extraordinary treatment can be most helpful in avoiding the technological seductions I have mentioned. I take that distinction to mean, in its traditional sense, that no one is obliged to undergo treatment that imposes too heavy a burden if there is no significant and corresponding benefit. A more conservative, nontraditional, sense has, however, recently become popular in some circles. It is that benefit to the patient consists of any non-burdensome treatment that will sustain life, whatever the condition of that life, even the zombie-like life of the victim in a permanent vegetative state (PVS). Moreover, if a non-burdensome antibiotic will sustain the life of someone with advanced cancer, there is, in this view, an obligation to provide it—even if the final death will be worse than that temporarily averted by the use of the antibiotic, and even if much worse than it would have been prior to the discovery of antibiotics.

For my part, I can imagine no conceivable moral or spiritual benefit in being kept alive technologically in a PVS state. It is a condition actually far worse than that of a newly fertilized egg; the latter has a potentiality for developing characteristically human traits, while the former has forever lost that possibility.

**F**or those who nonetheless believe there is value in preserving the life of someone in PVS, I suggest two questions they might put to themselves. Before respirators and artificial feeding existed, would they have wanted medical research to invent those devices for the *sole purpose* of keeping PVS patients alive? If one believes it a good to be kept alive in a PVS state, does this not imply that further research should be carried out to make such a thing even more possible—to keep those in that state alive longer and longer, even a full lifetime?

What about the cessation of artificial nutrition and hydration for the PVS victim? Is that moral? About a decade ago, when I first began thinking about this issue, I was far more reluctant to support such cessation than I am now. Two factual discoveries changed my mind. The first was that artificial nutrition and hydration were first developed only as a temporary means of helping a person overcome a temporary inability to eat or swallow water, e.g., as part of the recovery process in the aftermath of an operation. It was only in the 1970s, after some major improvements in the tubing and techniques of nutrition and hydration, that the procedure became more widespread, eventually being used routinely with PVS victims. My second discovery was that the inability to eat, and a failing desire to eat, is itself one of the classical symptoms of a dying body. An inability

to eat was not, in the past, taken as evidence that a patient was “starving” to death, but only manifesting a symptom of a dying body. The word “starving” was only recently introduced as part of the polemics about artificial nutrition and hydration.

These two discoveries led me to conclude that extended artificial nutrition and hydration for the PVS patient should be considered “extraordinary” treatment, neither “ordinary” medical treatment nor, for that matter, ordinary nonmedical caring. It was only because, once again, technology had coopted the sanctity of life principle that many came to see the cessation of artificial feeding as itself a killing. Once again, what had been a legitimate omission prior to the new technology was now turned into an act of commission. The perfectly natural process whereby a dying body can no longer take food or water has been transmuted into something that has become our fault if we don’t use the new technology to remedy the situation.

In sum, in the argument that a PVS patient ought to be sustained as long as possible I see the unhappy fruits of the three technological seductions I described above: death by “starvation” has now become our fault, not nature’s, if we omit treatment; the distinction between omission and commission is erased in the insistence that the stopping of artificial feeding is the same as killing the patient and, as too often

happens, a new technology gets legitimated and routinized by an invocation of the sanctity of life. And just to make matters worse, the still useful and traditional distinction between ordinary and extraordinary treatment has been corrupted, making it appear as if it is mere ordinary treatment to preserve the body of a PVS patient indefinitely.

Perhaps there are those who believe that it is a great medical step forward that we can indefinitely sustain the lives of those who have lost their human potential, or who believe that the sanctity of life is enhanced by large numbers of permanently unresponsive bodies being sustained through a network of feeding tubes at one end of those bodies and excretory tubes at the other. I think, on the contrary, that technology got the better of them once more. Medical science is very clever in making us feel guilty about accepting the end of human life; in its hubris it has led us to think of death as a curable condition, or at least indefinitely postponable. Human life had value before technology came along, and if death is an insult to the human condition, that insult requires a spiritual, not scientific, remedy.

DANIEL CALLAHAN is *President of the Hastings Center and author of the recently published book The Troubled Dream of Life: Living with Mortality (Simon & Schuster).*

## Responses to Daniel Callahan

### Gilbert Meilaender (An imaginary dialogue)

**GM:** I have to say right at the outset, Dan, that *The Troubled Dream of Life* is a superb book. I’ve read much of what you’ve written over the years, and this is the very best—thoughtful, provocative, and even (as one reviewer put it) pious. Anyone who finds your article in this symposium worth reading will certainly want to turn to the book itself.

**DC:** I’m pleased to hear you say that, Gil, especially since we don’t agree on every aspect of these questions. Pleased as I am, though, I suspect you’re not going to let praise have the last word.

**GM:** Oh, but I will. Of course, words of praise at beginning and end may still bracket a few dissatisfactions that need probing. I’m not always certain that some of your points are made as precisely as they should be. And in some respects I think you’re almost too concerned with stopping the growing euthanasia movement.

**DC:** Too concerned? Surely you don’t mean that.

**GM:** Yes I do. In order to draw a line that you think will work for public policy, a line that may keep euthanasia from becoming legally sanctioned, you have to ignore the fact that we may already be there. We may already be deliberately letting die people who aren’t really dying—and doing so simply because we think their lives aren’t worth preserving.

**DC:** That’s a serious issue, and, as you know, I’ve addressed it. But don’t you think it’s important that we try to undermine the growing sentiment in support of euthanasia?

**GM:** Of course.

**DC:** Then a line that makes sense to people—such as the line between omission and commission—may be exactly what our public policy needs, even if it doesn’t capture every distinction as precisely as we might like.

**GM:** Perhaps that would make good sense if one thought the line you draw will hold forever, but I don’t think it will. I suspect a day will come when we say, “Why not kill by commission? After all, we’ve been doing it by omission for a long time.”

**DC:** I'm not sure I follow you.

**GM:** Look, Dan, you know that I don't entirely disagree with you. Certainly if someone dies because I shoot him, I have caused that death in a way I haven't if I simply do not give him medical care that he needs to live.

**DC:** Agreed. That, indeed, is part of *my* point.

**GM:** But will you agree that there might also be occasions when I could be *culpable* even if I did not cause his death? Culpable because I failed to do for him what I could and should have done?

**DC:** Yes, of course, though I doubt that we'd agree on which cases fit that description.

**GM:** Probably not, but let's take what we can get for the moment. And let's suppose that in our society today there are in fact cases—more by my reckoning, fewer by yours—in which we are culpable for deaths we haven't caused. Culpable because we gladly seized an opportunity not to treat when in fact we should have treated. In such cases, then, our aim and intent is to bring about death—even if by omission rather than commission. And, therefore, I suspect a day will come when we look back upon this time as a transitional stage on the way to approved euthanasia. In that day we will say, "We were already doing the moral equivalent of euthanasia; we just weren't yet prepared to call it by its right name."

