

## Medicalized Death as a *Modus Vivendi*

### Death in the ICU

*Near Death*, Frederick Wiseman's documentary filmed in Boston's Beth Israel Medical Intensive Care Unit, is striking for its six-hour duration; the film immerses the viewer within the somber confines of the ICU, where she follows the chronic decline of several elderly patients along with their interactions with physicians, nurses, and their families.<sup>1</sup> The health care professionals are clearly intelligent and come across as exceptionally thoughtful. And yet, they readily admit the paucity of their powers of prognostication and the limits of their abilities to ward off death. Time is a scarce commodity in these noisy, sterile halls, but the physicians are attuned to their patients' needs for more of it—more time to come to a decision, more time to decide what one wants to do or try, more time to assess whether a particular intervention will purchase more of the precious asset itself and perhaps the chance to leave the hospital—given enough time, however, the question is usually rendered moot.

The physicians are seen to express concern for patient autonomy, at least as it has come to be understood in the last several decades. Phrases like “you're the boss” pepper their conversations while the patients, immobilized with central lines and intravenous drips, struggle to communicate through oxygen masks or while on respirators. Nurses attempt frank and compassionate discussions with patients about their medical options; however, the untrammelled opportunity to be surrounded by family and loved ones does not appear to be on the menu. Patients labor toward their deaths largely alone while their pulses are monitored remotely by the panopticon of the nurse's station. In Wiseman's film, one observes that dying is privatized in the sense that the individual is withdrawn from his or her usual community, but also exposed, along

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<sup>1</sup> Frederick Wiseman, *Near Death*, DVD, Documentary (Zipporah Films, 1989).

with his or her intimates, to the gaze of persons who were strangers theretofore.<sup>2</sup> Spontaneous expressions of grief are self-regulated in light of the hospital's own rhythms and out of consideration for nearby patients who are themselves struggling mightily. The institution values regularity and order, and persons are implicitly homogenized under the regulation of technique. The nurses closely regulate family visits, noting that visitors are often difficult to manage and tend to "get in the way"—of what, one might ask: ostensibly the professional management of dying. Some family members express the wish to be called only when their loved one experiences a change in medical status.

The keyword in the documentary, along with "choice," "chance," and "time," is "comfortable." Families plead, and physicians promise, to keep the patient "comfortable." This watchword extends to care of the family, too; one physician takes out his script and offers to prescribe a grief-blunting pharmaceutical to a woman whose husband's death is imminent. Even grief is apprehended physiologically when a physician acknowledges that one woman's decision to discontinue treatment and her ensuing death might trigger a heart attack in her surviving husband. One family member admits her essential unpreparedness when she confesses that the situation is "too real."

The ICU is host to countless "limit situations;" a motorcycle accident, aortic separation, or a pulmonary embolism could land one within its sterile walls; it is, for many, the site where human finitude and guilt are terrifyingly exposed. Here, relationships are rent, and opportunities for interpersonal reconciliation are, *prima facie*, foreclosed. Love and grief mingle with hope and anxiety as human lives come to their consummation among environs that are for most persons far removed from the site of everyday life. Wiseman's film illustrates that in recent decades the ICU

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<sup>2</sup> Cf. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1994).

has become a location for caring not only for those afflicted by accidents and emergencies, but also for those who are passing through what Christian ethicist Paul Ramsey termed “the acceptable death of all flesh.”<sup>3</sup>

In Wiseman’s film, 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. The ICU masks the alienation and fragmentation of families and communities by offering a professionally ordered realm oriented to clinical judgment. Out of earshot of patients and their families, physicians tacitly acknowledge the medical futility of many “cases,” and voice no real confidence that these patient-persons will return to health (medicine’s traditional goal) or even be discharged from the hospital, and yet the hospital is seen to perform 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.

Patients and their families, who were once asked to consent to potentially life-saving interventions, are later asked to make choices about their discontinuation. One is seemingly asked to assent to one’s own death, or to the death of one’s loved one, in exchange for a turn to comfort care:

Wife of patient: “So if he stops breathing, we just let him stop breathing?”

Physician: “Mmhmm.”

Wife of patient: “That’s so weird.”

