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CHANGING ATTITUDES TOWARDS DEATH AND SUFFERING: A CULTURAL PERSPECTIVE ON THE EUTHANASIA DEBATE.

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GENERAL INTRODUCTION

Why does the popular culture respond to euthanasia? We rarely find the question and never find the answer in bioethics. Dilemma ethics or quandary ethics, at the heart of the field, fail to address the root causes of the moral anarchy of our times. Despite calls from bioethicists, such as Daniel Callahan, for a communitarian bioethics[1] dealing with the moral life in its societal dimension, it is still lacking. This is disappointing considering the fact that cultural biases and attitudes almost single-handedly determine the shape and direction of society. The prevailing attitudes in a culture do not merely influence the debate; they determine the issues.

A revolution in attitudes towards death and suffering has taken place in our present age. It is not technology itself that has given us the euthanasia debate, but the attitudes towards death and suffering which it helped to shape. Moral debate doesn't occur in a cultural vacuum. The key issues are best understood within the context of the cultural background from which they emerged.

The euthanasia debate isn't about 'pulling the plug'. It's about our attitudes to the realities of death and suffering. It concerns our attitudes towards fellow human beings in their suffering and dying. It reflects our attitudes towards human dignity when it is assaulted by disease and dying. It will take more than equations-like moral mathematics to balance the modern drive for euthanasia. It will necessitate a critical analysis of contemporary attitudes towards death and suffering. Only then will we be nourishing the debate at its roots, rather than trimming its ends.

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[1] Daniel Callahan, ' Bioethics; Private Choice and Common Good' in *Hastings Center Report*, 24 (1994), 28.

Chapter one examines the changing attitudes towards death from the Middle Ages to the nineteenth century. The source for this remarkable panorama, is the seminal work of the acclaimed social historian, Philippe Ariès. His source material and investigative work is rich and varied. He dips into everything from churches, religious rituals, graveyards, wills, literature, letters and art, to reconstruct history. This study benefits greatly from his extensive research and his insights. In the period spanning the Middle Ages to the nineteenth century, there were subtle yet significant changes in attitudes towards death. They occurred so gradually that social commentators of the time would have barely noticed. The longest held attitude to death was that of calm acceptance to death as the common fate of the species. The focus gradually shifted to death of the self in the twelfth century and finally to death of the other in the eighteenth century.

Chapter two charts the revolution in attitudes towards death in contemporary society. This is supplemented by social theory which explains the denial of death in high-modernity. Dying is removed from the home to the hospital and is dissected into little bits. Those monumental reminders of death, the dying themselves, the sick and the aged, are systematically hidden from public view. Young people no longer grow up with death around them. They do not learn how to cope with suffering or death because their role-models have been removed from wider society. This reinforces fear and denial of death in the individual mind. The attempt to 'manage' death socially by hiding it and only letting it exert its influence in controlled circumstances is taken a step further in euthanasia. Euthanasia is the fulfilment of this desire to suppress death. However, suffering had to be stripped of meaning before euthanasia would be accepted.

Chapter three illustrates that attitudes to suffering and death are inextricably bound. Suffering is medicalised and in the process there is a trade-off between meaning in suffering and pain killing. Suffering is denied a metaphysical or cultural meaning. The human body is broken down into component parts to be fixed by medical specialists. This serves to 'deconstruct mortality'. When the component parts are fixed without reference to the whole, it distracts from the fact that one's whole being is mortal. It also gives rise to a dualism between the person and the body. This manifests itself in the euthanasia debate in relation to patients in the so-called persistent vegetative state. I am indebted to the staunch social critics of western medical civilisation of Ivan Illich and Arthur W. Frank, for much of my social analysis, in particular regarding the attack on a mechanistic philosophy of health care. Suffering was reduced to the reality of physical pain, which encouraged the treatment of patients as mere physical entities, rather than as human beings. Compassion in medicine faded as the focus of medicine became treating pain, not patients. These factors paved the way for killing pain at the expense of the patient.

Chapter four looks at the concrete ways in which contemporary attitudes towards suffering influence the euthanasia debate. For example, the denial of meaning in suffering leads to inappropriate quality of life judgements resulting in euthanasia of new-borns. The refusal to suffer the loss of freedom involved in illness and incumbent dependency, lead some to deny the humanity of non-autonomous human beings and to argue for their being euthanised. It demonstrates that the main argument for euthanasia, namely autonomy, doesn't hold up and that what really is at issue is a denial of any value in suffering. A sick person's request for euthanasia may be accepted whereas a healthy

person's request would be rejected out of hand. The value of the former is denied and of the latter affirmed. Moral theologians, ethicists and philosophers such as McCormick, Gormally and Finnis feature prominently in this chapter.

Chapter five presents an alternative approach to human suffering and indirectly death, of which suffering provides a glimpse. Suffering is discussed in the light of the Christian tradition. The latter has a rich history of a ministry of compassion to the sick. This chapter advocates that medicine return to its Christian roots in order to become once again a ministry of mercy. The Christian concept of mercy is outlined, based on the Encyclical Letter of Pope John Paul II on the Mercy of God, *Dives in Misericordia*. It sets out a different understanding of mercy than is exercised in 'mercy-killing.' In the Christian tradition mercy 'restores to value' the recipient, it does not destroy him. It is often said that we can suffer any 'what' if we know 'why'. The meaning of suffering in the Judaeo-Christian tradition is set out. Priority is given to the Christian meaning of human suffering revealed by Christ. This necessitates a treatment of the central message of the Apostolic Letter of John Paul II on human suffering, *Salvifici Doloris*. This powerfully demonstrates the meaning of human suffering and the value and dignity of those who suffer. By uniting their suffering to Christ they are a force for good in the world and contribute to humankind's salvation.

This thesis is not designed primarily to provide answers, but to raise questions about contemporary unexamined attitudes to death and suffering in modern society, and to challenge cultural biases. This is the only way those in the movement for life can overthrow a system of meaning which promotes death. I believe that deep debate on what we value as a society is necessary, not simply narrowly focused examinations of

hard cases. It is not within the scope of this thesis to put forward concrete proposals for cultivating a culture of life. However, I believe that restoring meaning to human suffering and value to the dying is a good place to start.

Chapter 1: Changing Attitudes Towards Death

This chapter examines the changing attitudes towards death that dominated western society from the Middle Ages up until the late eighteenth and early nineteenth centuries. Philippe Ariès coined the terms 'familiar death', 'death of the self', and 'death of the other', to describe the subtle shift in focus that slowly emerged in attitudes towards death during this vast time-scale.[1] They brilliantly capture the essential characteristics of the prevailing attitudes towards death during each period.

1.1 TAMED DEATH

This 'the first, the oldest, the longest held, and the most common' attitude toward death, is best summed up in the phrase 'and we shall die'[2]. In this period, life expectancy was short and so death was very familiar. It was accepted calmly as a common destiny of the species. This attitude, which spanned several millennia, dominated up until the Late Middle Ages. It is evident in the literature of the period, for example in the oldest romances.[3] In their description of the deaths of the knights of old, common characteristics emerge. The knights, for example, Roland, Tristram and Gawain had forewarning of death. Even king Ban, who was rendered unconscious by a bad fall, came round in time to discover blood dripping from his face[4]. He knew he was dying and prayed to God.

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[1] Cf. Philippe Ariès, *Western Attitudes Toward Death From The Middle Ages To The Present* (London: Marion Boyars Publishers, 1976).
[2]Ibid., 55.
[3]Cf. Ibid. (Re:chansons de geste).
[4]Cf. ibid.,3.

This reflects the attitude of this period that a sudden death was a curse because it deprived one of the opportunity to put their spiritual and earthly affairs in order.[5] This is in stark contrast to the popular wish today for a quick and painless death.

The attitude towards death in this period was marked by realism. This is reflected in the literature of the day. Even Don Quixote, who lived in a land of make-belief, did not attempt to day-dream his death away. It was the one and only thing that brought him back to reality. He calmly announced to his niece 'I feel that death is near'[6]. Saint Martin de Tours and the musician Bach both knew when they were approaching death and were resigned to their fate. Their realisation of their imminent departure from this world came, as with the knights, through natural signs or inner conviction. There was no suggestion of magic at work or of a supernatural premonition. [7]Jean Guitton, writing in 1941, also testifies to this simple attitude towards death when he reflects on the matter-of-fact attitude of the mother of Monsieur Pouget when she was dying of cholera in 1874. When death was imminent she called for the priest to administer the last rites. Guittion comments:

> We can see how the Pougets in these bygone days passed on from this world into the next, as simple and practical persons, observers of signs and above all of themselves. They were in no hurry to die, but when they saw that the hour had come, then without haste or delay, but with a sense of proper timing they died as Christians.[8]

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[5] H. Wass, F. M. Berardo, R. A. Neimeyer, *Dying. Facing the Facts*, (New York: Hemisphere publishing corporation, ²1988), 16.
[6] Ariès, *Western Attitudes Toward Deatth*, 4.
[7] Cf. ibid.
[8] Ibid., 7.

1.1.1 Death :A Household Event.

Death was a household event. The dying person presided over a ritual in which he had been an observer countless times before. The priests, parents, friends, neighbours and children crowded around the sick bed for this customary Christian ceremony. At the beginning of the eighteenth century, doctors, who knew more about principles of hygiene, began to complain about overcrowding.[9] Yet as late as the early nineteenth century 'passers-by who met the priest bearing the last sacrament still formed a little procession and accompanied him into the sickroom.' Death was desensitised by today's standards. Unlike now, children were not sheltered from death. 'Until the eighteenth century, no portrayal of a deathbed scene ever failed to include children'.[10]

The ritual of death was simple. The dying person followed a set protocol. First, he or she expressed sadness at their impending loss of life. This was a ritual moment and evoked no great show of emotion. Then, the dying person said their goodbyes. Finally, the priest granted absolution and the dying person commended their soul to God.[11]

Death was public, literally, as already outlined, due to the numbers present at the deathbed, but also in the sense that the people recognised that death of the individual diminished the entire community. Afterwards, they strived to reintegrate. This sense of community is almost completely alien to the modern mindset. These people saw themselves as Christians first, as members of the local community second and as individuals last.[12] This manifested itself in a calm acceptance of death as a common fate.