**DC:** I get the point all right. But I think it's a bad strategy to adopt; it just plays into the hands of those who build on current practices to win approval of euthanasia. And I still don't think you appreciate sufficiently the important difference that remains between omission and commission. We die because it is our nature to die. And the natural world is a "given" and a "limit" up against which we live. We cannot entirely reshape it, as if we could create our own world. And we shouldn't suppose that whenever someone dies we are responsible for not keeping him alive longer. Everyone must die sometime. We are not culpable because that day has come; yet modern medicine tends to make us feel as if we are. It makes us feel as if we must always choose life.

**GM:** And so we ought. Jews and Christians, at any rate, have said that we should always "choose life."

**DC:** But that's exactly my point. Religious believers, affirming (as they suppose) the sanctity of life, end up as slaves to our technology. They think they are morally obligated to follow wherever it leads.

**GM:** No, I think you've got it wrong there, Dan. There *is* a kind of surface similarity between two quite different ways of seeing death as an enemy. Medical science sees it as an enemy; so does religious faith. But religious faith does not affirm life as the ultimate good to be pursued, since it accepts God as the

limit to our plans and projects. Such faith allows us to acknowledge death when its time has come without choosing it or aiming at it.

**DC:** Are you sure that distinction you make has any cash value? From where I sit it looks as if you religious folk just end up always wanting to treat, and you never acknowledge death soon enough for that death to be a relatively peaceful and tolerable one. That's where you end up when you are never willing to acknowledge that life can become a burden we no longer wish to sustain.

**GM:** Let's consider one of your own examples. You object to a view (my own, as you know) that we can reject the burdens of *treatment* but should not reject the burden of *life* itself. Suppose, you say, "a non-burdensome antibiotic will sustain the life of someone with advanced cancer." Are we obligated to provide it? Or might we not just say that, in order to avoid a worse final death, we can act as if antibiotics had never been discovered and were not available. Is that a fair summary of your illustrative case?

**DC:** I think so.

**GM:** Here's a place where more precision seems needed. I'm confident you don't want to say that an otherwise healthy twenty-year-old with a severe case of bacterial pneumonia may properly decline antibiotics—thinking thereby to avoid a worse death fifty years down the road.

**DC:** Of course I don't.

**GM:** And I, in turn, don't want to say that the person with "advanced cancer"—that is, one who is already well into his dying—must necessarily accept an antibiotic. But it's important to be clear why I would say that. Is his life experienced as burdensome? Almost surely. Can we understand that he might want to die? Certainly. Is it morally permissible, therefore, for him to choose to die—to decline the antibiotic *so that* he will die? I don't think so.

**DC:** So he has to take it and suffer a worse death than he might otherwise have?

**GM:** No. I already said he didn't have to take it. He doesn't have to take it because—by the very terms of the case—he is already dying. For him this antibiotic has become just as useless as many treatments for his cancer, since—as Paul Ramsey once put it—the one dying is a person and not simply an ensemble of diseases.

**DC:** Well, that is not the way I would put the matter, but suppose we put it your way for the moment. We're still in agreement on the two cases. The twenty-year-old with pneumonia would be wrong to decline the antibiotic. The man or woman dying of advanced cancer would not.

**GM:** Shall we add one more version of the case and see whether we continue to agree? Suppose now that our patient is a seventy-seven-year-old man, relatively robust physiologically for his age, but suffering increasing dementia. Suppose now that he is the one with pneumonia.

**DC:** I suppose you'd say we ought to give him the antibiotic.

**GM:** Yes, I would.

**DC:** Even though we may be keeping him alive to suffer a worse death down the road?

**GM:** Who can say whether that will be the case? You are the one who has written—very eloquently—about the moral failure involved in our attempts to control and shape the whole of life. In this case the antibiotic would clearly be useful in preserving his life, and the treatment itself would not be a burden to him.

**DC:** Yes, but his life may be a burden.

**GM:** Of course. And I already granted that we might even wish or pray that he would die. That's quite understandable, and I don't think there's anything wrong with it. But if the burden I seek to rid him of is not the treatment but the life, then I fear I am doing more than wishing he could die. If I don't treat him for that reason, there would be no way to describe my "plan of action" other than by saying: "I won't treat him *so that* he will die." And that I wouldn't want to say. If the burden to be gotten rid of is his life, then that life is what I'm taking aim at.

**DC:** Well, I doubt that we can reach agreement on this case. But perhaps I can press you just a bit. Are you going to put a feeding tube in such a patient if he can't or doesn't eat? You have, after all, written in defense of artificial nutrition and hydration.

**GM:** True. But here again we need to make some distinctions. Suppose we try to feed him by tube and he constantly pulls at it, seeming to find it burdensome. I wouldn't restrain him in order to feed him. I'd accept the fact that this *treatment* was burdensome for him. What I've noted in earlier writings, however, is that such an argument cannot work in the case of patients in a persistent vegetative state, since, as far as we know, they do not find a feeding tube burdensome.

**DC:** All the worse! So we have to sustain the life of people in what I can only call a "zombie-like" state?

**GM:** Shall we ask ourselves for a moment what the best way to describe these people is? One of the really beautiful parts of your book—a part that doesn't make it into what you say in your short essay here—is the section (in chapter 4) on "Mourning the Loss of the Optimal Self." You suggest that there is no ideal point in life at which we are most truly ourselves.

And while granting that we cannot bear to think of ourselves as having lost our intellectual capacities, you even say: "[I]t may be no less a mistake to think that we must have an optimal mind than that we must have an optimal body." Our lives do not lack dignity when our mental capacities fail. I take it that you and I agree about that.

**DC:** Yes, I think we do. But surely treatment—including feeding by tube—for the PVS patient is a perfect example of futile treatment. And you yourself allow that we have no obligation to provide useless treatment. An inability to eat is a perfectly natural part of the process of dying. That a person in a persistent vegetative state cannot take in nourishment is not our fault; it is simply "a symptom of a dying body."

**GM:** If I were persuaded of that, Dan, I think we could agree about proper care for PVS patients. Indeed, when I first wrote about this question I noted that "at least in some cases . . . lapsing into permanent coma might be a sign that a person is trying to die." If it is—whenever it is—I would have no moral objection to withholding or withdrawing a feeding tube. But, as you know, the true PVS patient is physiologically robust; he may live for years if given nourishment. It's rather hard to see such a person's failure to eat as a symptom of a dying body. I suspect, in fact, that the real symptom is our failure to feed—a symptom of our profound dis-ease before one who is clearly one of us yet so unlike us.

**DC:** Well, if you don't like my description of these patients as dying, what alternative would you offer?

**GM:** I would describe a Karen Ann Quinlan or a Nancy Cruzan not as a dying person but as a severely disabled person. Similarly, a quadriplegic is severely disabled and unable to feed himself, but he is not a dying person. The fact that he is unable to give himself nourishment is not a symptom of a dying body; it is the result of a severe injury and disability.