As medical staff reflect upon the plight of their patients, they hint at medical overtreatment and acknowledge the socialized costs of “doing everything [medically]” for patients. Yet several nurses and physicians confess that even with the benefit of their medical training and experience

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<sup>3</sup> Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, Second Edition (New Haven: Yale University Press, 1970, 2002) 129.

they would not know what to choose if they were in the situation of their patients or their families. In this environment, hope and trust are calibrated to the statistical likelihood of a body's responding favorably to a medical intervention. Prognostication of death's immanence is reduced to a sort of diagnostic positivism when a physician explains to a family member that the patient's "numbers" are "all we can go by right now."

This preoccupation with medical indications serves an evasive function, according to Eric J. Cassell: "The mechanical events involved in a body becoming dead, which occur in the technical sphere, are confused with the process of dying, which occurs in the moral sphere."<sup>4</sup> The passing of the person involves moral problems, including conscience, the knowledge of what is right, and the nature and obligations pertaining to relationships that are undergoing a profound severance. The depersonalizing tendency of the modern hospital is to obscure "the moral content of the passing of the person by using the facts and artifacts of the death of the body as the vehicle for [human] interchanges."<sup>5</sup> The patient, as person, is passed over before he or she has passed away.

Over twenty years have elapsed since Wiseman's documentary was released, and the picture needs some updating. Today, hospital personnel are more likely to work to get families together (for a family meeting) than to discourage loved ones from lingering at the bedside. The intervening decades have also seen growing ranks of dedicated palliative care specialists. As part of the Medicare benefit, 'hospice' has become a household word (at least some of the ICU patients in Wiseman's film would be encouraged to enter hospice if they were hospitalized today). Nevertheless, while hospice is often considered an alternative to "medicalized" dying, many patients delay entering the program until the final days before death because they and/or

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<sup>4</sup> Eric J. Cassell, "Dying in a Technological Society," *Hastings Center Studies*, Vol. 2, No. 2, (May 1974), 33.

<sup>5</sup> *Ibid.*

their family members are unwilling to relinquish the fight against disease; by that point, many patients lack the time and consciousness to benefit from the aims of friendship and companionship that originally motivated the founding of the modern hospice movement, and so receive mainly the “medical” aspects of the program, i.e., pain control. In addition, hospice itself has trended toward both increased professionalization and institutionalization and has in many locales become a veritable *part* of the health care system, rather than an alternative to it. As such, critics complain that hospice has become overly standardized and bureaucratic, and has abandoned the distinctive ethos of the originally volunteer-led movement;<sup>6</sup> institutional assessments demand continuing preoccupation with medical indications.<sup>7</sup>

### **Medicalized Death as a *Modus Vivendi***

“Medicalization” has been described as “a process by which *human problems* come to be defined and treated as medical problems.”<sup>8</sup> Despite Elisabeth Kübler-Ross’s “death awareness” movement, which sought to naturalize and integrate death into the life cycle,<sup>9</sup> the medical management of death has proliferated under an expansive philosophy of palliative care—or what has been termed “biopsychosociospiritual medicine”<sup>10</sup>—a totalizing regime staffed with physicians, nurses, psychiatrists, social workers and chaplains working together to keep the patient (and his or her family) “comfortable” through a medically managed death. By using the phrase “medicalized death” I do not wish to indict deaths that occur under medical supervision or with appropriate pain relief, but rather to characterize a practice in which the moral, ethical,

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<sup>6</sup> Beverley McNamara, Charles Waddell and Margaret Colvin, “The Institutionalization of the Good Death,” *Social Science and Medicine* 39 (1994): 1502.

<sup>7</sup> Stephen R. Connor, *Hospice: Practice, Pitfalls, and Promise* (Washington, D.C.: Taylor & Francis, 1998), 104-105.

<sup>8</sup> John Z. Sadler et al., “Can Medicalization be Good? Situating Medicalization Within Bioethics,” *Theoretical Medicine and Bioethics* 30 (2009): 412, emphasis mine.

<sup>9</sup> See Elisabeth Kübler-Ross, *On Death and Dying*, (New York: The MacMillan Company, 1969).