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[9] Cf. ibid., 11, 12.
[10] Ibid, 12.
[11] Cf. ibid., 13.
[12] Cf. Wass and Berardo, R. A. Neimeyer, *Dying,* 16.

1.1.2 Grave Dancers

The familiarity with death had what John of Chrysostom considered an unsavoury element i.e. the coexistence of the living and the dead[13]. The Ancients honoured their dead but kept the worlds of the living and the dead separate. In the Middle Ages, despite interdicts of Canon law, tombs were built inside city walls. This practice grew up around the cult of the martyrs. The people believed that if they were buried near the tombs of the martyrs, they would be protected from hell. The exact resting-place of the bones did not matter, so long as it was close to the martyrs, the saints or the church, which contained the Holy sacrament[14]. Church and cemetery amalgamated in the Middle Ages. Dead bodies were entrusted to the church. The cemetery was a public place. Traditionally, it was linked to the notion of asylum, but people began to meet there to carry out business, shop or even dance. In 1231, the church Council of Rouen was forced to forbid dancing in cemeteries or churches – under pain of excommunication[15]. This promiscuity between the living and the dead is in complete opposition to the hiddenness of death in modern society. In the seventeenth century, signs of intolerance began to appear, yet for more than a thousand years:

> The spectacle of the dead, whose bones were always being brought up to the surface of the cemeteries, as was the skull in Hamlet, made no more impression upon the living than did the idea of their own death. They were as familiar with the dead as they were familiarised with the idea of their own death[16]

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[13]Cf. Ariès, *Western Attitudes Toward Death*, 15.
[14]Cf. ibid., 22.
[15]Cf. ibid., 24.
[16] Ibid., 25.

1.2 DEATH OF THE SELF

In the twelfth century, the traditional attitude towards death was modified due to a new emphasis on the self. The focus shifted from the notion of collective destiny, to one's own death. This was reflected in a change in eschatology. Christ came to be seen as Judge rather than Saviour. Moreover, the moment of judgement was brought forward from the end of time to the precise moment of the individual's death. The phenomenon of interest in macabre themes emerged in this period and there was a revival of tombs.[17]

1.2.1 Eschatology.

The tomb of bishop Agilbert, who died and was buried around 680, is typical of the eschatology of early Christendom. It bears the apocalyptic image of Christ, returning at the end of the world in majesty, surrounded by the four evangelists. Another image portrays the resurrection of the dead with arms upraised, acclaiming the returning Christ. There is no suggestion of judgement in evidence. The dead who had died in Christ would rest in peace until his second coming when they would be given paradise.[18]

However, in twelfth century there was a shift in ideas. The eschatological imagery changed.[19] The apocalyptic vision of Christ was accompanied by a new image inspired by the book of Matthew, that of the last judgement. Christ was depicted separating the just from the damned. In the thirteenth century, this portrayal of Christ as Judge almost completely supplanted the image of Christ as Saviour.[20]

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[17] Cf. ibid., 28, 29.
[18] Cf. ibid., 29.
[19] Ariès is refering to a different emphasis on the Last Judgement rather than a totally new iconography. See also Arthur Kingsley Porter, *The Crosses and Culture of Ireland*, (New Haven: Yale University Press, 1931), 73.
[20] Cf. Ariès, *Western Attitudes Toward Death*, 29, 31.

Each person's life was conceived of in terms of a balance sheet wherein his or her good and bad deeds would be recorded. Originally, in keeping with the attitude towards death as the as the common law of the species, as previously discussed, this was seen as a cosmic account book. However, with the rise of individualism, it degenerated into an individual balance or tally, which was closed at the end of each person's life. The risen were depicted wearing these account books around their necks, as some sort of passport that gained them entry into heaven when presented at its gates on the last day. Hence, the individual biography was not closed at the time of death. It was extended at least until the end of time, when the just win eternity and the damned are snuffed out.[21]

The fifteenth and sixteenth centuries witnessed the moment of judgement brought forward to the moment of death. In other words, the account book was balanced immediately at the time of death, rather than in space, at the Second Coming. This modification in thinking is evident in the books or treatises, which set out the proper manner of dying.[22] They bear witness to the tainting of the simple ceremony, characteristic of the traditional attitudes to death. The calm scene of the dying man in his sick bed, surrounded by family and friends, engaged in a simple ritual, is interrupted by something visible only to the dying man. Supernatural beings have invaded the bedchamber and are vying for the dying man's soul. 'On one side are the Trinity, the Virgin, and the celestial court, on the other Satan and a monstrous army of demons.'[23]

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[21] Cf. ibid., 32.
[22] Cf. ibid., 36 (artes moriendi).
[23] Ibid., 34.

The account book is still present, but God is no longer judge, only arbiter. The scene may be interpreted as a battle between the forces of good and evil or a trial on which the fate of the dying person rests. The dying person will see their whole life, as contained in the book, before his eyes. He will endure a final temptation, either to despair of his sins or give in to vainglory over his good deeds, or passion for things or persons. His attitude at the moment of death can cancel out the book charting the deeds of his life[24].

Spiritual writers found themselves trying to displace the popular notion that a virtuous life wasn't that important because a good death redeemed everything. However, the belief that the attitude one took towards one's own death, behaviour in dying, and circumstances surrounding death, had a moral importance, endured up until the twentieth century when it was rejected by industrialised societies.[25]

1.2.2 Macabre Themes.

The phenomenon of macabre themes begins in the thirteenth century, but is more common in the fifteenth century. It involves the appearance of the rotting corpse or cadaver in funeral iconography and literature. These macabre themes are seen by many today, including Ariès, as an exposition of the love for life, in the portrayal of the horror of death[26]. It may also be interpreted as the overthrow of the Christian world-view. However, the presence of such themes was limited to Eastern France and Western Germany and was never really accepted in Italy or Spain.

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[24] Cf. ibid., 36.
[25] Cf. ibid., 38.
[26] Cf. ibid., 40.

In this period last wills convey the understanding of death as a peaceful passing.

> The horror of physical death, of which the cadaver could be considered a sign was completely absent, which leads us to assume that it was also absent from the common mentality.[27]

However, macabre themes were present in sixteenth century poetry and they included not only physical decomposition but also illness and old age.[28] These poets are not simply referring to biological demise, but are aware of the universal presence of corruption in nature. The corruption comes from within, not simply from outward forces working on the body.[29] This corruption, evident in rotting corpses, is a sign of humanity's failure. The sense of failure in the Late Middle Ages is the complete antithesis of the contemporary notion of failure. Today, failure is seen as personal failure, namely the failure to realise the potential we had in our youth. It is tied up with not having achieved ones dreams. In the Late Middle Ages, people lived constantly in the shadow of death. They knew their pleasures, people, places and possessions, were only on loan to them for a while and that they themselves were only passing through this world. Their sense of failure was more an awareness of the transience of life. For this reason, they had a love of life, which has been shattered by today's increased longevity.[30]

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[27] Ibid., 41.
[28] "Je n'ay plus que les os, un sequelette je semble/décharné, démusclé, dépoulpé..."(Ibid., 42.)
[29] "Chascun conduit [du corps] /Puante matière produit/Hors du corps continuellement."(Ibid).
[30] Cf. ibid., 44-45.

1.2.3 Tomb Revival.

The individualisation of tombs is the final and perhaps most obvious phenomenon in the manifestation of the focus on death of the self.

In Ancient Rome, everyone, even the slaves, had their own burial place marked by an inscription.[31] Countless funeral inscriptions dating from that period survive today. The tradition of burial sites, bearing the identity of the deceased at their actual resting-place, persisted into the beginning of the Christian era. Some sepulchres even included a portrait of the deceased. However, by the fifth century, both inscription and portrait had disappeared, and burial sites became completely anonymous[32]. In the thirteenth century, when the focus shifted to death of the self, funeral inscriptions began to reappear after an absence of almost a century. They were rare at first, marking only the tombs of saints or queens e.g. Queen Mathilda, the first queen of Norman England[33]. Some tombs bore not only inscriptions but also portraits. At first, the portraits depicted the deceased in their glorified humanity, risen from the dead. Later, it became realistic and reproduced the face of the person whilst alive. It went on to portray the death mask. By the early seventeenth century, the tomb might brandish two portraits of the individual, one representing them whilst alive, the other in death[34]. The emphasis on one's own death was complete with the personalisation of tombs.

The most common form of funeral monuments, from the thirteenth to the eighteenth centuries, were plaques. They were the most affordable way of commemorating the dead.

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[31] Cf. ibid., 46.
[32] Cf.p. 9.
[33] Cf. Ariès, *Western Attitudes Toward Death*, 47.
[34] Cf. ibid., 48.

Approximately thirty to forty centimetres wide, they bore a simple 'Here lies ... inscription'.[35] They were fixed to church walls and 'reveal the desire to render the burial place individual and to perpetuate the memory of the deceased in that spot'[36]. However, in the nineteenth century, the attitude toward death changes from focus on one's own death to death of the other.

1.3 DEATH OF THE OTHER

Beginning in the eighteenth century, death came to be seen not as the common destiny of the species, (tame death) nor as the concluding act in an individual's biography, (one's own death) but as a violent yet beautiful sundering of intimate relationships (death of the other).

1.3.1 Romantic Death.

In the fifteenth century, death began to take on erotic undertones. The iconography of the sixteenth century depicted death raping the living. Death, like the sexual act, was seen as something, which tore people from everyday reality plunging them into an irrational, violent and beautiful world. Thanatos and Eros became related in art and literature. The ultimate love scene in Romeo and Juliet was the death scene. The idea of romantic death was also present in the works of the Bronte sisters in England and Mark Twain in the States.[37]

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[35] Ibid., 50.
[36] Ibid., 49.
[37] Cf. Ariès, *Western Attitudes Toward Death*, 57, 58.