**DC:** And in an earlier age you would have tried to develop a feeding tube for the sole purpose of keeping alive a person in a persistent vegetative state?

**GM:** I would have tried to do anything I thought might benefit the life the person has. That doesn't necessarily mean developing a feeding tube. It might mean spending hours trying to provide some nourishment by mouth. That such an attempt would fail is no doubt true, but, as you well know, we don't have an obligation to succeed.

**DC:** Let's talk more another time.

**GM:** Agreed. And, Dan, it really is an excellent book.

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## William B. Smith

Daniel Callahan is surely correct that stern proponents and opponents of euthanasia can share the same obsession—control. Some medical types resent death because it seems outside their technical “control”; some pro-choice types resent any suffering or discomfort, again outside their “control.”

Life control, birth control, death control—there is a controlling logic here, a gnostic “worldly” wisdom that does not like the world we have been given and by supreme effort seeks to construct a world that can be controlled.

No convinced Christian is obliged to prolong life “indefinitely,” nor should he even try. Medicalizing technology to prolong life indefinitely is as futile as it is obscene. But I would differ with Callahan on what motivates the obsessed controllers; I doubt that it is fear of non-beneficial benefits as much as it is loss of belief in the afterlife.

Guessing at motives aside, what I fear is the loose use of language, especially by bean counters who will find some system (rationing, rating, capitation) to declare non-beneficial benefits not cost-effective and thus no longer available.

When functional definitions are wedded to financial decisions, some folks are going to be defined off the human list. I take it as a guiding principle that all social engineering is preceded by verbal engineering. Thus, I am reluctant to accept neologisms and am uneasy with such terms as “merely physiological existence,” or “biologically tenacious individuals,” or, as Daniel Callahan would have it, “the zombie-like life of the PVS victim.”

In time, words shape (engineer) the deeds we do and sanction. Not long ago, there were special provisions in place ensuring that, in most instances, assisted nutrition and hydration was outside the category of “extraordinary” care for PVS patients. Legally, this is no longer the case. Legally, the list of patients deserving human care is shorter today. On the caring list, PVS is now an unlisted number—not only in the dying context where nothing more reasonable can be done, but now in the chronic cases who are simply not dying fast enough.

What has changed so fast in so few years? I suspect not the discovery of some medical history about what motives helped introduce some new technology, nor the announcement that it is symptomatic of the dying body not to want food. The latter simply begs the question by smuggling the word “dying” into the description, thus verbally converting a chronic case into a dying one.

What has changed, I think, is a bit of verbal engineering. Where Callahan focuses on “potential for development,” others speak of capacity for “cognitive-affective” behavior. If or when that potential or

capacity is lost for the PVS patient, then the human status deserving of medical-nursing care is lost as well. When we draw that kind of quality-of-life functional line, some folks are going to qualify and some won't.

The PVS designation is treated as a label whose time has come. It is presented as an air-tight scientific diagnosis as stringent in its discovery as it is unarguable in its outcomes. Indeed, some professional groups (or spokesmen for same) have so declared. Long ago, T. S. Eliot warned us: “words spread.” I may be slower than others, but I do not find in the literature absolute statements of the clinical factors unanimously agreed to by medical professionals defining PVS. Such unanimity would be important when the PVS label automatically removes someone from the human care list.

I accept the conventional ordinary/extraordinary distinction of received Christian teaching: ordinary = obligatory; extraordinary = optional. I further accept the definition of euthanasia put forward by the Congregation for the Doctrine of the Faith (CDF) in its *Declaration On Euthanasia* (1980): “Any act or omission which of itself or by intention causes death.” I also accept the CDF view that “when inevitable death is imminent in spite of the means used, it is permitted . . . to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.”

“Imminent” in the above view is to be understood as hours or days, not six months or a year. Also, while the failed “treatment” aspect of the above quote is often cited, the qualification—“so long as the normal care . . . not [be] interrupted”—is often omitted.

The CDF *Declaration* addresses but does not precisely answer all cases of PVS. An excellent resource paper of the U.S. Bishops Pro-Life Committee issued in 1992 further specifies the assisted nutrition and hydration question (“Nutrition and Hydration: Moral and Pastoral Reflections”). Wisely, in my view, the U.S. Bishops did not try to resolve every PVS situation case antecedently, but they did propose a nuanced statement of correct principles and presumptions that are helpful in the resolution of each PVS situation—case by case. This case-specific approach seems wiser to me than a one-size-fits-all label that is scientifically unavailable and morally dubious.

In the non-dying context, the presumption is for assisted N&H unless specific pathological factors urge otherwise. Often, unfortunately, the clinical factors do not turn the moral fulcrum but rather legal and procedural elements do: family wishes, signed directives. We live in a society that seems more concerned with signing the right forms than with doing the right thing. Procedural ethics continue to swamp and consume substantive ethics at every turn and in every context. The fact-specific calculus may not sit



well with the legal mind, but common or general laws seem uncommonly clumsy instruments for such fine-line detail.

There are exceptions to the pro-N&H presumption. Surely, for a patient who can no longer assimilate food, N&H provides no benefit; similarly, some stomach cancer cases result in feeding the tumor instead of the patient; and there are those who are so fragile that almost any invasive insert causes more problems than it relieves.

In these cases, I assume death is truly imminent. But in the chronic case, where the patient is not in imminent danger of death, the omission of assisted N&H is a lethal omission, for by that omission we set in motion a chain of events known to be death-dealing.

Of what benefit is this assistance? The support—caring even where there is no curing—affirms human solidarity in both directions: care-giver and care-receiver. It is a human virtue to care for those who cannot care for themselves, and in that act of caring we affirm that it is a human person we care for—not some mere physiological process. After all, we water live plants with regularity. Do our own kind deserve less?

But once the “potential for development” sock is fitted to all PVS patients, how does one control the logic of that functional standard? There are some persons so badly compromised at birth that they do not or never will have such potential. I don’t suggest that doctors and nurses will not feed them, but I’m not sure the bean counters will.

Some judge, in some jurisdiction, will soon discover that someone’s “right to privacy” is broad enough to include the “right” not to care, or that suicide or assisted suicide are implicit in the “concept of ordered liberty.” Several courts have already sanctioned dehydration as the “treatment of choice”—if it is so chosen by the patient, or by the patient’s proxy.

In my view, the PVS situation should be considered case by case with agonizing attention to case-specific detail. A one-size-fits-all label seems to simplify a difficult matter, but it simplifies too much by simply removing a whole category of persons from the human care list.

About that removal, bean counters may have no scruples; but ethicists should.