<sup>10</sup> See Jeffrey P. Bishop, Philipp W. Rosemann, and Frederick W. Schmidt, “*Fides Ancilla Medicinae*: On The Ersatz Liturgy of Death in Biopsychosociospiritual Medicine,” *The Heythrop Journal* XLIX (2008): 20-43.

religious, and political aspects of death and dying are subsumed under the umbrella of biopsychosociospiritual medicine, and are only allowed into the clinical arena insofar as they serve clinical norms, i.e., the relief of symptoms.

The medicalization that functions to shield dying individuals and their loved ones from the metaphysical realities of dying and death expresses in shorthand what I intend to advance through the phrase “*modus vivendi*.” a way of getting along through liminal situations in which shared ultimate values cannot be supposed. While preoccupation with medical indications and interventions forms the more obvious aspect of medicalization, the philosophy of palliative care, which was intended to counteract this narrow and impersonal focus, has arguably reified the medical management of death by diffusing it. The management of death is no longer simply physiological, but is now extended to the assessment and treatment of psychological, social and spiritual aspects of dying. Fiona Randall and R. S. Downie have criticized this palliative care approach for its impracticality and overreach, which they contend is exemplified in the World Health Organization’s definition of palliative care, here quoted at length:

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care provides relief from pain and other distressing symptoms, affirms life and regards dying as a normal process, and intends neither to hasten nor to prolong death. Palliative care integrates the psychological and spiritual aspects of patient care and offers a support system to help patients live as actively as possible until death. It also offers a support system to help the family cope during the patient’s illness and in their own bereavement. Using a team approach, palliative care addresses the needs of patients and their families, including bereavement counseling if necessary. It enhances quality of life, and may positively influence the course of the illness...<sup>11</sup>

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<sup>11</sup> As quoted in Fiona Randall and R. S. Downie, *The Philosophy of Palliative Care: Critique and Reconstruction*, (Oxford: Oxford University Press, 2006), 117-118.

At first glance, it may seem uncharitable or even curmudgeonly to critique such a statement for fear that criticism might be mistaken for an argument that the dying should suffer, or that the needs of the vulnerable should go unaddressed. Randall and Downie insist, however, that the animating philosophy of palliative care should be open to critique and tested for coherence; the implications of this statement are profound, and ought to be interrogated. For the purposes of this essay, I will briefly consider several of the statement's points.

One may begin by noting that in order to improve "quality of life" one must first define it; this is no easy task in a pluralistic society wherein "quality of life" may be invoked to promote both physician-assisted suicide and the provision of artificial nutrition and hydration for a person in a persistent vegetative state. "Quality of life" is a contested concept that relies on an idiosyncratic appraisal of human capacities and purposes—linked to disparate metaphysical schemes. It is an inherently evaluative concept which some have tried to capture with econometric instruments (so-called "Quality Adjusted Life Years", or QALYs); despite attempts to develop standardized assessments, one person might consider himself to have a high quality of life so long as he could hold his loved one's hand and pray, while another would prefer to succumb to the complications of diabetes rather than to live with an amputated toe or foot. In the absence of societal consensus, biopsychosociospiritual medicine will promote "quality of life" according to the statistical analysis of patient self-reports or according to uncritical notions of happiness and well being. With respect to the latter, Randall and Downie observe that as part of a strategy to enhance "quality of life," palliative care professionals might encourage dying patients to plan a family vacation or to make alternative career plans.<sup>12</sup> In the absence of an enduring relationship, such expansive pretensions to enhance quality of life border on the inappropriate and intrusive; the efforts of medical professionals to promote "quality of life" through non-

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<sup>12</sup> Ibid, 86-87.

medical means exceed the bounds of medical expertise and threaten a new kind of depersonalization: an attempt to influence the intimate economic and familial affairs of persons whom one has, in all likelihood, only recently met.