Public deathbed scenes still took place, but with a difference. In the past, they were solemn events, dictated by custom and rather banal. The dying person presided over the ritual and those present were passive. However, by the nineteenth century, the attitude of those present had changed. They were stirred by a passionate sense of loss, which they openly expressed. The ritual was still fulfilled, but was rendered unique by spontaneous outbursts of emotion from family and friends. Separation from loved ones was no longer as easily tolerated.[38] In this period, people were not simply moved by death scenes, but by the very idea of death itself. This is the period of romantic death, as already outlined. One contemporary, a young French girl, wrote:

> Dying is a reward, since it is Heaven ... The favourite idea of my entire life is death, which has always made me smile ... Nothing has ever been able to make the word death lugubrious for me.[39]

1.3.2 Children Familiar with Death.

It was no different in Victorian England. Gorer tells of the familiarity of death due to high rates of infant mortality. Children were encouraged to think about the death of others and their own death. Practically everyone had witnessed the death of at least one person[40]. Adults prepared children for facing death by encouraging them to learn from

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[38] Cf. ibid., 58.
[39] Ibid., 60.
[40] Geoffrey Gorer, 'The Pornography of Death' in *Encounter*, 5(1995),51.

the dying. The fact that deaths took place in the home meant that:

> children learned how to cope with the death of the other and by implication their own, in essentially the same way that they acquired the more mundane domestic skills; that is by observing and taking part in the household's daily activities.[41]

The children's literature of the period also prepared children for death. Its fictional accounts of young people dying, desensitised children to death and dying and instructed them how to cope with death in real life. This isn't to say that children didn't experience fear or bereavement in relation to the death of others or anxiety at the prospect of their own death. However, they weren't entirely without resources to deal with it should it arrive, and in some sense it was expected.[42]

1.3.3 Mourning

Mourning in this period was a matter of social convention. Mourning imposed limitations on the mourners' social activity, but also required that they receive visits from relatives and friends. This was not entirely negative because it gave the family time to grieve, but also ensured they accept visits, thus protecting them from the excesses of grief. However, it also may have forced a family to demonstrate sorrow for a certain period of time, perhaps even when they had ceased to be sorrowful.[43]

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[41] Michael Mulkay, 'Social Death in Britain' in David Clark (ed), *The Sociology of Death* (Oxford: Blackwell Publishers, 1993), 43.
[42] Cf. ibid., 42.
[43] Cf. Ariès, *Western Attitudes Toward Death*, 66.

In the nineteenth century, the social conventions regarding mourning were not observed. People engaged in exaggerated, ostentatious and spontaneous mourning, which could include crying and fainting in public. After seven centuries of sobriety, the people had returned to the excessive mourning of the Early Middle Ages. The nineteenth century was a period of hysterical mourning. A scene in Mark Twain's "The Californian's Tale," from 1893, beautifully illustrates this. A man who had never come to terms with his wife's death, awaits her return on the date of their anniversary nineteen years later. Family and friends are present at the 'party' and help him maintain the illusion[44]. Fear of death in the nineteenth century was fear of death of the other.

1.3.4 A Cult of Memory.

The cult of tombs in the nineteenth and twentieth centuries has, at its heart, concern for the death of the other. It is very different to the period of antiquity when the dead were entrusted to the care of the church or even the seventeenth century desire for funeral inscriptions. The accumulation of the dead within church grounds became intolerable in the eighteenth century. This represented a complete break with what was common practice for almost a millennium[45]. It was due to a twofold concern for public health and the dignity of the dead, whose bones continued to be exhibited in the charnel houses[46].

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[44] Cf. ibid., 66.
[45] Cf. ibid., 69.
[46] Cf. ibid., 70.

They recalled the ancient piety for the dead, evident in their tombs at Pompeii. The survivors' unwillingness to accept the departure of their loved ones manifested itself in an unwillingness to hand their bodies over to the church. They wanted them 'at home' and so buried them on family properties or else nearby in a public cemetery where they could visit them often. Moreover, they wanted the burial site to belong totally to the deceased and his family, where they could cultivate his memory. They didn't want to share the spot with the church. They visited their dead at their burial site as they would visit them in their home. This was a cult of memory.[47]

Cemeteries were reinstated as a central place in the city, as they had been in antiquity. They grew in size due to the new piety and respect for tombs. It was no longer acceptable to pile corpse upon corpse, as they had done in the charnel houses of the Middle Ages. The public authorities wanted, during the reign of Napoleon III, to deconsecrate the Parisian cemeteries, which had been originally constructed outside the city, but had been enclosed by urban expansion. Unanimous public opinion prevented such plans[48]. Today, the cult of the dead is also tied up with patriotism. The anniversary of world wars is about remembering the dead soldier and is centred around a visit to a monument which perpetuates his memory.[49]

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[47] Cf. ibid., 72.
[48] Cf. ibid., 75.
[49] Cf. ibid., 76.

The mental attitudes towards death, and tombs and monuments to the dead, were one throughout Western civilisation in the late eighteenth and early nineteenth centuries. But whereas the United States, England and a part of North Western Europe, remained faithful to the old model of cemeteries, which were simple in design, Continental Europe – France, Germany and Italy – constructed extravagant monuments for its dead, in the baroque style. This may in part be put down to religious differences. However, the division of church into Catholic and Protestant came long before the divorce in funeral attitudes[50]. Perhaps the biggest influence may be the rate of industrialisation and urbanisation. 'Neo-Baroque funeral attitudes developed in cultures in which, even in towns and large cities, economic growth was less rapid and rural influences persisted.'[51]. Whatever the reason, a fault line appeared and continued to widen throughout the twentieth century. The great twentieth century refusal to accept death came about, and progressed, on only one side of that frontier.[52]

Death denying, as will be examined in the next chapter, coincided with the removal of death or dying, from the home to the hospital. Death was medicalised and in the process was stripped of meaning. It was not technology itself that posed the problem, rather the way it impacted on our self-conception as human beings and our attitudes to great human mysteries like suffering and death. The technological mentality was instrumental in bringing about the great twentieth century refusal to accept death.

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[50] Cf. ibid., 80.
[51] Ibid., 81.
[52] Cf. ibid., 82.

Chapter 2: Death Denying

2.1 FORBIDDEN DEATH

The changes in attitudes towards death from the Early Middle Ages to the mid-nineteenth century occurred so slowly, and over such a long period of time, that they were barely noticeable by contemporaries. However, there has been such a brutal revolution in attitudes towards death in our present day age that social observers couldn't fail to comment. The subject of death became a taboo. This phenomenon began in the U.S. and spread to industrialised Europe. The truth of death began to be challenged in the name of compassion. There was a desire to spare the sick from the seriousness of their illness. However, this sentiment was supplanted by a modern sentiment, namely the desire to preserve not the dying, but those around them and society in general, from the disturbance and ugliness of death. One must pretend death doesn't exist 'for it is henceforth given that life is always happy or should always seem to be so.'[1] Death had to be stripped of its meaning in order to preserve society's raison d'être of collective happiness, which had been reduced to maximum pleasure.[2] The medicalisation of death facilitated the process of 'hushing up'.[3] The removal of dying form the home to the hospital between 1930 and 1950 was an important physical phenomenon. Originally, the sick went to the hospital to be healed, or to struggle against death. Eventually the person went to the hospital for the specific purpose of dying – it had become inconvenient to die at home[4]. Death became a matter of technical expertise.

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[1] Ariès, *Western Attitudes Toward Death*, 89.
[2] Cf. ibid., 89-94.
[3] Ibid., 87.
[4] Ibid., 88.

It was no longer a ritual presided over by the dying person or even the family but by medical professionals. Death became bound up with the cessation of care. The medical narrative became the only acceptable narrative of sickness and death.

> Death has been dissected, cut to bits by a series of little steps, which finally makes it impossible to know which step was the real death, the one in which consciousness was lost, or the one in which breathing stopped. All of these little silent deaths have replaced or erased the great dramatic act of death, and no one any longer has the strength or patience to wait over a period of weeks for a moment which has lost a part of its meaning.[5]

Doctors determine the circumstances of death. Meanwhile, 'they try to obtain from their patients 'an acceptable style of living while dying.'[6] Acceptability is judged in terms of what is tolerable for onlookers. The 'embarrassing graceless dying' must be avoided at all costs. It may evoke uncontrollable emotion in survivors and public displays of any emotion other than happiness are strictly forbidden. One has a social obligation to contribute to the collective happiness by appearing always to be happy and choking back tears. Crying is only permitted in private. It is considered bad manners to be morbid.

Gorer compares the contemporary interdict on death to the taboo on sex in Victorian England. Modern society has traded-off the taboo on sex for a taboo on death. Death is now shameful and unmentionable whereas sex is openly discussed. Death has become the new 'not in front of the children' subject. Few children today are told that they were found under a cabbage. However, they may be told that their late grandfather is 'at rest in lovely gardens'.[7]

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[5] Ibid., 89.
[6] Ibid.
[7] Gorer, 'The Pornography of Death', 51.

Everything relating to death and dying in modern society must be discrete. Outward manifestations of suffering are suppressed. The practice of wearing dark clothes to signify mourning has been discarded. 'The ugly facts are relentlessly hidden; the art of the embalmer, is an art of complete denial.'[8] Embalming is very popular in the United States. Americans don't like death to disappear, because it is a profit-making industry, so instead they transform it, put make-up on it. This hides the nature of death because the deceased 'thanks to embalming is still present, as if he were awaiting you to greet you or take you off on a walk.'[9]

Embalming isn't as dominant in Europe because the practice of viewing corpses has declined. In Ireland, we still view corpses, but the wake has almost been abandoned. Funeral homes with their perfumed air are purpose built for visitation of corpses. Crowds are directed in one door and out another door with conveyer belt efficiency.

In 1885, the image and name of 'undertakers' changed. They became known as funeral directors and modern culture embraced them as 'doctors of grief'. Their job was not simply mechanical, but to help mourning survivors to return to normality in the shortest possible time.[10]

Cremation is the most popular method of disposal of remains in England. This probably has less to do with conservation of land and more to do with cremation being 'the most radical means of getting rid of the body and of forgetting it, of nullifying it'[11]. While the practice of visiting graves has not been altogether abandoned, urns are rarely visited.

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[8] Ibid., 51.
[9] Ariès, *Western Attitudes Toward Death*, 100, 102.
[10] Cf. ibid., 99.
[11] Ibid., 91.

