

Response to Michelle Harrington's "Medicalized Death as a *Modus Vivendi*"
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Michelle Harrington raises many provocative points in regards to present approaches to death, but for the purposes of this response, I wish to highlight two aspects of her essay. The first is her suggestion that the hospital functions like an asylum. The second is William May's assertion that physician authority at the deathbed derives from hope for a death deferred. I will look at these in turn and conclude with a reflection on the relationship between them.

First, is the hospital an asylum? And if so, then an asylum of what type? In Harrington's words, "the hospital is seen to perform the role of the asylum, sheltering persons on the outside from the harsh realities of physical and existential suffering that might disturb the relative equanimity of the everyday world." On first reading, this calls to mind the insane asylum, or madhouse, the precursor to the contemporary psychiatric hospital. Although one finds mention of charitable institutions for the mentally ill throughout history and across cultures, the more recent lunatic asylums – as popularized by novel and film – proliferated in the West starting about the 18th century. They offered an institutional response to what had been a domestic problem. By removing the "madness" from families and local parishes, the insane asylum sheltered the outside world from the harsh realities of the suffering of the mentally ill. Insane asylums ensured a relative equanimity for the everyday world of the sane.

Is this what Harrington means? After likening the hospital to an asylum, she proceeds to describe how it offers "a professionally ordered realm oriented to clinical judgment . . . perform[ing] an important custodial function for family members and friends who cannot afford, personally or professionally, to keep company with their loved one throughout his or her lingering death." But this "ordered realm" that serves a "custodial function" evokes something more akin to the church asylum than the lunatic asylum. Church asylums gave order to the disordered lives of refugees of all sorts, vulnerable individuals who, for a variety of reasons, could not afford to live on the outside. Some church asylums took in the indigent or the orphaned; others, especially in medieval Europe, provided asylum to criminals, requiring them in turn to confess their sins and submit to the authority of the Church. Such asylums aimed to provide life, health, and wholeness. They did not shelter persons on the *outside*, as with the insane asylum, but they did serve a custodial function to the refugee in much the same way that the hospital takes in the destitute sick. Patients confess their weaknesses and submit themselves to the authority of the hospital.

The second point in Harrington's essay that I wish to address is the question of who ought to provide care for the dying. Here Harrington turns to William May, who asserts that physician authority in the care of the dying derives from patients' hopes that doctors will defer death and relieve suffering. May calls these revered physicians the "technological priesthood." The doctor provides the "medical miracle, wrapped up in a Latin mystery, and accompanied by authoritative instructions."

Is the doctor the new priest at the bedside? Shai Lavi, in his book *The Modern Art of Dying: A History of Euthanasia in the United States*, traces the movement of the deathbed out of the realm of religion and into the medical and subsequently legal domains. He accepts as his starting point two theories which govern such historical change: Max Weber's notion of the disenchantment of the world, and Michel Foucault's theory of the rise of biopolitics – a term that Foucault used, Lavi explains, to describe “government practices ordering biological practices.” But Lavi contends that these two theories must be thought of not merely as interdependent but as a unified whole: ethical considerations governing the deathbed have shifted from the religious to the medical (and even into the legal) because of the decline of art and the rise of technique or “technical mastery” in the modern world.

Thus, I believe that Harrington's assessment of the *modus vivendi* as simply “a way of getting along” through the dying process is correct. There is no *art* of dying in an “expansive philosophy of palliative care” with its team of players, enormous goals, and endless tools for assessing and diagnosing; rather, there is simply the furthering of the goal of achieving technical mastery of dying. And the structure of the medical institution and the role of its technological priest are uniquely oriented toward this end.

Is the hospital, then, an asylum for the dying, a church asylum, with a technological priesthood? Perhaps. But whereas the church asylum strove for human flourishing, Harrington's description of the *modus vivendi* falls far shorter; the *modus vivendi*, she concludes, “should not satisfy everyone.” And, I would hasten to add, it truly satisfies no one. With this in mind, her conclusion resonates particularly clearly. Medicalized dying, according to Harrington, “cannot do justice to the considered convictions of Christians who profess a faith formed around death and resurrection.” Rather, it is through the celebration and commemoration of the One who laid down his life for others, Harrington asserts, that dying and even death itself can be reappropriated.