In addition to promoting quality of life, the WHO statement also professes to regard dying “as a normal process.” While dying may be a “normal” process insofar as it is species-typical, universal, and inevitable,<sup>13</sup> deaths can also be violent, unjust, untimely, and tragic. One may undergo a “good death” or a “bad death” according to culturally conditioned expectations; one may, perhaps more importantly, die *well* or *badly* according to religious understandings. In its more traditional manifestations, Christian theology has linked death to sin, so that despite its ubiquity, dying remains a profound innovation in the scheme of salvation history<sup>14</sup> and a deep mystery for every individual.<sup>15</sup> One senses that these objections are not what the authors of the WHO statement had in mind, but rather that the process of dying is “normal” insofar as it is predictable and manageable: “distressing symptoms” can be relieved.

The distressing symptoms of dying often include pain; laudably, palliative care specialists have been at the forefront of developing and employing powerful modalities of pain relief that can assuage forms of suffering once thought to be intractable—bone pain from metastatic cancer, and neuropathic pain, for example. The generous and judicious use of pharmacological agents, expertly employed, can maximize comfort, consciousness, and clarity of mind, giving dying persons the opportunity to be present to loved ones and to put their personal and spiritual affairs in order. Yet, the “distressing symptoms” of dying and the “problems” associated with life-

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<sup>13</sup> For elaboration of the principle that ischemia will kill us all, see Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter*, (New York: A. A. Knopf, 1994).

<sup>14</sup> Bonnie J. Miller-McLemore, *Death, Sin, and the Moral Life: Contemporary Cultural Interpretations of Death*, (Atlanta, GA: Scholars Press, 1988), 23-25.

<sup>15</sup> See Karl Rahner, *On The Theology of Death*, (New York: Herder and Herder, 1961).

threatening illness are not only physiological, and palliative care specialists purport to treat these, too.

Dame Cicely Saunders, the founder of modern hospice, popularized the concept of “total pain”—against narrow physiological conceptions of pain and impersonal forms of care, she insisted on attention to relational, spiritual, and existential sources of distress in dying persons. The palliative care movement is obviously indebted to her approach, but its practices with respect to the treatment of psychological and spiritual distress are rather more active than Saunders’. Where she advocated consistent presence, companionship, and nondirective listening, institutionalized palliative care relies on standardized tools of assessment and interventions based on implicit norms about the good life (and death).

The WHO statement avers that “the treatment of pain and other problems, physical, psychosocial, and spiritual” relies on “early identification and impeccable assessment.” Bishop’s analysis of one such assessment helps to illustrate the expansive purview of biopsychosociospiritual medicine. The RCOPE is one instrument used by palliative care specialists—an inventory of questions that can be administered to patients to assess “how religion aids psychological coping.”<sup>16</sup> This assessment enables a palliative care professional to uncover whether a patient’s religious and spiritual commitments are contributing to “positive coping” or “negative coping,” where the former is taken to promote social function and cohesion, and the latter its inverse. It is important to note that religion is here evaluated *functionally*, from psychological and sociological perspectives, and assessed quite independently of its own truth claims, content, and obligating features:

in terms of functioning, one does not necessarily have to deal with genuine claims about the relationship of the individual and society to the Other writ large, that is to say, with

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<sup>16</sup> Jeffrey P. Bishop, “Biopsychosociospiritual Medicine and Other Political Schemes,” *Christian Bioethics* 15(3) (2009): 262. doi: 10.1093/cb/cbp017

God. Society and its functioning serve as that which transcends the individual, even while constituting the individual... One can easily see that the inventory is designed to uncover those who believe that God is punishing them and that this belief gets in the way of return to normal social function.<sup>17</sup>

The RCOPE is only one assessment, but there are others, including those designed to assess whether one's grief is "complicated," and thus warranting of the bereavement counseling offered by the palliative care "support system"—a support system where individuals and specialists meet as strangers and do not typically depart as friends, and the family members of the deceased may be regarded as clients or co-patients: their grief is managed, but not shared.

In the foregoing, I have attempted to substantiate the thesis that an expansive philosophy of palliative care comprises 'a way of getting along through liminal situations in which shared ultimate values cannot be supposed'—that along with traditional forms of medicalized death, which were preoccupied with medical indications, an unchastened practice of palliative care constitutes a *modus vivendi* in the political sense. Standardized assessments and interventions purport to provide a way of coping with the fundamental questions of human existence with only instrumental reference to the diverse beliefs of religious traditions; they threaten to homogenize and manage the patient and his or her intimates according to a generic spirituality that serves clinical norms and efficient social functioning; one must not grieve too loudly or too long.