2.2 SOCIAL THEORY ON CONTEMPORARY ATTITUDES TO DEATH

Anthony Giddens believes that contemporary attitudes to death are inextricably linked to the project of 'late' or 'high' modernity – our present day world.[12] The sequestration of death, the enforced absence from public space of considerations of mortality, can only be understood within the context of central features of what is popularly called post modernity. Giddens favours the term 'high' modernity because, like Bauman, he believes that post modernity is not the end of modernity, as the prefix suggests, but rather the fulfilment or victory of modern culture. 'High modernity is a period in which the consequences of modernity are becoming more radicalised and universalised than before'[13]. The overriding characteristic of modernity is a desire for control[14]. Order is understood as manmade. Nature was the enemy as was anything spontaneous, unpredictable or contingent.

Modernity was concerned with subordinating nature to human purposes. It was characterised by instrumental reason, which has been defined as 'the application of humanly organised principles of science and technology to the mastery of the natural world'.[15] The transformations involved were unprecedented in history. The natural world, not least of all human nature, became raw material to be moulded according to human design. The natural world was de-spiritualised. 'Once a matter of providence and revelation, life had turned into the object of *techne*.'[16] The impulse for order and control

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[12] Philip Mellor 'Death in high modernity: the contemporary presence and absence of death' in David Clark (ed.), *The Sociology of Death* (Oxford: Blackwell Publishers, 1993) 12.
[13] Anthony Giddens, *Consequences of Modernity* (Cambridge: Polity press, 1990), 3.
[14] Idem, *Modernity and Self-Identity: Self and Society in the Late Modern Age* (Cambridge: Polity press, 1991), 12.
[15] Ibid., 145.
[16] Zymunt Bauman, *Intimations of Postmodernity* (London: Routledge, 1992), 35.

was reflected in a search for utopias – the perfect world in which nothing was unaccounted for or left to chance. Urban planning reflected this drive for perfection. 'In the city of reason there were to be no winding roads, no cul de sacs and no unattended sites left to chance – and thus no vagabonds, vagrants or nomads.'[17] The incessant drive for the perfect order would not be complete until "every blade of grass was tidied into a park with concrete paths and iron railings"[18]. Happiness was to be found in a carefully controlled world.

Modernity is a post-traditional order. All beliefs and practices are open to wholesale revision and technological intervention, even human life itself. Modernity is generally identified with industrialised societies, which have been cut loose from their moorings in tradition. Modernity dismantled the meta-narratives of tradition because they have a binding normative character and moral content which run counter to modernity's mobilising dynamics of control. Universal moral principles make tradition an inertial force, which may lead society to block the technical power to introduce something new. But whereas modernity sought to replace the traditional truths it dismantled with new certainties, albeit unsuccessfully[19], post-modernity 'did not seek to substitute one truth for another, one life ideal for another'[20]. Post modernity 'denies in advance the right of all or any revelation to take the place vacated by the deconstructed or discredited rules'[21]. Post modernity banishes truths, standards, ideals and ultimately meaning from its world.

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[17] Ibid., xv.
[18] Oliver O Donovan, *Begotten or Made* (New York: Oxford University Press, 1984), 5.
[19] Cf. Giddens, *Consequences of Modernity*, 29, 176.
[20] Bauman, *Intimations of Postmodernity*, ix.
[21] Ibid., ix.

2.2.1 The Sequestration of death from public life.

Berger argues that all human societies create structures, which give people a sense, of what is meaningful and real.[22] In other words, society contributes to our sense of identity and purpose. The power of society, therefore, does not merely rest on social structures or what Berger calls 'machineries of control,' but on society's 'ability to constitute and impose itself as reality.'[23]. Our 'world' is a social construct. According to Foucault, death 'strips away sociality to reveal the heart of an otherwise invisible truth'[24]. This truth for Foucault is pure individuality. Death raises existential questions for the individual which threaten what Giddens calls 'ontological security'. 'Ontological security' refers to the sense of order and meaning persons find in their day to day lives[25]. Berger proposes, as already outlined, that this sense of order and security is largely defined by society. Ontological security can be threatened by any form of disorder which may throw into question the meaningfulness and reality of social life. Death is a potent threat to ontological security and the social order, because it undermines even the most basic assumptions upon which social life is constructed. It shatters ontological security because it 'signals the threatened irreality of the self-projects which modernity encourages people to embark upon.'[26] This can result in a paralysis of the will and hence prevent people from participating in society's conventions or even cause the rejection of the legitimacy of social frameworks.

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[22] Cf. Mellor 'Death in high modernity', 14. See also P. Berger, *The Sacred Canopy: Elements of A Sociological Theory of Religion* (New York: Doubleday, 1967).
[23] Mellor 'Death in high modernity', 14.
[24] David Clark, *The Sociology of Death*, (Oxford: Blackwell Publishers, 1993),3.
[25] Mellor 'Death in high modernity', 12.
[26] Cf. ibid., 19.

For this reason society 'brackets out' questions such as death which, were the individual to seriously contemplate them, would pose a potent threat to ontological security and hence the social order itself. Death challenges both modernity and it's bracketing process. It defies social containment or control. It is the point at which 'reflexivity,' (defined as 'the systematic and critical examination, monitoring and revision of all beliefs and practices in the light of changing circumstances)[27] central to high modernity, is rendered useless. A dead person can no longer plan or revise. Giddens notes that 'death remains the great extrinsic fact of human existence ...death becomes a point zero, it is nothing more than the point at which human control over human existence finds an outer limit.'[28] It is difficult to bracket out because it is an inevitable fact of human existence. Its presence and absence in modern society is paradoxical. In short, death is sequestrated from high modernity in order to retain the individual's commitment to the social order.

Death cannot be answered within the framework of high modernity so it is conspicuously denied an answer. The enforced absence of death from the public realm means that individuals are left to make sense of death alone. Individuals, forced to deal with death in private, find it an even more terrifying subject. 'Because meaning has been so privatised, any attempts to construct meaning around death are now inherently fragile.'[29] In a secular world, devoid of communally constructed values or tradition, the

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[27] Giddens, *The Consequences of Modernity*, as reported by Mellor, 'Death in high modernity', 17.
[28] Giddens, *Modernity and Self-Identity*, 162.
[29] Mellor 'Death in high modernity', 21.

individual is at best left to choose their approach to death from a multiplicity on offer in the culturally diverse modern society. The emphasis on personal preference underscores the point that if everybody is right then nobody is right.

Therefore, death is doubly frightening for the modern individual. First, because it opens the individual up to the terror of the meaningless of their everyday lives and second, because they are unable to construct meaning around death in high modernity. In such a context the temptation to run for cover is too hard to resist. Death denying is infectious. Society has encouraged the individual to become an active participant in the process.

2.2.2 The decline in the capacity to act.

Children in present day society, unlike the elderly or children of past generations are not expected to die. Society expects childhood to be death free. Excluding neo-natal deaths, accidents are the most common cause of deaths amongst children[30]. In cases of accidental death, the future parents anticipated for their child is wiped out without warning and, more often than not, without consolation. The individual finds it difficult to construct meaning around death in post-modernity. Due to decline in belief in life after death, many parents do not have the hope of reunion with their child in the next life. Professionals may provide counselling, but relatives and friends pointedly avoid talking about the death because they are uncomfortable with the subject. They manifest all the symptoms of society's flight from death. They begin to avoid the bereaved or reduce contact with them because they don't know what to do or say. *Handlungsverlust,* the

[30]Mulkay, 'Social Death in Britain', 43. Cf. S. Foster and O.Smith, *Brief Lives,* (London: Arlington Books, 1987).

decline of the capacity to act, is a term coined by Gehlen to describe the plight of individuals faced with death following the deconstruction of tradition[31]. The bereaved are socially isolated, just as the dying and the elderly, because they are living reminders of the unavoidable reality of death. The obligation to suffer alone exacerbates the sense of loss experienced by the bereaved.

In the case of death from cancer, family and friends are given an opportunity to readjust their relationships with the dying person. They take a shared response.[32] Unfortunately, that response often takes the form of a denial of death. A pretence of recovery or normality is maintained until the biological demise becomes so obvious that pretence is no longer possible. Prior to this, the gravity of illness is not discussed with the patient, particularly if he or she is young. Oftentimes, children follow their parents lead and stop asking questions. Hospital visits to the patient are marked by hollow cheerfulness and oftentimes the staff collude in the conspiracy of silence. This deprives patient and parents of precious time, which could have been used to help both come to terms with the imminent death.

2.2.3 Institutional Sequestration of the Elderly.

Modernity removed madness, criminality, sickness and death from ordinary life[33]. Modernity's sequestration of such features, which were hitherto seen as 'given,' was part of the modern project, described in an earlier section, which saw nature as something to

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[31] Philip Mellor, 'Death in high modernity', 20.
[32] Mulkay, 'Social Death in Britain', 45.
[33] Cf. Giddens, *Modernity and Self-Identity*., 157.

be transformed by human will. Social control over such extrinsic forces of nature took the form of incarceration. The mentally ill, criminals and the sick were segregated from normal society in the mental asylum, prison and hospital, respectively. Originally, such places were seen as 'houses of correction' whereby the individuals would be restored to society when they were able to function normally i.e. conform to social conventions. However, 'custody' came to almost completely overshadow 'cure', with the main aim of incarceration being to shield the normal society from alternative representations of reality, which may lead to existential questions[34]. The latter could be repressed and the social-construct of reality protected if contact with social 'deviants' was avoided.
The same principle is at work today with regard to the elderly who remind us of death.

The causes of death have changed dramatically since the nineteenth century. Long-term degenerative diseases have replaced short-term infectious diseases[35]. Mortality rates amongst children and young adults are low. Death today is concentrated amongst the elderly. The vast majority of people today die in a hospital setting. This reflects our desire to sequestrate death away from the public gaze. We shut ourselves off from those in whom death becomes a more imminent concrete prospect. The presumed imminence of death amongst the elderly causes us to sequestrate them spatially in nursing homes. They are denied meaningful interaction with their family just when they are likely to need it most[36]. 'Whereas in some pre-literate societies the unwanted old are physically buried alive, in our society they are immersed in residential homes where, out of sight and largely out of mind, they can be left whilst the process of biological decline takes its

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[34] Cf. Giddens, *Modernity and Self-Identity*., 157.
[35]Mulkay, 'Social Death in Britain' ,31.
[36] Cf. Mellor, 'Death in High Modernity', 21. See also N. Elias, *the Loneliness of the Dying*, (Oxford: Blackwell Publishers, 1985).

inevitable course.'[37] Those who place old people in homes do so in the knowledge that they will not 'come out alive.'[38]

This awareness of the transition from 'normal' life to the home is so acute that they engage in 'anticipatory grief'[39]. The elderly are mourned as if they are already dead, even though they may go on to live for many years in the nursing home. For all intents and purposes, the elderly are dead for those who live in the outside world. Even though the elderly may be visited in the home by their relatives, the symbolic divide between the full actors in society, and the physically and socially sequestrated residents, makes any relationship between the two, little more than a pretence[40].