MSGR. WILLIAM B. SMITH is Professor of Moral Theology at St. Joseph’s Seminary, Dunwoodie, in Yonkers, New York.

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## M. Therese Lysaught

How can a theologian resist commending Daniel Callahan for his closing line: “[I]f death is an insult to the human condition, that insult requires a *spiritual*, not scientific, remedy”? This insight in

itself makes Callahan’s an important article. Overall, I agree with him, I disagree with him, and I want him to push the logic of his argument to a more complete conclusion.

Where do we agree? He is correct that it is crucial to maintain the moral distinction between acts of omission and commission. Further, his analysis of the relationship between medicine, technology, and the fact of death is compelling, although ultimately he gives too much agency to technology: it is primarily the ideology behind technology, and not the technology itself, that does the damage. And finally, I appreciate his challenge to recover the distinction between ordinary and extraordinary treatment; this would certainly be a helpful, practical first step in beginning the process of reassessing and reordering our relationship with technologies at the end of life.

Where do we disagree? This retrieval of the ordinary/extraordinary distinction is more a “scientific” solution than a “spiritual” one, and I am concerned that this technique alone will, in the end, primarily treat a symptom rather than cure the disease. For as Callahan rightly notes, our captivity to technology results from its implicit ideology—our confusion over the meaning of death. But while his solution—recovering a notion of death as natural—could alleviate the agony of particular dying individuals and their caregivers, I am not convinced this will effectively ameliorate those conditions that impel public opinion toward the “potentially disastrous” outcomes of euthanasia and assisted suicide.

Why? The problem lies with the notion of the “natural.” Natural can be construed in two diametrically opposed ways. On the one hand, we live in a culture that is thoroughly Baconian, evidenced best in capitalist expansion and medical pioneering. In this view, nature, especially construed as raw, unfettered, unpredictable power, is there to be mastered, overcome, shaped, and directed to meet human needs and ends. To be human is to control nature, to decide how it will serve human ends. Within this framework, therefore, to define death as *merely* natural may well fuel the impetus to denaturalize it, to work to overcome it. This is one source of the tyranny of technology and may well only further it.

On the other hand, understanding death as a natural event may further fuel the impetus toward euthanasia and assisted suicide: if death is merely natural—the end of a reasonable span of a full and meaningful life with nothing to be feared—it may well be fully rational, completely reasonable, to end it when the capacities of (natural) life no longer meet the needs, goals, and wishes of the individual. Certainly Jack Kevorkian and his patients accept death as natural.

Thus, Callahan is correct that implicit in the tyranny of technology is the ideology of our understanding of death. But here his logic compels him to go further:

implicit in our understanding of death is the ideology of the autonomous individual, in short, our anthropology. Clearly, Callahan recognizes that anthropology is central to the problem; he notes that our culture places “excessive emphasis on choice and self-determination,” and that this compels us to want to find a human decision behind every death. But he does not pursue this further. It is this anthropology that must be addressed; this is the *spiritual* issue at stake.

That the issue at stake is a spiritual one is evident in the religious imagery that pervades Callahan’s account of technological medicine: that the war on death is a search for “immortality”; that the dying patient might be “saved”; that medicine is seen as “omnipotent, holding life and death wholly in its hands”; that a lobbyist equates heart attacks, cancer, and strokes with sin (interesting rhetoric in the public sphere, but I’ll save that discussion for another day).

In most cultures, questions of immortality, salvation, sin, and the meaning of death have been answered and continue to be answered within religious traditions. Buddhists, Christians, Hindus, Jews, and so on recognize a power in life—identified with a sense of the sanctity of life—and a power in death, insofar as death seems to overcome, eliminate, evacuate the power of life. But generally, life is not considered essentially sacred, that is, in and of itself. Rather, it is considered sacred because it is a gift from the source that holds the power of life. It is a gift held in trust; a gift to be returned to the giver throughout the course of life in the form of worship, procreation, a good life, and finally in death. In short, life derives both its limits as well as its meaning from a wider context ordered to interrelated ends—nature, community, and/or relationship with the transcendent. Likewise, human bearers of that life draw their identity, self-understanding, and the meaning and limits of their agency from a context ordered to ends beyond their individual choosing or effecting.

We have, however, lost our sense of being part of anything larger than our single selves. The Baconian turn demythologized nature and the Enlightenment elevated the autonomous human individual to the status of the transcendent. No longer does human life—and correlatively human dying and death—draw its meaning from the context within which it is situated, be that the rhythms of nature or the story of God-in-history. Human life is now *essentially* sacred rather than sacred by participation. Consequently, “salvation” becomes equivalent either with the prolongation of biological human life at all costs or with individual control over the way a particular life ends. Medicine and medical technology have become our soteriology.

Thus, the problem is not so much that technology has seduced the sanctity of life. Rather, individualism and autonomy have seduced the meaning of human life, and therefore, the meaning of human

death. Human persons have become idols, worshipped as ends in themselves, cut off from any sort of context that might provide them with meaning. We don’t know who we are, we don’t know how to live (well), we don’t know how to talk together about these questions, and we don’t know how to die. This is precisely a spiritual crisis.

Callahan has taken an important step toward overcoming the tragedies of lives unnecessarily prolonged by out-of-control medical technology. He has helpfully challenged the idolatry of technology, but the problem of idolatrous human life remains. The problems of euthanasia and assisted suicide point us to deeper spiritual questions: questions of human identity, agency, control, finitude, and humility before the aspects of reality that truly transcend human existence. These are first questions of how to live well before they are questions of when to die and how to die peacefully.

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## Caroline Whitbeck

Daniel Callahan makes a constructive contribution to the discussion of medical interventions at the end of life by emphasizing that the dying person often ceases to want or take food, not because of depression or out of an attempt to starve to death, but because his or her body can no longer metabolize food. He is to be commended for abandoning his earlier position that the dying should be fed, even against their wishes.

The middle class in the United States is unused to seeing death, or birth either. (The white middle class may be especially culturally deprived.) Ignorance of many matters of birth and death often leads people—medical ethicists, patients and their families, and even health care providers—to make misinformed or inadvertently cruel decisions. It is nurses and nurses’ aids who now attend women in labor, care for newborns, and provide most of the care of those who are seriously ill or dying. For most of humanity these aspects of what we regard as nursing care are provided by family or neighbors.

It has become common for us to have serious decision-making responsibilities when we are facing one of our first experiences attending a dying person. Most of us are doubly unprepared: we do not understand the constantly changing array of medical options, and our culture’s obsession with self-determination has permitted us to turn away from uncomfortable realities of the human condition because they are relegated to our “private lives.” As a result most of us are seriously unprepared for some of our most important responsibilities for those closest to us.