If one, with Cassell, takes seriously that the process of dying occurs in the moral sphere and involves "moral problems, including conscience, the knowledge of what is right, and the nature and obligations pertaining to relationships that are undergoing a profound severance"<sup>18</sup> one is implicitly prompted to consider her own status as a moral agent with respect to death and dying—one's own future death, and that of others—within her social milieu. Who ought to

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<sup>17</sup> Ibid.

<sup>18</sup> Supra note 4.

provide care for the dying and to what ends? What obligations do the dying have, if any? To what, or to whom, does one look for help? With respect to traditional conceptions of medicalization, William F. May contends that the physician's authority in these matters is derived from the hope that reckoning with death may yet be deferred and that suffering in all its dimensions can be relieved. In the absence of adequate religious and/or communal preparation for death, patients and families turn to the "technological priesthood."

The family looks to [the physician] for a medical miracle, wrapped up in a Latin mystery, and accompanied by authoritative instructions on how to behave, so that 'everything may be done that has to be done.'<sup>19</sup>

An expansive philosophy of palliative care promises to extend this way of getting along, compensating for the fragmentation of contemporary lives, relationships, religious institutions, and civic society. A one-stop regime of total care, for the dying patient and his or her family alike, responds to the needs and desires of the polity and in turn effects a further deskilling of the general population—in turn, reinforcing demand for unlimited healthcare. May links the sustainability of health care institutions and the hope of universal access to health care with an increased emphasis on patient responsibility and to more realistic expectations with respect to the practice of medicine.

The success or failure of a system depends on the 'habits of the heart' of a citizenry. Patients must be active partners in their health care... The system cannot gratify all wants, tamp down all worries, or remove the mark of mortality from our frame. We need some self-control over our wants, some composure in the midst of illness, and some courage in the face of dying. No system of itself can bring these virtues to us. We need to bring them to the system so that its benefits may sustain us more fully.<sup>20</sup>

The *modus vivendi* serves political purposes, and bears a complex relationship to human freedom and responsibility. Early in the first term of President Barack Obama's administration,

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<sup>19</sup> William May, "The Metaphysical Plight of the Family," *The Hastings Center Studies*, Vol. 2, No. 2, Facing Death (May, 1974), 28.

<sup>20</sup> William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics*, Second Edition, (Louisville, KY: Westminster John Knox, 1983, 2002) 220.

efforts toward health care reform sparked panic about “death panels” revealing some citizens’ fears that “unproductive” members of society might be dispatched by proxy, or rather, slated for medical non-treatment.<sup>21</sup> Proposals that physicians be reimbursed to discuss with patients their end-of-life care wishes in advance of need were likewise met with suspicion, as though a meeting designed to promote patient autonomy, as it has come to be understood in the biomedical literature, might commit the patient to an early grave. These political flashpoints suggest how thoroughly death has come to be apprehended as a medicalized phenomenon in our culture. They reveal the presupposition that justice lies in being able to have all the stops pulled out on one’s own behalf within a nation that is loathe to talk about limits to healthcare and finds the prospect of transparently articulated rationing anathema. It is therefore a matter of political and moral significance to inquire about the understanding of the self that is invoked when freedom is taken to consist in “a claim to equal consumption of medical services” tacitly expected to culminate in an equal ‘clinical death.’<sup>22</sup>

Socrates scrutinized the political implications of medical management in Book III of Plato’s *Republic*, criticizing the chronic incapacity and prolonged dying that fastidious medical regimens were making possible in his time on the grounds that excessive attention to the body made an individual incapable of fulfilling his or her role within the city.<sup>23</sup> Socrates paints the overreliance of free men on doctors and lawyers as an unseemly failure to order one’s life virtuously, and as a threat to personal and political freedom. He evidences, too, a proleptic grasp

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<sup>21</sup> To be sure, these debates highlight very real concerns about health care inequities that have ample historical precedent. The advent of kidney dialysis saw an initially limited number of machines made available to individuals from the same socioeconomic milieu as that of the members of the public committee who selected them, to choose just one example of the ‘bourgeoisie sparing the bourgeoisie’ in what were clearly life-or-death decisions. David Sanders and Jesse Dukeminier, Jr., “Medical Advance and Legal Lag” p. 378 as quoted in Paul Ramsey, *The Patient as Person*, (New Haven: Yale University Press, 2002), 248.