This drive within the modern person, to separate himself or herself apart from those who are near death, is present amongst the segregated elderly themselves. The 'fit' residents separate themselves form the 'frail'. The elderly residents themselves vigorously ostracise the 'frail' residents, in order to find some meaning in their own existence, rather than waiting for death. The home becomes a microcosm of what is happening in society. The staff eagerly participate in the apartheid regime, spatially distancing the 'fit' from the 'frail'. This allows them to focus on the former and gives them a sense that the home is more than mere dying rooms. The staff interact differently with the two categories of elderly. They refer to death implicitly and explicitly amongst the 'frail', whereas in their dealings with the 'fit', staff stressed their liveliness and talked

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[37]Mulkay, 'Social Death in Britain,' 36. Here Mellor is quoting J. Goody, *Death Property and the Ancestors* (London: Tavistock Press, 1961).
[38] Ibid., 36. See also. J. Hockey,(1985) ' Cultural and Social Interpretations of "Dying" and "Death" in a Residential Home for Elderly People in the North East of England', in *Curare*, 8(1): 35-43.
[39] Cf. ibid. See also R.Fulton and J.Fulton, 'A Psychological Aspect of Terminal Care: Anticipatory Grief ' in *Omega* 2(1971)91-100.
[40] Ibid., 37.

in ways that denied the immediate relevance of death.[41] This served to foster a sense of personal worth and social significance in the fit, which they clung to mercilessly. The unfortunate consequence for the frail, of the collusion between the fit and the staff, is that 'they are systematically excluded from participating in this last, ultimately impoverished setting, in much the same way that the elderly in general are excluded from the wider society.'[42] Ironically, the 'fit' may die suddenly and the 'frail' long outlive them. The frail are rendered socially dead long before their biological death and so the transition from the home to the grave goes by largely unremarked.[43]

This whole idea of institutional sequestration may seem more like a conspiracy theory, than a social theory, to some readers. However, we can see evidence of such active segregation of the elderly from 'normal' society on a regular basis. Here in Ireland, for example, the health boards solution to the current beds crisis in our hospitals, is to remove the elderly, who are deemed to be blocking beds. Minister for Health and Children, Mr. Martin, has provided funding for the health boards to move five hundred elderly patients from hospitals into nursing home beds. These 'step down' facilities are part of the Health Board's strategy to free up hospital beds. Hospital Consultants rightly condemned the move, describing it as an ageist attitude. The Health and Children Correspondent for the Irish Times, after speaking to Consultant Geriatrician Dr. Des O' Neill, got to the heart of the matter when he wrote, ' I put quotation marks around "freed-up" because actually the beds won't be freed-up at all. They will be occupied by younger people. If you are an older person you are a bed blocker. If you are young, you are a

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[41] Cf. Mulkay, ' Social Death in Britain,' 37. Cf. Hockey, (1985) et al. J. Hockey., (1990), *Experiences of Death: An Anthropological Account,* Edinburgh: Edinburgh University Press.
[42] Ibid.
[43] Ibid., 38.

patient occupying a bed, which has been "freed-up."[44] It seems we don't even want the elderly sick to get the same treatment as ordinary sick people. They will receive separate and sub-standard care. Today, they're blocking beds in hospitals. Tomorrow, maybe we'll find that we have no room for them anywhere at all. We have already done this to them socially and to a great extent spatially. If this attitude is taken to its logical conclusion, the elderly in Ireland, like the elderly in Holland, will live in fear of being involuntarily euthanised. Medicine's move from being a ministry of care, to a mechanistic-instrumentalist discipline, which will be discussed in the next chapter, sheds some light on how this situation came about.

[44] Padraig O'Morain, "Step-down" facilities to free more beds will only maroon the elderly in an ageist world' in the *Irish Times* (3 January 2001), 5.

Chapter 3: Contemporary Attitudes Towards Suffering

3.1 MEDICALISING SUFFERING

According to Ivan Illich, our society has been medicalised to such an extent that it is no longer a culture (system of meaning), but a system of techniques and thus more properly called cosmopolitan medical civilisation[1]. Modern medicine is instrumental in modernity's war against the contingency of nature. The human body is contingent because it is subject to outside forces, which cannot be controlled[2]. Modern medicine seeks to counteract the loss of predictability and control incurred in sickness. Disease can cause anything from shortness of breath, loss of memory, tremors, seizures to uncontrolled expulsion of bodily fluids[3]. The latter is acceptable in infants, but when adults lose control they are stigmatised. Sick people are not held accountable for their sickness but for how they present themselves. They are expected to conceal their contingency as best as possible in order to avoid embarrassing others with the spectre of lost body control[4]. Sick people must suppress their spoilt identity with medicines or hospitalisation in order to protect normal society from the sight of sickness, which is an intimation of mortality and the failure of the modern project.

Suffering is a distinctly human phenomenon because it requires not simply physical pain but awareness. Suffering is bound up with the contemplative or spiritual aspect of our being as well as the bodily[5]. Human suffering begs the question, why? However, modernity has deprived suffering of its personal meaning and reduced it to the unifying

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[1] Cf. Ivan Illich, *Limits To Medicine. Medical Nemesis: The Expropriation of Health* (London: Marion Boyars Publishers, 1995), 33.
[2] Cf. Arthur W. Frank, *The Wounded Storyteller. Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 1997), 31.
[3] Ibid., 31.
[4] Ibid.
[5] Stan Van Hooft, 'The Meanings of Suffering', in *Hastings Center Report*, 28 (1998), 13.

view of clinical medicine[6]. Human suffering has also become a matter of *techne*. Whereas traditional cultures make pain tolerable by integrating it into a meaningful setting and interpreting its necessity, cosmopolitan medical civilisation detaches pain from any social context or meaning in order to annihilate it[7]. Modern medicines single-minded telos of cure has dehumanised the patient's experience of suffering and ironically sapped society of its ability to tolerate any level of pain.

3.1.1 Deconstructing Mortality.

Suffering and dying have been claimed by technocracy as malfunctions from which society must be institutionally relieved[8]. Suffering is a mystery and thus by its very nature doesn't admit solution. It is therefore a scandal to modernity – something it cannot control. But by reducing human suffering to physical pain, modernity has been able to reassert control. Over the last few centuries the physician's attitude to suffering has changed and with it medicine's interest from the sick to sickness[9]. The self has been separated from the body; the latter being degraded to the status of a broken-down car which has inconvenienced its occupant. The hospital has been transformed into a 'compartmentalised repair shop'[10] to deal with mechanical trouble. The threat of mortality is denied by the specialisation of modern medicine, which breaks down the human body into component parts. Bauman calls this 'deconstructing mortality'[11]. By dividing illness into discrete parts, organs or tissues, the mystery of suffering becomes a

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[6]Cf. Frank, *The Wounded Storyteller,* 11.
[7] Cf. Illich, *Limits To Medicine,* 134.
[8] Cf. ibid., 132.
[9] Cf. ibid., 138.
[10] Ibid., 163.
[11]Frank, *The Wounded Storyteller, 83*; see also Zygmunt Bauman, *Mortality, Immortality and Other Life Strategies* (Stanford: Stanford University Press, 1992), 167.

series of puzzles which admit solution. The breakdown is thus fixable and sickness, as intimation that my whole being is mortal, is forestalled[12]. This works for both patient and doctor. The latter concerns himself or herself with fixing this or medicating that and thus hasn't to consider the big issue of mortality. Thus specialisation in Medicine facilitates deconstructing mortality. Meanwhile, the patient is distracted from the law of their being, by fulfilling a series of tests and treatments. The mystery of suffering, which can only be faced up to, doesn't have to be, while we still have puzzles to solve.

3.2 SOCIAL MANAGEMENT OF SUFFERING

Parson's theory on the 'sick role' outlines what society expects from the sick person. The core obligation is that they present themselves to a health-care professional for treatment. This expectation is institutionalised and validated by social norms in matters such as sick leave from work and medical care.[13] The sick person is exempt for normal obligations whilst under the care of a physician. The physician is an agent of social control in a twofold sense. His obligation is to ensure that the privilege of sick leave isn't abused and that the patient receives medical attention so that they may return to normally functioning society as soon as possible. The physician regulates the time given to patients to recover. He must ensure that the sick person is given enough to recover, but not too much, lest he or she produce a social dropout.

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[12] Cf. Frank, 86; see also William F. May, *The Patient's Ordeal* (Bloomington: Indiana University Press, 1991).
[13] Cf. Frank, *The Wounded Storyteller*, 81.

'The physician is there not to pander but to prod gently but firmly'[14]. Parson's theory doesn't concede the failure of modern medicine to cure. This reflects the core expectation of society from the physician, which is restitution, in other words, that the doctor return them to society 'as good as new'. Modern society inculcates this expectation. Stories of medical heroism are told to the exclusion of other stories of illness. They are bought wholesale by the general population because people do in fact get better and even those who don't get better want to go on believing that they will[15].

However, the chronically ill or the silent 'remission society', both of which have temporary visa status in the healthy world, have long-since ceased to tell their story of illness in terms of prospective restitution[16]. Their stories being of chaos, instead of control, are suppressed in modernity. Oprah, the American chat-show queen, interviews recovering or recovered anything from alcoholic to nymphomaniac. Even if someone enters the show in chaos, through the help of counsellors or health-care professionals, they leave a success story in the making. Advertisements for private hospitals or clinics and health insurance companies promise the possibility of outwitting suffering. V.H.I. promises to help us to 'dance away the heartache, dance away the pain.' The hype over the mapping of the human genome was irresponsible. It was not only generated by those in the fields of science and medicine but by the U.S. President and Britain's Prime Minister. This is a current example of Western society's assertion of its preference for the restitution narrative even when the claims of cure are grossly exaggerated or at the very least still in the pipeline.