Medical ethics might have made a concerted effort to overcome the dangerous ignorance of the American middle class, but it has not. The dominant voices have not been those of nurses and other providers of care informing us about medical interventions, nor the voices of patients and families who have faced these experiences, nor those of the lay and ordained pastoral caregivers who have supported and advised members of their faith communities as they tried to understand and respond well to these complex and frightening situations.

The dominant voices in medical ethics in the last twenty years have largely sought to fit wrenching human problems to abstract models, especially the model of "dilemmas," that is, "forced choices between two equally unacceptable options." Such abstract representations have distorted those problems and often undermined public understanding of them. A common approach to resolving the artificial abstract problems is to propose general "principles" from which one might simply deduce a response.

In the last decade major figures from Alasdair MacIntyre to Annette Baier, Stephen Toulmin, and Albert Jonsen have offered a variety of powerful arguments against abstract approaches to ethics and, in particular, against the attempt to address moral problems by formulating "principles." Objecting to the formulation of such abstract principles does not require that one altogether dispense with principles in moral argument. I agree with MacIntyre that although there are no timeless, ahistorical principles or moral rules, there are enduring principles, principles linked to a domain of application and that have stood the test of time, "surviving a wide range of challenges and objections, perhaps undergoing limited reformations or changes in how [they are] understood, but retaining [their] basic identity through the history of [their] applications."

Moral change does not necessarily require formulation of new principles, however. For example, some hospitals, such as the teaching hospital in which I help teach the students from the Harvard-MIT Program in Health Sciences and Technology, have made significant changes in their policies in the last few years. Thus it is no longer their policy to attempt resuscitation on any patient who undergoes cardiac arrest unless there is a "Do Not Resuscitate" (DNR) order. Such changes are certainly due in part to the recognition that the attempt to resuscitate often breaks the bones of an older patient's breast plate, a condition from which the patient never recovers and which causes the patient great pain.

(Hospital policies have also been influenced by recognition that the concentrations of the HIV virus rise significantly in dying AIDS patients, and most health care workers who have contracted AIDS from their patients have done so performing interventions like cardiopulmonary resuscitation with dying pa-

tients. Therefore, reforms such as changes in policies about the necessity of DNR orders may be less common in regions where there have been fewer AIDS patients.)

It is heartening to see Callahan take account of some particulars about dying, but he does not go far enough. I agree that the difficult problems surrounding health care at the end of life ought never to have been constructed as a dilemma with involuntary euthanasia at the bottom of one slippery slope and force-feeding of dying patients at the bottom of another. But why should we blame "technology" for this construction? There is a criticism to be made of our common expectations of technology. Stephen Lambers has made the point that our society regularly looks to technology to solve perennial human problems. Such problems as suffering and death are ones that we cannot solve, however; we can only cope with them. The difficulty is not with technology but with our unrealistic expectations of it.

The construction of a forced choice between involuntary euthanasia and force-feeding of the dying (or those in a persistent vegetative state) arises from inattention to the actual situation. As one moves closer to the situation the illusion of a slippery slope disappears and some levels of terracing become clear. However, neither the principles nor the distinctions that Callahan offers take us very far.

Callahan's first principle—that "no one should have to die a worse death as a result of medical technology than would have been the case prior to the invention of that technology"—helps only with the few cases in which one is certain how and when the patient will die if treated. Most cases are like the one I encountered some years ago at one of the medical schools at which I taught. A Roman Catholic priest, who was showing signs of rejecting a transplanted kidney, clearly expressed the desire, if and when the transplant failed, to die in the company of his friends, also religious, who visited him regularly. He expressed great concern that he not die alone and that his death not be dominated by medical interventions.

The person who brought the example to my attention was a young nurse, a Roman Catholic herself, who understood the priest's expression as not merely a preference but a spiritual concern in keeping with his whole set of religious convictions. She was gratified that the priest's physician was fully supportive.

One Monday the nurse returned after a weekend off to find that the priest had gone into crisis. The priest's regular physician was away and the physician in charge had begun a vigorous effort to "save the life" of the priest. It was not certain when the intervention began that the conclusion would be death. However, that was the result. The priest died, isolated from his spiritual support and surrounded by a flurry of medical activity. The nurse was appalled at

this betrayal of the priest's trust. She was confident that the priest's own physician would have permitted comfort measures only.

This was a worse death, but it was not fully predictable when the intervention began. Furthermore, it is not by some applicable-to-all "quality of death" measure that this death is judged worse. Identical interventions might have been quite appropriate with another patient in the same medical circumstances but for whom surviving to see the birth of a grandchild held special meaning. What was wrong with the care of the priest can be understood only in relation to the practices by which the sacred was recognized and celebrated in this person's life.

The distinction between ordinary and extraordinary fails for many of the same reasons as Callahan's first principle, although I certainly agree that it is wrongheaded to seek to force on patients "any non-burdensome treatment that will sustain life, whatever the condition of that life."

The word "ordinary" can be heard in many different ways, such as: what is routine (at this facility); what is covered by health insurance; what is an established, as contrasted with an experimental, treatment. The language of ordinary/extraordinary is dangerous since it is likely to be misunderstood. In one widely known case a couple who witnessed a series of harrowing interventions on their newborn child after they had specified "no heroic measures" said, "It all looked heroic to us." The staff had interpreted their words to allow all procedures that were routine in the *newborn intensive care* facility.

The criteria of "burden" and "benefit" that Callahan specifies for application of the ordinary/extraordinary distinction are vague. As with the criteria for his first principle, these fail to take into account the uncertainty that prevails about the results of medical interventions, and do not consider such specifics as the place of practices in which the person experiences or participates in the sacred. Surely these ought to be a part of any consideration of the sanctity of life.

Even the established distinction between omission and commission may cause confusion, especially if not tempered with the principle of double effect. Many of the medications for severe pain also depress respiration and so hasten death. Families often face a double bind—either risk killing their loved one, or risk letting the person suffer unnecessarily. They escape that double bind by refusing to have their family members die at home—which may have worse results yet.

Callahan's second principle addresses health care providers, or at least physicians. Let us interpret it as a specification of the physician's responsibilities rather than, literally, as a stipulation of what physicians should feel. Locating moral responsibility with people is better than scapegoating "technology." However, the question of a person's participation in

meaningful practices is a matter about which physicians may not be knowledgeable. For example, suppose that a given patient now either dying or in a PVS had experienced the risk of starvation for some period in life. Contrast this patient with another with the same medical profile but who had fasting (as an aid to spiritual centering) as a part of his or her spiritual practice. Supposing the patient to have any awareness of the care being given, might not the cessation of feeding be different in the two cases because of the difference in the meaning of hunger for the two? For the first patient one might continue giving food after antibiotics had been stopped, but do the reverse for the second.