<sup>22</sup> Ivan Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (London: Marion Boyars, 1976) 197.

<sup>23</sup> Plato, *Republic* III 403d-410e.

of what has come to be known as “medical hermeneutics” or the “ethics of diagnosis”<sup>24</sup> when recounting to his interlocutors how persistent complaints, often resulting from bad habits and/or a poor lifestyle, proliferate when they get diagnosed—that is, *named*—by a physician who confers a socially-recognizable reality on the ailment that functions to absolve the patient from responsibility for his health, and legitimates ongoing treatment that directly or indirectly excuses the patient from the work that is his to do.<sup>25, 26</sup> Socrates suggests to Glaucon that the growing need among free men for skilled doctors and lawyers foretells their diminishing agency and indicates a troubling heteronomy:

Don't you think it's shameful and a great sign of vulgarity to be forced to make use of a justice imposed by others, as masters and judges, because you are unable to deal with the situation yourself?<sup>27</sup>

Nearly two and a half millennia later, Ivan Illich wrote a sociopolitical critique of medical “nemesis” (that is, the fateful counterpart of hubris in Greek thought) in a society that had dispensed with historical qualms about extending medicine’s reach to death. The concept of iatrogenesis, or healer-induced harm, has been recognized since antiquity; from it we derive the bioethical principle of nonmaleficence, now colloquially known by the phrase “first, do no harm.” The value of this principle is easy enough to understand if one recalls the bloodlettings of centuries past and the toxic side effects of chemotherapies administered to cancer patients today. Physicians who live with awareness of the reality of the harms they can inflict in the course of the healing enterprise remind themselves not to vanquish their patient in the war against disease.

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<sup>24</sup> See José Luis Peset and Diego Gracia, eds., *The Ethics of Diagnosis* (Dordrecht: Kluwer Academic Publishers, 1992).

<sup>25</sup> Plato, *Republic* III, 405d-407c.

<sup>26</sup> See Talcott Parsons, “The Sick Role and the Role of the Physician Reconsidered,” *The Milbank Memorial Fund Quarterly*, 53:3 (1975): 257-278.

<sup>27</sup> *Republic* III, 405a-b in John M. Cooper, ed., *Plato: Complete Works*, (Indianapolis, IN: Hackett Publishing, 1997), 1042.

At its best, the corollary principle of nonmaleficence gestures to the vision of health one seeks to attain, or to maintain.

Clinical forms of iatrogenesis constitute an important and readily recognizable component of medical nemesis; Illich includes them in his critique, situating them within the complex nodes of professional allegiances and the public authorities that sustain them.<sup>28</sup> His fundamental concerns, however, are *social* and *cultural iatrogenesis*, which he defines, respectively, as “impairments to health...due to those socio-economic transformations which have been made attractive, possible, or necessary by the institutional shape health care has taken”<sup>29</sup> and, even more provocatively, that which “sets in when the medical enterprise saps the will of people to *suffer their reality*.”<sup>30</sup> By “health,” Illich intends the “degree of lived freedom” that individuals exercise, a word “used to designate the intensity with which individuals cope with their internal states and their environmental conditions.”<sup>31</sup> This understanding of health incorporates the inherent limitations—indeed, the anguish—of the human condition, but also emphasizes the freedom of the individual to exercise responsibility for his or her life, to shape one’s own environment, and to care responsibly for others, even through periods of suffering, diminishment, and death. On this reading, the healthy person is characterized by an autonomous vitality; she retains her powers of perception, subjectivity, and self-definition, and engages health care resources insofar as they catalyze her internal resources for healing.