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[14] Ibid., 82.
[15] Cf. ibid., 92.
[16] Cf. ibid., 8.

Science can never deliver a world free of suffering and yet it conditions people to expect and accept only restitution stories of illness. Chaos stories i.e. stories of illness, which don't end in cure, rarely receive coverage because they provoke anxiety in others and represent the failure of the modern project. Most people switch off when they hear chaos stories whereas interviewers twist the story so as to end on a note of optimism. 'In his analysis of how interviewers elicit Holocaust stories, Langer notes that one device they use to keep the talk tolerable for themselves is to steer the witness toward what the interviewer takes as the end of the camp experience, liberation.'[17] However, for the survivors, liberation is an almost bigger horror than what went before. In the words of one survivor 'Then I knew my troubles were *really* about to begin'.[18] Liberation from hospital can provoke a not dissimilar horror: the trouble of finding purpose in a world which, has changed for the post-illness person, but to everybody else still looks the same. Modern medicine seeks to return people to the world, exactly the same as they were before they became sick. But for many the experience of illness renders this impossible as a moral choice[19]. Yet society hasn't got the ears to hear their story. Just as the interviewer of the Holocaust survivor tries to mould the story to what he wants to hear, society patronisingly tries to smooth away people's pain. "You'll be fine," is a common platitude even if it defies all logic and medical prognosis. Visitors to hospital wards enter equipped with that phrase, a hollow cheerfulness and a forced smile enough to bully any patient into false optimism. It can be very frustrating for sick people when others refuses to listen to their pain. A common response to a chaos story is to suggest a remedy. It

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[17] Ibid., 105, based on Lawrence Langer, *Holocaust Testimonies: The Ruins of Memory* (New Haven: Yale University Press, 1991),67.
[18] Ibid., 106.
[19] Cf. Frank, *The Wounded Storyteller*, 91.

never enters the other person's head that in the sick person's case, a formula for health couldn't be found. One Holocaust survivor told his story to a group of children in school and one child responded with an elaborate plan as to how he could have escaped[20].

The most common model of the restitution story is the TV commercial for painkillers, non-prescription drugs and frequently cold remedies[21]. The commercial that springs to my mind advertises a common painkiller. A man is grumpy in the morning because he had a headache and complains to his wife that he can't find the paracetamol. The harmony of the household, the man's ability to go to work or at least the mood he is in when he arrives at work are at stake. The caring wife provides the remedy.and is thus validated. The man pops a pill and kisses his wife goodbye. She says, 'Have a good day'. He replies "I will" to which she concludes aloud "He will". Order is restored in the commercial and people are conditioned to expect the same in real life. There is no question in the advertisement of the remedy not being available. Therefore, future interruptions to health are expected to be finite and remediable. 'In the extended logic of restitution, future sickness already will have been cured'[22]. It is noteworthy that what cures the body is a commodity[23]. This is why we are called healthcare consumers. We perceive our freedom as consumers. It is a freedom not to suffer[24].

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[20] Cf. *ibid.*, 102.
[21] Cf. ibid., 79.
[22] Ibid., 90.
[23] Cf. ibid., 86.
[24] O' Donovan, *Begotten or Made*, 9.

3.3 KILLING PAIN

Pain is no longer seen as 'natural' but as a 'social curse from which society must be institutionally relieved'[25]. Anaesthetic consumers demand 'artificially induced insensibility, unawareness and even unconsciousness'[26] and, in the context of the euthanasia debate, death. Pain came to be seen as a mechanical response, which can be regulated, measured, verified and objectified[27]. The physician was trained not to recognise the questions pain raises for the person. Instead, he records their pains in medical charts, which the patient isn't allowed to read. He uses a specialised abstract language, which deprives the patient of even meaningful words to describe their suffering. The physician is a master in the mechanics of pain. A century and a half after pain had been reduced to a physiological entity, a medicine labelled painkiller was marketed in La Crosse, Wisconsin. When pain like everything else in the modern age was made a matter of *techne*, it seemed rational to flee it rather than face it[28]. This marked a major departure from what had been a universal way of dealing with pain in traditional societies. The latter didn't deny the necessity to bear pain. They took an integrated approach to dealing with pain, which included remedies, care, comfort and consolation. Their emphasis was on healing the person, not simply treating symptoms. They encouraged the individual to take responsibility for their experience, by fostering an art of suffering. Cultures have always provided models of behaviour in suffering, which

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[25] Cf. Illich, *Limits To Medicine, 135.*
[26] Ibid.
[27] Cf. ibid., 170, see also Frank, *The Wounded Storyteller,* 5, 6.
[28] Illich, *Limits to Medicine*, 152.

encouraged people to bear their pain with dignity[29]. The saint, the martyr, the warrior and in the case of Christianity, God, encouraged the individual to a virtuous performance in suffering and gave their experience meaning. This gave rise to a myriad of virtues and qualities to deal with pain e.g. courage, patience, forbearance, fortitude, resignation, self-control, perseverance, duty, love, fascination, prayers and compassion[30]. Compassion has become obsolete because pain has been deprived of any social context to give meaning to the experience of the sick. Compassion has come to mean the elimination of suffering at all costs, rather than sharing with someone in their suffering or helping others bear their suffering. But the modern logic balks at this: why share in something that has no meaning?

3.3.1 Treating patients as pets.

It is something that our generation finds very hard to believe, but traditional societies were far more progressive in their attitudes to suffering or what we would call 'pain management'. They recognised that the human experience of pain is conditioned, not simply by the intensity of the pain stimulus or genetic factors, but by the way we interpret pain, which hinges on our culture. The meaning we ascribe to pain is instrumental in our capacity to tolerate it. All human suffering begs the question why?

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[29] Cf. ibid., 145.
[30] Cf. ibid., 134.

'Observers that are blind to this referential aspect of pain are left with nothing but conditional reflexes. They are studying a guinea pig, not a human being'[31]. A physician doesn't come close to understanding an individual's suffering if he diffuses the value-loaded question and concerns himself with managing a systemic entity. Animals are used to test the effectiveness of "pain-killing" drugs or surgical interventions. The validity of the results of these tests are verified on humans[32]. If both guinea pigs and humans live in experimental conditions, the effects of the drugs will be the same. However, in a normal situation, the affects of pain-killing drugs on the sick will not be directly in line with results obtained in controlled conditions. 'In the laboratory people feel exactly like mice, when their own life becomes painful they usually cannot help suffering, well or badly, even when they want to respond like mice'[33]. It is a failure of compassion to treat 'patients like pets'[34]. Unfortunately, this situation will prevail under the clinical reduction of suffering to a physiological entity. Clinical medicine admits no category for 'living a life of overwhelming suffering and trouble'[35]. When patients, who are treated like pets, act as humans and despair, it is documented as depression in order to redefine it as a treatable condition and hence place it within the framework of restitution[36]. Clinical staff can once again take control. This is another example of the restitution narrative demanding dominance; 'it denies chaos and requires chaotic bodies to be depressed and thus fixable'[37]. Prozac is just another painkiller. Drugs that change affective states are

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[31] Ibid., 142.
[32] Cf. ibid., 143.
[33] Ibid.
[34] Ibid., 152.
[35] Frank, *The Wounded Storyteller*, 112.
[36] Ibid., 110.
[37] Ibid.

philosophically suspect[38]. The same conspiracy of happiness which publicly denies death, and insists on telling sick people ad nauseam, you're looking well, tries to enhance the patient's psychic well-being by chemical warfare. Modern medicine or psychiatry fails to recognise that anxiety is produced by alienation and prozac cannot "cure" our collective form of life or healthcare system in which alienation takes root[39]. Cases of depression have increased in the United States from 50 people per million in the 1950's to 100,000 per million today[40]. This tells us we need to change the whole ideology behind our society of which our healthcare system is the brainchild. Unfortunately, the technological mentality from which modern society operates, fails to see that there are certain areas of life in which technological intervention is inappropriate. 'Sufferings of the soul cannot be addressed nor ameliorated by chemicals.'[41] This kind of palliation is an attempt to reassert order and control over inner suffering, but can actually exacerbate the situation by disconnecting the sufferer from their pain, thus inhibiting healing. 'Instead of covering up symptoms, compassion seeks connection with the sufferer, without seeking to negate suffering.'[42] Time not tranquillisers, 'compassion not palliation in the service of a quick fix, help suffering souls begin their healing.'[43] We need to learn from traditional societies, which understood that strictly medical factors are rarely the most crucial to healing. Otherwise, we will continue to treat the loneliness of the sick and the dying with drugs or even death.

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[38] Peter D Cramer, 'The Valorization of Sadness' in *Hastings Center Report*, 30 (2000),13.
[39] Carl Elliott, 'Pursued by Happiness and Beaten Senseless' in *Hastings Center Report*, 30 (2000),7.
[40] David Healy, 'Good Science or Good Business?' in *Hastings Center Report*, 30 (2000),19.
[41] Dan Dugan, 'When Suffering is More than Physical Pain' in *The Park Ridge Center Bulletin*, (Sept/Oct 1997), 4.
[42] Ibid., 5.
[43] Frank, The Wounded Storyteller, 110.

3.3.2 The Traditional Approach to Pain.

The role of the physician in modern society is to remove pain. This is a complete aberration in the history of Western civilisation. In the classical West, 'the Greeks didn't even think about enjoying happiness without taking pain in their stride'[44]. They understood pain as an inevitable reality in a flawed universe and saw it as something, which helped the soul to evolve. For Aristotle, body and soul were in complete unity. Hence, the language of bodily pain was equally applicable to the soul. The two were divorced in Western thinking by Descartes[45]. Before this the idea of professional technical pain killing was alien to all European civilisations. First, as already intimated, because pain was 'man's experience of a marred universe, not a mechanical dysfunction in one of its sub-systems. The meaning of pain was cosmic and mythic, not individual and technical'[46]. Second, as corruption was part of nature and so was man, one couldn't eliminate suffering without eliminating the sufferer. Third, pain was an experience of body and soul. There was no such thing as pain that wasn't suffered.[47]

> One approach to pain was however unthinkable, at least in the European tradition, the belief that pain ought not to be suffered, alleviated, and interpreted by the person affected, but that it should be – ideally always –destroyed through the intervention of a priest, politician, or physician.[48]

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[44] Illich, *Limits to Medicine,* 147.
[45] Ibid., 150.
[46] Ibid., 149.
[47] Ibid.
[48] Ibid.