My arguments and examples are meant to illustrate how the role of what Alasdair MacIntyre and Stanley Hauerwas call "internal goods" need to be considered in forming policies about medical care. As they argue, ethics has gone astray by focusing exclusively on "external goods," that is, on the goods that are the external ends or goals of some activity or practice. (For example, producing crops is the external goal of farming.) The goods that are continually neglected are those that are internal to the practice, that is, those that are achieved *in* the practice. Hauerwas gives as examples of practices with significant internal goods, baseball and the worship of God.

A good death is to be understood not only in terms of the relative absence of pain and disability but also in terms of whether we keep faith with each other and ensure that the dying are neither betrayed, abandoned, nor invaded in the care they receive, in particular, that recognition and support is given those spiritual concerns that have been central to their lives.

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## William E. May

Daniel Callahan is quite correct, I believe, in saying that one of the principal reasons for the growing acceptance of euthanasia in our society is the legitimate fear many have of a "technologically induced bad death for themselves and their family members." It is crucially important to respect the right of competent patients, and of persons charged with the care of those whom the late Paul Ramsey termed "voiceless" patients, to refuse burdensome and useless treatments. This was the precise issue examined so thoroughly and competently by Germain Grisez and Joseph Boyle in their very important, but unfortunately little noticed, study, *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate*, published in 1979.

Callahan is also quite correct in recognizing the crucial moral difference between killing and allowing a person to die his or her own death, inasmuch as it can be morally right to withhold or withdraw life-prolonging measures when their employment is unduly burdensome and/or useless. Yet Callahan, I fear, too easily equates "allowing a person to die" with acts of omission. *Some* acts of omission are lethal, because they are adopted precisely as a means to bring about someone's death. As the *Declaration on Euthanasia* prepared by the Congregation for the Doctrine of the Faith in 1980 correctly observed, "By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."

This brings us to the central issue of Callahan's essay, the proper care of persons in the so-called "persistent vegetative state." Callahan's basic argument, so it seems to me, is that we ought not provide these persons with food and hydration by tubal means *because their lives are of no value to them*. He has passed, so it seems to me, from judging whether a *treatment* is burdensome and/or useless to a person to judging that some individuals' *lives* are burdensome and/or useless to them. He describes their lives as "zombie-like," and says that the condition is "actually worse than that of a newly fertilized egg" (I'll return to the question of the "fertilized egg" below). The implicit judgment is that persons in the so-called PVS condition are better off dead than alive and that, therefore, it is of no use or value to them to be given the food and water necessary to sustain their burdensome and useless lives. But if it is indeed true that the lives of PVS persons are of no value to them and it is morally legitimate to withhold or withdraw food and hydration from them in order to relieve them of the burdensomeness of their useless lives, then surely it would be morally legitimate to hasten their deaths, which would undoubtedly be prolonged were they not to be fed or hydrated, by some active means.

Callahan also presupposes that PVS persons are in the process of dying. At one time I shared this presupposition, but I have since learned that this is *not* the case. In fact, the American Academy of Neurology has explicitly recognized that such persons are not in danger of imminent death because of their condition, a matter well brought out by the Catholic Bishops of Pennsylvania in their carefully constructed statement, "Nutrition and Hydration: Moral Considerations."

With regard to Callahan's comparison of the lives of PVS patients with the lives of "fertilized eggs," I would simply note that once an egg has been fertilized it is no longer an egg but a new living being, and in the case of the human species, a new *human* being—surely a being of incomparably greater value than an "egg."

Callahan poses two questions for those who, like me, believe there is value in preserving the life of someone in a PVS state. The first is whether they would have wanted medical research to invent respirators and artificial feeding for the sole purpose of keeping PVS patients alive. To this I answer first that I do not think it morally obligatory to keep PVS patients alive by the means of respirators, for their use would, I believe, be unduly burdensome. I likewise do not think that I would have wanted medical research to invent artificial feeding for the *sole purpose* of keeping PVS patients alive, because it is quite evident that tubal means of providing food and nourishment are valuable for persons suffering from various sorts of disorders, and that they are also of value for PVS patients. Callahan also asks whether the belief that it is good for a person in the PVS state to be kept alive does not also imply that "further research should be carried out to make that even more possible, to keep those in that state alive longer and longer, even a full lifetime." To this I answer that the issue of "further research" raises a whole host of questions regarding allocation of our resources. It would be preferable, in my judgment, to allocate resources to the alleviation and prevention of many other disorders, to the prevention of persons from becoming injured to such an extent that they are in the PVS state, and to investigate avenues of helping improve the condition of PVS patients.

In conclusion, I believe that Eugene F. Diamond's comments in the *Linacre Quarterly* (February 1992), reflecting on the Pennsylvania Bishops' Statement, are pertinent. Dr. Diamond observed: "The focus of the debate [over providing PVS patients with food and hydration] should be kept where it belongs. It is not about the terminally ill patient who is imminently dying and who will die anyway whether or not food and drink are continued by whatever means. The issue relates to the patient who is not dying but rather is being provided food and drink by so-called 'artificial' means because of inability to feed himself. . . . For such a patient, tube feeding is *useful*, in that it sustains his life, and *is not excessively burdensome* because it can be provided at low cost and by unskilled personnel."

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### Eric Cassell

Physicians are a pragmatic group devoted to action. In caring for the kinds of patients Daniel Callahan discusses they rarely say to themselves,

"I'm going to save Smith's life," or, "I'm not going to let Jones die," even when they are doing just those things. Instead, the situation in front of them—Smith sick as spit or Jones dying—is converted by their thinking into a specific *medical* (technical) problem. Smith had a heart attack and is going into shock. Heart attacks present distinct problems calling for defined actions. Transfer to the Cardiac Care Unit. Start this or that medication. Attend to the monitors, alert to certain events that threaten. Possibly going into shock? Place a Swann-Ganz catheter to monitor pulmonary wedge pressure. Put in an A line to monitor the blood pressure. Consider aortic balloon counter pulsation. And so on. Each act in the here and now, concerned only with the present. Each act is an instrumental goal in itself that supports the saving of Smith's life. The larger goal is pushed aside, however, by technology and the medical science on which it is based, and multiple subsidiary goals are substituted. At the bedside, doctors are uncomfortable about philosophical issues because they get in the way of action.

The same is true of keeping Jones from dying even if Jones is a demented old lady who hasn't looked or acted like a responsive human being in months. There she lies, mouth open, eyes shut, contracted limbs and bedsores for all to see. Her blood culture showed bacteria so the doctor treats that infection. She is dehydrated so she gets fluids intravenously. She cannot eat. A feeding tube is inserted. Back in medical school, her doctor took a course in ethics and patients like Jones were discussed. Should they be kept alive? Is food or fluid like any other treatment? The doctor believed that it was inhumane to keep such people alive. Yet here he is, doing just what he didn't believe in. Afraid of the Chief of Medicine, the hospital counsel, and what the other house staff might say. For keeping Jones alive there are established procedures and guidelines for treatment. For allowing the patient to die no such guidelines yet exist. Hannah Arendt's banality of evil is forced to mind, but now banality just as thoughtlessly in the service of benevolence.

