

A medicalized death cannot be a *modus vivendi*: A response to Michelle Harrington

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In her essay, “Medicalized Death as a *Modus Vivendi*,” Michelle Harrington argues that the best we can hope for is a modus vivendi agreement in the way that we care for the dying, and that a medicalized death is a modus vivendi agreement. I take modus vivendi political agreements to be agreements that assist disputing parties in getting along toward shared proximate goals. However, the disputing parties have rather different and conflicting life-worlds, and therefore cannot commit to the thicker metaphysical moral goods. Harrington documents the ways in which our deeply held, value laden, metaphysical moral beliefs animate what we believe about healthcare at the end of life, the various meanings and purposes of our lives, and the very meaning of life and death itself. In addition, she shows how medicine can come to structure overtly the care offered to the dying in problematic ways. In so doing, she draws on a couple of my earlier essays, (Bishop 2009; Bishop, Rosemann, and Schmidt 2008) as well as Ivan Illich’s classic work, *Medical Nemesis* (Illich 1976). Harrington, pointing to the political brouhaha over “death panels,” notes that the very possibility to discuss a topic like death and dying results in highly controversial conversations, if one can call them conversations at all.

Harrington argues that many current palliative care practices do function as a modus vivendi politico-moral agreement, creating the structures within which a morally divided pluralistic society can offer care at the end of life. I agree with

Harrington that a kind of *modus vivendi* agreement ought to be in place that would allow those communities and people with robust metaphysical moral agreements to remain committed to them. Harrington believes that a biopsychosociospiritual medicine is the lowest common denominator in palliative medicine. However, I shall attempt briefly to show that a medicalized death is not a *modus vivendi* precisely because medicine is committed to thick metaphysical moral positions. Thus, a *modus vivendi* political arrangement in end of life care is just not possible.

As I have already noted, Harrington acknowledges the way in which end-of-life care plays itself out inside a kind of biopsychosociospiritual medicine, which is intended to promote a good death, where the patient's biomedical, psychological, social, and spiritual needs are nurtured and supported. I, however, have argued that a person's death is managed according to a statistical medicine. A

biopsychosociospiritual medicine can be totalizing in nature, which Harrington seems to acknowledge. In my own work on this topic—in *The Anticipatory Corpse*—I have shown the way in which a medical understanding of the body forms medicine's own metaphysical beliefs about the body (Bishop 2011). I claimed that the dead body is epistemologically normative for medicine and that it has become an ideal-type for medical practice. Tied to this epistemological shift, I argued, was a shift in medicine's metaphysical understanding of the body. Medicine minimized formal and final causation, and elevated material and efficient causation of the body.

In this shift in medicine's understanding of metaphysical causation, the goal of care moved from offering care and support of the dying person, to offering care and support of the dying body, and finally to the control of the dying body. That

control plays itself out in the machines of the ICU, but also in medicine's understanding of brain death, its drive for organ procurement, and its drive toward the legalization of physician-assisted death. I have even shown that it shapes the biopsychosociospiritual medicine promoted by palliative care.

More specifically, in *The Anticipatory Corpse*, I claimed that medicine's shift in its understanding of causation plays itself out in medicine's understanding of end-of-life decisions. I showed that many thought leaders in medicine no longer see a moral difference between turning off a machine and killing a patient (Miller and Truog 2008; Miller, Truog, and Brock 2010; Truog 1997; Truog and Miller 2008; Truog 2012). I claimed that the reason these thinkers no longer see a moral distinction between killing a patient and allowing a patient to die is precisely because they no longer understand formal and final causation as part of scientific investigation, thus allowing them to focus on the metaphysics of efficient causation.

However, I did not claim that modern medicine is merely scientifically reductive, but that it imports a much more robust and hidden metaphysics of final causation. In other words, medicine, in embracing a particular understanding of material and efficient causation, does not abandon formal causes; it embraces a formal causation of the patient's self-will and sovereignty. Likewise, , it does not abandon final causation; instead, it shifts its final causes to the political *telos* of the late-modern state, bent on the control of the body politic. Harrington suggests that the way forward is articulating a more robust notion of autonomy (self-will) that allows the patient to enact her own *telos*. Yet, I have argued in contrast that the socio-moral apparatus that is modern medical science creates an illusion of

sovereign self control over the dying body and structures all decisions where the clearest “choice” that a patient can make is either to turn off the machines of medicine, or to kill oneself, or to donate one’s organs (and in so doing kill oneself). In other words, the social apparatus of modern medicine is a robust metaphysical moral system that promotes a certain kind of good death, one that has little or nothing to do with existential, moral, or spiritual well-being, but seeks only the well-being of the functioning of the socio-moral apparatus of modern medicine.

This shift in medicine’s metaphysics does not mean that medicine becomes a mere reductive science, devoid of a value-laden structure. Modern medical science brings with it a robust metaphysics, such that whenever we deploy medicine, we are deploying a much thicker metaphysical moral system than we recognize. This metaphysics, with this ontology—dead matter animated by power—and indeed this theology—the sovereign—makes it very difficult for medicine to participate in a *modus vivendi* political agreement. It is not that medicine has no *telos* and patients do; it is that medicine has a fundamentally different *telos* that it projects onto all bodies.

A “medicalized death” can never be a death that plays out within a *modus vivendi* agreement, precisely because a “medicalized death” is one in which the body of the dying person is caught in social structures that are committed to medicine’s robust metaphysics, which (I argue) is part of the modern liberal state. This metaphysics has its own formal and final notions of causation, its own ontology and its own theology. Medicine already has thick metaphysical moral commitments, and because of these commitments, it already violates any *modus vivendi* agreement in

which it might participate. In other words, I agree with Harrington that a *modus vivendi* agreement ought to be achieved such that care at the end of life can be offered in a pluralistic society without violating the robust metaphysical moral commitments of the members of particular communities in that society. However, the very biopsychosociospiritual medicine that would offer that care is already committed to a very different thick metaphysical moral system, rendering a *modus vivendi* impossible.

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