3.4 MORAL THEORY AND SUFFERING.

The moral theory of Proportionalism reflects society's wider identification of progress with the reduction of the sum total of suffering. Proportionalism, as the name suggests, is concerned with bringing about a proportion of good over evil. "According to Proportionalism, an act which would otherwise be immoral can be justified morally if the overall good or evil involved in doing the action compares favourably with the overall good or evil which the avoidable alternatives would bring about"[49]. The emphasis is placed on the outcome of acts. Proportionalists believe that the moral agent must determine, prior to choice, which action will bring about the greatest good or the lesser evil and act accordingly. Secular ethicists known as 'consequentialists' are guided solely by the principle of the lesser evil. The most common form of consequentialism is utilitarianism. It has its roots in the classical secular belief that there is really only one good that human action pursues, namely pleasure[50]. Therefore the central tenet of utilitarianism is to bring about the greatest good or happiness for the greatest number of people. Catholic proportionalists, coming from a Christian perspective, reject the oversimplified identification of good with pleasure[51]. They also recognise that individual rights cannot be violated for the benefit of society.

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[49] R. Lawler, J.Boyle and W. E. May, *Catholic Sexual Ethics* (USA: Our Sunday Visitor Inc., 1996), 79.
[50] Ibid., 80.
[51] Ibid.

They accept some moral absolutes e.g. that one should never seek to lead another into sin.[52] However, they reject traditional Catholic absolutes e.g. thou shalt not deliberately take innocent human life.

Actions are morally evaluated by weighing up the good and bad effects. For example, in the case of direct abortion, the bad effect would be the intentional destruction of the unborn child whereas the good effects may include preservation of financial security, career prospects, existing relationships etc. The moral agent must decide for herself which values are most important to her. She subjectively constructs a hierarchy of goods. 'This approach seems to suggest that there is no rational way to determine the lesser evil'[53]. One doesn't choose the moral good, one merely decides arbitrarily what to call the moral good in accordance with one's own personal preference.

A morality of principles will use proportionality in moral evaluation when there are no moral absolutes at stake. However, if an act is wrong or immoral in itself, it cannot be done. Proportion doesn't come into it e.g. direct abortion will always and everywhere be wrong because it is the deliberate destruction of innocent human life. It precludes the overriding of a basic human good in the name of overall good. It holds that authentic love requires a respect for persons that absolutely prohibits certain types of actions:

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[52] Ibid., 80.
[53] Ibid., 85.

> The Christian faith has seen that there are in fact evil kinds of deeds, deeds that always involve assaults upon the love of persons. Such deeds must never be done; there can be no "proportionate reason" for doing them. We must not do evil that good may come of it".[54]

Therefore, a morality of principles upholds universal absolutes or moral norms because they are the requirements of genuine love. To do the right thing, even if it has tragic consequences, is from the perspective of a morality of principles the lesser evil. Secular consequentialists are more concerned with the foreseen effects of actions. Whereas the classical moral tradition has always been more concerned that the faithful respect the good. The latter has always been deemed more important than producing good effects or having wonderful things happen in our lives.[55] This attitude is not the result of a desire for moral rectitude or insensitivity to human problems, but recognition that ours is a fallen world – and that our ability to make the world good is limited. This approach acknowledges that plenty of actions will have unfortunate aspects to them and the only realistic and moral attitude to take is to respect the good rather than engaging in impossible calculations about the supposed outcome of actions in order 'to create a world in which the maximum possible amount of good is realised'.[56]

The latter invariably results in assaults against the goods of individuals. Instead of trying to overreach our limits as human beings, we should accept that the problem of evil will not be solved in this world. A morality of principles rejects the this-worldly approach of proportionalists and is open to the deeper meaning of human existence

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[54] Ibid., 92.
[55] Cf. Lawler, Boyle and May, *Catholic Sexual Ethics*, 93.
[56] Ibid., 91.

revealed in Jesus Christ.[57] It doesn't show contempt for human tragedy but rests on the confidence that God will restore all that is good in the next life. The attempt of proportionalists to bring about the maximum amount of good possible, rather than respecting simple requirements of love, reeks of utopianism. This moral theory reflects society's wider dissatisfaction with the world 'not because it was dreary or sinful or lacking in enlightenment or threatened by barbarians but because it was full of suffering and pain'.[58]

3.5 A RESIDUAL HORROR.

One would think society's attempt to minimise suffering would have maximised happiness. It hasn't. I already quoted statistics on depression, but a direct consequence of induced insensitivity to pain seems to have been an inability to enjoy life's more simple pleasures. 'Increasingly stronger stimuli are needed to provide people in an anaesthetic society with a sense of being alive'.[59] Sports like bungy jumping and sky diving have never been more popular. The use of more worrying stimuli like drugs and violence is on the increase. Our generation plays music louder because it seeks excitation through noise. The amount of young boys who get killed on the roads every year due to speeding is another example of destructive thrill seeking. It is salutary to note in the context of this study that the TV commercial supported by the National Safety Council,

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[57] Ibid., 92.
[58] Illich, *Limits to Medicine*, 151.
[59] Ibid., 152.

whose slogan is 'Slow down boys,' uses the image of a boy rendered disabled by a car accident to frighten young men into driving slower. The abiding image of the boy, first shown speeding, is of him sitting in a wheelchair, in an empty gym, bouncing a basketball. The monotonous, repetitive thud of the ball hitting the ground, reinforces the dull look in his eyes. The message is clear; disability is more frightening for most people than death. Medical civilisation's war against suffering has sapped the will of the people to suffer. The word suffering itself, nowadays, has superstitious undertones. The reminder that suffering is a responsible activity is 'misinterpreted as a sick desire for pain: an obscurantism, romanticism, dolorism or sadism'[60]. It is tantamount to advocating masochism in a world where only the self-punishment of the rat race is acceptable. Personal participation in facing up to the reality of unavoidable pain, is blasphemy in a consumer society. And yet this passive society still seeks stronger sensations by subjecting themselves to films containing scenes of gratuitous violence. Gorer points out that as denial of natural death increased, so did our voyeuristic fascination with violent death.[61]

Today's society cannot see in suffering a possible symptom of health. And yet health means, 'to be able to feel alive in pleasure and in pain, it means to cherish but also to risk survival'.[62] Medical civilisation, in seeing pain as a problem to be *produced* out of existence has opened up people to another kind of horror: the experience of artificial painlessness. Lifton gives an account of survivors of the bombing of Hiroshima who walked amongst the injured and dying in a state of numbness. 'They experienced their

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[60] Ibid.
[61] Gorer, 'The Pornography of Death', 51.
[62] Illich, *Limits to Medicine*, 128.

anaesthetised passage through this event as something just as monstrous as the death of those around them, as a pain too dark and too overwhelming to be confronted, or suffered'.[63] The cumulative affect of modern society's expropriation of pain is similar to the experience of survivors of Hiroshima. It creates a residual horror. It leaves a dull after-taste of meaninglessness. 'The new experience that has replaced dignified suffering is artificially prolonged, opaque, depersonalised maintenance. Increasingly, pain-killing turns people into unfeeling spectators of their own decaying selves'.[64] Is it any wonder that people seek death as an emergency exit from this kind of horror? Similarly, society's preference for the restitution narrative, to the exclusion of other stories of illness, means that people frame their experience in the language of survival. 'Professional medicine institutionalises having nothing to say beyond the language of survival'.[65] Therefore, when those who have lived their experience of illness in the language of survival find that restitution is no longer on the cards e.g. terminal illness, they find they have nothing left to say. 'It is a tragedy if having nothing left to say means that these people have no further use for themselves'.[66] The technocracy of medical civilisation that brought them to that place by treating patients as pets can then take technological intervention one further step to kill their pain permanently.

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[63] Ibid., 154.
[64] Ibid., 153.
[65] Ibid., 153,154.
[66] Frank, *The Wounded Storyteller*, 95,96.

3.6 THE RIGHT NOT TO SUFFER

'Compassion is an empathic sharing in the misfortunes of another'.[67] The original meaning is to suffer with someone (*cum passio*), but today it is taken to mean the elimination of suffering at all costs. In the case of euthanasia, the cost is the patient. In the case of abortion, the cost is a baby. Abortion has been embraced by most Western societies as a tool for eliminating suffering. Originally, it was designed to eliminate the suffering of the woman who didn't want to be pregnant. Increasingly, it has been used to eliminate the suffering of babies themselves by killing them before they are born if they have defective genes or even rectifiable conditions like cleft palate. Death is deemed preferable to any level of suffering. By subjecting children to quality control tests before they are born, we reduce the amount of suffering in the world that healthy people must witness. This seemingly makes life more pleasant for everyone. Women who are expecting twins but wanted only one baby can 'selectively reduce' their pregnancy. The following lyrics from a Leonard Cohen song called 'The Future' echoes Pope John Paul II's criticism of our culture of death: 'Destroy another fetus now/ We don't like children anyhow.'[68] Most Western nations have below replacement fertility because children require parents to make sacrifices and 'giving up something we want for the sake of something worthier, frustrates our desires and might for that reason be thought of as suffering'[69].

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[67] Raymond Jaffe, 'Conservatism and the Praise of Suffering', in *Ethics*, 77 (1967), 255.
[68] John J. Rock, '*Evangelium Vitae*: Some Highlights' in *Linacre Quarterly*, 64 (1997), 6.
[69] Stan Van Hooft, 'The Meaning of Suffering', in *Hastings Center Report*, 28 (1998), 15.