Why? Because all the technical issues involved in the cases—from the anatomical definition of coronary artery disease to the readout on the monitor for blood pressure—are abstractions from the lives of these patients. These serve wonderfully well as guides for the actions of physicians when patients can represent themselves. How about in the care of Jones, who hasn't been self-determining for ages? Here, medical abstractions are inadequate representations of the person who is Mrs. Jones.

**W**hat is meant by Smith's or Jones' life in this context? In fact, who is Smith in the CCU? Or Jones lying in her bed? Their doctors hardly know anything about them, not because they cannot, but because they are not trained to find out. Both pa-

tients are in the throes of illness, something from which no life is ever free. Over the centuries, but particularly in the last two hundred years, two reductive steps have moved medicine away from the complex social, psychological, and personal dimensions of illness. The first step was to substitute the modern idea of "disease" for the illness. The second step was the introduction of medical science and its purely biological view of disease. And the consequent technologies (X-ray, laboratory test, EKGs, etc.) that allow medicine to consider diseases at a distance from the patient.

These two strategies have led to the phenomenal advances of biomedicine and the conquest (nothing less) of many diseases. Alas, they have also fooled everyone (including doctors) into the wrongheaded notion that the fundamental personal problems of life and death—bonding, growing, developing, becoming, being, declining, leaving, and grieving—are also open to technological fixes. Of which euthanasia and legalized assisted suicide are just two examples. It is not medicine or science that is the enemy, but the continued abstraction from the real life of real humans of which they are both the parents and the children.

I believe that Daniel Callahan is incorrect in suggesting that physicians have coopted the principle of the sanctity of life. They share it with the rest of their culture. It is not only medicine that urges the continued treatment of patients like Jones or those in a persistent vegetative state. Nor doctors alone who do not want to remove feeding tubes and the like. I think he is also wrong in believing that the courts are longstanding champions of allowing the hopelessly ill a way out. There may even have been commentators in these pages who strongly argued—in the name of life's sanctity—the error of allowing someone to die by removing nutrition and hydration. What is the life that is sacred, the body's life, the person's life, Jones' life? In most discussions it is not life in the sense that you and I know or live it, but some abstraction as remote from Smith and Jones as the doctors' technological abstractions.

At the end of the nineteenth century it appeared as though Western culture was beginning to come to terms with human life as persons actually live it. In this century, however, the project has faltered. Instead, it has been reductionist and oversimplifying in its sciences (including social science), graphic arts, music, and philosophy. Little wonder that ethics as much as medicine is cursed by abstractions that separate them from the richness of human existence. Things are changing, though, and again the complexity of the real is forcing itself into cultural consciousness (evident not only in recent trends in medicine and ethics—witness Callahan—but the arts and philosophy as well). In examining the issues raised by Callahan, we must return to the hard reality of the cases and the phenomena involved. It is this sick

person we should concern ourselves with, not some ghostly abstraction.

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### Daniel Callahan replies

My commentators have raised important issues and advanced some potent objections. I appreciate that. Yet I was immediately struck by how little was actually said about the main issue on my mind, that of the power of technology to distort our thinking about matters of life and death. Eric Cassell, who has written in a penetrating way elsewhere on technology, only alludes to it here, while Caroline Whitbeck and M. Therese Lysaught are the only ones who really mention it directly at all. But Whitbeck thinks the only problem is with our "unrealistic expectations" of technology, while Lysaught believes the real problem is "the ideology behind technology."

I am reminded here of a common slogan of those who oppose any serious limits on the availability of hand guns: "It is not guns that kill, but people," as if the widespread availability of guns themselves had nothing to do with the high rate of death by guns. As happens in medicine as well, that kind of attitude underestimates the independent (if sometimes uncanny) power of technology to shape us, those who think we only shape it. The availability of medical technologies changes the way we think about their use and the way we think about the life and death that they can influence.

I would note in this respect two points of historical significance, one bearing on medical progress, the other on the way technological advances reshape our thinking. My first point is that just about all of the major debates of late on the care of the dying have been occasioned by the advent, and then routinized use of, a relatively new technology. It was not until the 1960s that there was any significant argument about turning off respirators or extending the life of low birthweight babies in neonatal ICU units (NICUS). Neither respirators nor NICUS were much used before that time. It was not until the early 1980s that the debate over artificial nutrition and hydration emerged, mainly because it was only in the 1970s that such a form of treatment came into widespread and routine use because of technological improvements.

I conclude that the great, and still unappreciated, problem is what to think and do about technological innovation—and particularly that form of innovation that does not cure but is able to keep a severely ill or

damaged person alive but in terrible shape. We will see more and more of such nasty "progress" in the future. A difference between my critics and me is that they seem to assume that if a new technology comes along that can sustain life, the benefit of any doubt must be toward the use of that technology. In no case, moreover, ought we be allowed to take into account the kind of life, or the burden of life, that the new technology may create or allow to be sustained. By contrast, I am trying to work with the notion that we should be free not to use a new technology—to give it no benefit of the doubt at all—and in any case not use it if it promises us a worse burden of both treatment and life than was the case before it appeared.

Gilbert Meilaender, William E. May, and William B. Smith seem to think that since we can now technologically keep PVS patients going by technology, therefore we must do so, that some traditional moral principles compel us. If they are correct, then we should either reconsider those principles to make them more technology-resistant, or ask whether they really exact such obeisance to technological possibility. In any case, I want to find a better way to distance ourselves from the technological imperative; they seem to me in danger of being captured by it.

My second historical point turns on the way technological change leads us to redefine some basic concepts. May and Smith think that a person in a PVS state is "disabled," not "dying." Recollect, however, that when Karen Ann Quinlan's respirator was turned off in the mid-1970s there was every expectation she would die, and great surprise when she did not. Such patients were not then thought "physically robust" at all, to use Meilaender's phrase. Until that point in medical history, a person in a PVS state ordinarily died in a relatively short time: hence, to be a person in a PVS state was to be a dying person.

My surmise is that it was precisely the improved methods of artificial nutrition and hydration, plus other medical advances, that made it possible by the mid-1970s to keep Karen Ann Quinlan alive so long (ten years). Biological inevitability could be forestalled by medical ingenuity. Yet for just this historical reason, it is perfectly reasonable to refer *still* to people in PVS as biologically dying, not simply disabled. The fact that we can arrest, or suspend, the underlying fatal condition for a time, even a long time, does not change the underlying biological reality: a PVS patient has been captured by a fatal condition which, if we do not artificially stop it, will kill the patient. It is only technological prowess (and maybe some hubris) that has led us to redefine "dying": nature will not presume to tell us who is dying; we will leave that to our technology.