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<sup>28</sup> A dated, but illustrative example is drawn from the mid-nineteenth century: the first gynecologist to use antiseptic procedures in his wards (to great success in the reduction of puerperal fever) was dismissed and ostracized by his colleagues, who were offended at the idea that physicians could be carriers of death and continued to eschew hand washing for some time thereafter. Ivan Illich, *Limits to Medicine*, 20-21 n. 28. With respect to modern end-of-life care, Arthur P. Wheeler indicates that cardiopulmonary resuscitation (CPR) is frequently iatrogenic (and ineffective) when used in attempt to save and sustain life among the terminally ill. Arthur P. Wheeler, “Suffering and Pain: The Body Beleaguered and Besieged” in Jean Bethke Elshtain and J. Timothy Cloyd, eds., *Politics and the Human Body: Assault on Dignity* (Nashville: Vanderbilt University Press, 1995), 116.

<sup>29</sup> Ivan Illich, *Limits to Medicine*, 40.

<sup>30</sup> *Ibid.*, 127, emphasis mine. Cf. the positively utopian, if not religious definition of health promoted by the World Health Organization: “a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity.”

<sup>31</sup> Ivan Illich, *Limits to Medicine*, 242.

Like Socrates, Illich advanced the inherent tension between autonomy and medicine, forwarding the thesis that beyond a therapeutic threshold, demand for medical care itself becomes iatrogenic, injuring not only the physical health of individual patients, but crippling and fragmenting the entire social milieu. He argued that medical hubris becomes a nemesis to the health of the polity when individuals begin to doubt that they are capable of doing for themselves that which was formerly mastered, or at least coped with, at home and within their communities:

Social iatrogenesis is at work when health care is turned into a standardized item, a staple; when all suffering is ‘hospitalized’ and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labeled a form of deviance.<sup>32</sup>

When each stage of life is perceived to bear within itself specific risks that require medical monitoring and potential crises that necessitate emergency medical intervention irrespective of the potential for cure, Illich judges that health, understood as a particular kind of autonomy, has been “expropriated.”

The “expropriation of health” is functionally synonymous with medicalization. In the foregoing, I have indicated that medicalization bears a complex relationship to the apprehension of reality, and thus, to human freedom and responsibility. I argue that in the absence of a substantive consensus about the meaning of death—the counterpart to pluralism with respect to the meaning of life—twenty-first century Americans grasp for a common authority: a church who grounds her art on scientific foundations, and holds out the possibility of technological salvation. Medicalized and professionally managed death have become a *modus vivendi*; in our morally pluralistic society, medical values have come to be regarded as morally “neutral.”

[M]odern interpretations of death have tended to neglect the moral component, focusing instead almost entirely on technical, physical, and psychological aspects... We lose sight of the idea that death entails a web of moral obligations and responsibilities for all parties

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<sup>32</sup> Ibid, 41.

involved and raises issues of ultimate judgment about the moral and religious significance of our lives.<sup>33</sup>

A *modus vivendi* is, to be sure, a way of getting along, and a potentially fitting response to the exigencies of the social milieu (moral pluralism, the increasingly tenuous bonds of community and tradition, the geographic dispersion of families, social trends toward privatization and individual choice, for example). Yet, by its very nature, a *modus vivendi* should not satisfy everyone. It has been my contention that the medicalized dying described above cannot do justice to the considered convictions of Christians who profess a faith formed around death and resurrection. When contemporary practices are interrogated with respect to the values they posit as normative, alternative practices, commitments, and interpretations are brought into view, along with the possibility of dying in ways that are more authentic and faithful to one's most deeply considered convictions. Christian practices celebrate the death of one who self-consciously laid down his life for others—although as the Gospels relate, not without trepidation, fear, and trembling. Christians reenact this death in their initiatory rite of baptism and commemorate it, sometimes daily, in the Eucharist. Participation in this ritual formation may be understood as “learning how to die,” that is, both how to receive one's life from God as gift, and to offer it back to God in freedom. I want to suggest that churches and other faith communities, as sites of moral discourse and personal and communal formation, might be places where death and grief are reappropriated according to particular and content-full understandings in ways that give rise to freer, more responsible, and more faithful dying.

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<sup>33</sup> Bonnie J. Miller-McLemore, *Death, Sin and the Moral Life: Contemporary Cultural Interpretations of Death* (Atlanta: Scholar's Press, 1988), 3.