The importance of this mistake—letting technology redefine biological reality—is pertinent also for another problem in the responses to my article,

that bearing on “uncertainty.” Whitbeck, I think, falls perfectly into a familiar technological trap, arguing that because a worse death might not be predictable, a doctor is justified in going ahead with treatment. The difficulty here is that contemporary medical technologies are usually powerful enough to bring uncertainty to almost any medical decision. We might be able to say, in a general way, that a patient is dying, but it gets harder and harder to say that a given technological intervention will not buy us a little more time. It probably will, which is why it is common to observe that most patients now die as the result of a conscious decision to stop or not to start treatment; it can hardly be otherwise given the power of technology to extend almost any life to some extent. The result too often here is that uncertainty is dealt with by a technological bias: don’t stop aggressive treatment until there is some definitive evidence it will do no further good. Technological progress renders such evidence increasingly elusive.

Now it is exactly that problem that sets us up for the suspicion that Meilaender has about the current practice of omission of treatment. “We may already,” he writes, “be deliberately letting die people who aren’t really dying.” That may indeed be the case (even though I know of *no* direct evidence to support such a trend), but there may be a harder judgment to be made here than he allows. If we come to define as “not dying” a person whose process of dying technology can suspend for a time (redefining him as just disabled), then of course every time a physician allows a patient who might be given a few more hours or days to die, he will be open to the charge that he is just part of the “transitional stage” to euthanasia. That would not seem to me a fair or reasonable judgment.

Nor do I think it fair or reasonable to interpret what doctors customarily do when they terminate treatment of a patient whom their technology might continue to sustain as displaying an “intent . . . to bring about death” (which is, incidentally, what many euthanasia supporters also say). If a doctor wants a patient to die and terminates treatment with that as the specific purpose of the termination, that is wrong. But if, instead, a physician believes that the patient as a person no longer benefits from his efforts to suspend or arrest the dying process—either because of the burden of treatment or the burden of life—and then stands aside to allow death to take its inevitable course, no wrong has been committed. The intention is not to bring about death, but to allow the death that nature has built into our lives to take place. This is very different from saying that some “lives aren’t worth preserving” (Meilaender) or that “their lives are of no benefit to them” (May). I do not hear doctors saying that, nor should they.

**I**n this respect, however, it strikes me as neither clear nor helpful to draw a sharp distinction be-

tween a burden of treatment and a burden of life. A painless, superficially non-burdensome, treatment that allows a painful or unwanted medical condition to continue should be as much feared as a painful treatment; who knows, or could ever know, whether Meilaender’s demented seventy-seven-year-old pulls at his feeding tube because the tube causes him discomfort or because the kind of life the tube is sustaining is not one he wants to live? Would Meilaender tie down his hands (a not uncommon practice) if he suspected the latter alone was the man’s motive? I doubt it. But I say it does not matter anyway: whatever his reasons, the patient does not want the tube, and that should be respected.

Medicine becomes increasingly clever in devising non-burdensome technologies to prolong miserable lives that a kinder nature would have allowed to end more peaceably in an earlier era. That is exactly the kind of medical “progress” we should question, just as we should have questioned in the 1970s whether we really wanted to go down the road of improved ways of extending the life expectancy of those in a PVS state.

Smith is worried that “the list of patients deserving human care is shorter today.” Maybe he lives around a different group of doctors and families and ethicists from those I do, but I know of no one who says that people should not have “human care,” if by that is meant comfort, palliation, and non-abandonment. The only “shorter list” I see operating is one bearing on the use of medical technology, and a good thing that is.

As far as I can guess, just about everything that would be on Smith’s longer list would be some technology that came into widespread use only within the past two to three decades. Those decades were a period of enormous technological development and aggressive, usually compulsive, application. Thus at first it was thought imperative always to keep respirators going, then to keep all technologies going at top speed in NICUS, and then to keep artificial nutrition and hydration going. The technological imperative was in the saddle, and to doubt its value was to be judged guilty of lacking both the secular virtue of loving progress and the religious value of the sanctity of life. That’s what created Smith’s longer list—but it was the creature of a particular, and limited, historical era. The error is to take the practices of that era as some timeless norm of respect for human life. It was more likely a bemusement with technology that was calling the moral shots.

**W**e seem to have come out of that compulsive era, gradually returning to standards of an earlier time, when it was not always thought a terrible thing that nature brought life to an end, especially when it spared a person further suffering or a humanly empty prolongation of life. I can recall many religious people in that pretechnological era speaking



of some deaths as a "blessing," even thanking God for bringing the suffering to an end. Was that wrong on their part? Should they instead now be thankful that the PVS loved one can be kept alive for years, and be full of pity for those earlier generations who were unaware of the benefits that medical technology could bring them? I'll take the shorter list myself, and I think the tradition would support my doing so.

To accept the shorter list does not, however, entail an embrace of euthanasia or physician-assisted suicide. There is a great gap between omitting treatment and directly killing. When we omit a treatment, we are doing what medicine has always done, and has always had to do. We do not by such actions change the historical institution of medicine. There is, to be sure, always the danger that we may omit treatment too early, or deliberately and wrongly aim to end a life by doing so. But that hazard has always been present, and the tradition has lavished great attention on where and how to draw the appropriate lines and proceed with the right intentions. Euthanasia utterly changes all that: it is we, not nature, who kill; and

medicine becomes an institution that legitimates the taking as well as the saving of life.

A word on the "potential for development" notion, which so concerns Smith. I take it that we distinguish human beings from other species because of a characteristic range of capacities and potentialities that only humans possess. These include self-consciousness and the capacity for a wide range of emotions, reasoning skills, and interpersonal relationships. I simply fail to see what benefit any form of treatment can have for a person who has lost those capacities. The quadriplegic has those capacities and so do most of the severely demented, even if the latter's capacities are much diminished (and despite Meilaender's guess, I favor more treatment of the demented than he has guessed). The PVS patient is utterly different. By virtue of the loss of the cerebral cortex, the human capacities of PVS victims are permanently lost. It is hardly surprising that, before we invented effective tubes to nourish such beings, nature let them die quickly. It knew what it was doing. ☐

## April

One day without warning Spring arrives,  
 As predictable and unexpected as a death.  
 Birdsong and the smack of dripping water, car tires  
 Spitting on wet pavement sound strange and loud  
 In the soft air.  
 I am as empty as the trees and snowless land,  
 Stripped of winter's enfolding wrap.  
 Now robins tug at swollen worms,  
 Raw green shoots split the earth.  
 Nature has her way.  
 In December the ground was frozen  
 Hard as a bone. It took a backhoe to dig the hole.  
 As long as I left traces in the snow  
 You still were here.  
 What's dead is dead and I can live with that;  
 This rebirth's an intolerable affront.

Suzanne Jane



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