'There is a wide spread belief that stress, pain, confusion and disappointment are unmitigated evils to be shunned or 'cured' at all costs, that unruffled happiness or contentment are a human right, that a 'normal" life should be free of any sort of anxiety, conflict or vexation'.[70] This is why modern members of society (I don't use the term citizens because most are unwilling to contribute to the whole even by voting) conceive of their freedom passively, as a 'freedom not to suffer'.[71] It is freedom not to be imposed upon even in the interests of the common good.. It demands freedom from the limits of morality and the 'common-sense restrictions that have to be placed on one's personal rights when they collide with those of another person.'[72] Hence the right to life 'has come to mean the right to enjoy life – the right to be let alone"[73]. This generation uncompromisingly asserts its rights but refuses to accept its responsibilities. The rejection of suffering manifests itself in a refusal to suffer with someone, in other words to be compassionate. Thus modern 'compassion' looks for a quick-fix elimination of suffering. For example, Irish society welcomed short-term Kosovar refugees into the country but exhibits widespread resistance to long-term Romanian refugees. People suffer from compassion fatigue when problems aren't short-term.

Only our consumer society could produce advertisements for products, which show a complete lack of regard for the suffering of other peoples. One abstract commercial in a glossy magazine caught my attention. It read "millions are starving every day". It was

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[70] John F.X. Harriott, 'The Aspirin Society' in *The tablet*, 244 (1990), 334.
[71] O'Donovan, *Begotten Or Made*?, 10.
[72] Mary Ann Glendon, *Rights Talk.* The Impoverishment of Political Discourse. (New York: The Free Press, 1991), 20.

an advertisement for a nourishing conditioner for hair. Another example of this kind of fickleness is an advertisement which reads 'free the unjustly imprisoned'. It wasn't part of a campaign by Amnesty International but belonged to a footwear company – the unjustly imprisoned were feet, which should be in sandals for the summer months. The latter are obvious examples of a failure of compassion but most modern examples are subtler. It is the kind of compassion that can identify with a woman with unplanned pregnancy, but not the baby she carries. It is 'a virtue of motivation rather than of reasoning'[74]. It rushes to action without considering what is in fact the right course of action. It presupposes that an answer has already been found to the question of what to do. Inevitably, in our fast moving society, compassion is meted out with super-efficiency. If a woman becomes pregnant as the result of rape, she is offered the surgeon's table instead of a listening ear. Society assumes it's the obvious answer. The rape victim is made to feel like she is carrying a monster, not a baby. If people actually took the time to look into the matter, they might think differently. One woman, Sandra Makhorn, conducted a study researching the experience of pregnant rape victims. She interviewed a number of women, some of whom had their babies (and either kept them or gave them up for adoption) and who aborted their babies. Makhorn discovered that of those who had their babies, none of them regretted their decision. The same could not be

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[73] Ibid.
[74] Ibid.

said of those who had had abortions. The women, whose cases were reviewed in the study, who let their babies live, said it had helped to heal the horrific experience of rape because by having their babies they had responded with compassion to an innocent child even though they themselves had been treated with brutality and violence. Of the rape victims who had abortions, many experienced the abortion as a second violation and felt that it had exacerbated feelings of anger and low self-esteem caused by the rape.[75] I think the true example of compassion is not our society's approach, which pressurises rape victims into abortion, but is shown by rape victims themselves who choose to let their babies live. That decision is not easy and undoubtedly involves grave suffering and sacrifice, but it truly is compassion. Unfortunately, today's society can see no value whatsoever in suffering. It does not have the patience and selflessness that true compassion requires, so it carries out acts of grave cruelty e.g. abortion and euthanasia, in the name of compassion.

In the next chapter, we see this short-term compassion at work in relation to disabled newborn babies and dying patients. The "better off dead" approach is almost a perversion of the calm acceptance of death in the Middle Ages. I keep referring to a refusal to accept death in contemporary society. This is true because death is not accepted as a mystery or as something we must go through, but is dominated and controlled. However, manipulation takes the form of a kind of glamorisation of death when it comes to those who are suffering. Death, it seems, must be accepted at the earliest possible opportunity. Against this cultural backdrop, the Irish Muslim religious leader, at the Oireachtas Hearings on the Constitution said, in relation to the suggestion

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[75] Cf. Sandra Mahkorn, 'Pregnancy and Sexual Assault' in *Psychological Aspects of Abortion*, Mall and Watts (eds) 5(1997).

that non-viable babies be aborted: 'if they had only one day to live, let them live it.' Unfortunately, his kind of thinking is not currently en vogue. The most dangerous place for a baby to be today is in his or her mother's womb. I'm afraid that it is becoming increasingly dangerous for so-called defective newborns (a term I abhor because it is generally used in relation to goods) to be in hospital. A calculated regime of neglect is increasingly being employed in paediatrics in order to deal with 'lives not worth living.' Inappropriate quality of life judgements, leading to euthanasia, are being imposed on patients at both ends of the spectrum of life.

Autonomy is put forward as the main argument for euthanasia. The next chapter demonstrates that a false notion of freedom is certainly a major contributory factor in the acceptance of euthanasia. However, the treatment of disabled neonates, and other factors discussed later, show that at the heart of this debate is a refusal to suffer or to tolerate any level of suffering in the world.

Chapter 4: The Euthanasia Debate in its Cultural Context

4.1 DEFINING EUTHANASIA

The word euthanasia comes from the Greek 'eu' and 'thanatos' meaning good death.[1] Euthanasia today generally refers to mercy killing. 'By euthanasia is understood an action or omission of an action which of itself or by intention causes death in order that all suffering be eliminated.'[2] An example of euthanasia by commission is if a doctor were to inject a patient with a lethal dose of a drug in order to induce death.[3] Euthanasia can be performed equally by omission e.g. if ordinary means to sustain life or indeed normal care e.g. food and water are withdrawn or withheld from a patient.[4] Proponents of euthanasia generally advocate the competent consenting patient model.[5] The notion of autonomy is central to their argument. Death must not only be beneficent but the free choice of a competent patient.[6] They support voluntary euthanasia which, put simply, is the deliberate intervention of a doctor to kill a competent patient at their request.[7]

Involuntary euthanasia involves the killing of a patient with the intent to relieve suffering, without the patient's consent. For some, this term applies to any case of killing without the patient's consent.[8] However, others reserve the term for those capable of giving consent, namely competent patients. They assign the term non-voluntary

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[1] Cf. Gerard Dworkin, *Euthanasia and Physician Assisted Suicide* (Cambridge New York: Cambridge University Press, 1998),108.
[2] B. M. Ashley and K. D O'Rourke, *HealthCare Ethics. A Theological Analysis*, 4th ed., (Washington, D.C.: Georgetown University Press, 1997), 417.
[3] Cf. Canadian Bishops/Senate Testimony, 'What Euthanasia Is and What it is Not' in *Origins*, 24(1994) 394.
[4] Cf. ibid., 394.
[5] Cf. Gerard Dworkin, *Euthanasia and Physician Assisted Suicide*, 68.
[6] Cf. ibid.
[7] Cf. Richard M Gula, *Euthanasia: Moral and Pastoral Perspectives* (Mahwah, N.J: Paulist Press,1994), 6.
[8] Cf. ibid.

euthanasia for incompetent patients e.g. infants, the mentally ill or brain damaged who cannot give consent.[9]

The terms 'active' and 'passive' euthanasia are discounted by many because of their potential to confuse. The term 'passive euthanasia' is employed by some to describe the withholding or withdrawal of treatment, which is not medically indicated or proportionate.[10] However, the use of the adjective "passive" 'contributes to the notion that the removal of life support is unethical even when the treatment is futile or the burdens disproportionate to the benefits.'[11] One of the best ways to gain acceptance for the unacceptable is to confuse it with what is in fact acceptable.[12] For this reason most people in the movement for life reserve the term euthanasia for acts or omissions intended to bring about death.[13]

A further classification is at work in the euthanasia debate. If a physician does not administer death personally but helps the patients to kill themselves by providing the tools for death e.g. poison or pills, this is called physician-assisted suicide.[14] The latter appeals to many that reject straightforward euthanasia.[15] It creates the illusion of a distance between the doctor and death - dealing and in some minds helps protect the medical profession's integrity. For others, it is 'a thinly veiled attempt to soften or camouflage what is really being done because we expect physicians to care for human life, not take it.'[16]

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[9] Cf. Episcopal Diocese of Washington, D.C on Medical Ethics, *Assisted Suicide and Euthanasia, Christian Moral Perspectives* (Washington, DC: Morehouse Publishing, 1997),12, 13.
[10] Cf. Bonnie Steinbock, *Killing and Letting Die* (Englewood Cliffs, NJ: Prentice-Hall, 1980) 63.
[11] Canadian Bishops, 'Euthanasia', 394.
[12] Cf. Gula, *Euthanasia,* 5.
[13] Cf. Episcopal Diocese of Washington., 13.
[14] Cf. Gula, *Euthanasia,* 6.
[15] Cf. Episcopal Diocese of Washington.,14.
[16] Canadian Bishops, 'Euthanasia', 394.

Ethically, whatever about legally, it makes no difference because either way the physician bears moral-responsibility for death.[17] 'Putting the means in the patient's hands falls little short of administering them.'[18] Physicians who assist suicide do so because they believe it is a morally acceptable means to relieve suffering.[19] Such formal co-operation with an evil is morally unacceptable. Even if a physician expressed views to the contrary but merely went along with the patient's wishes, his actions cannot be justified. 'One has a prima facie obligation not to assist evil.'[20] In short, the distinction makes no difference to the values at stake in the euthanasia debate and so many ethicists ignore it for the purposes of moral discussion. I will do likewise.

The possibility of murder by omission is real. Omission is not merely the same as doing nothing.[21] Omission refers to the failure to do what ought to have been done. Positive action carries the presumption of intentionally whereas with omission the intention is not as clear. If an act is omitted intentionally to bring about death, the agent is as culpable as if he or she had performed a positive act to achieve the same purpose. However, an agent may neglect to perform an act for morally exculpating reasons. But if the agent's reasons were not exculpating, they bear the responsibility for the result of their voluntary action even though it was not intended.[22]

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[17] Cf. Gula, *Euthanasia*, 6.
[18] Hans Jonas, ' The Right To Die' Thomas A. Shannon (ed.), *Bioethics*, 3rd ed., (Mahwah,, New Jersey: Paulist Press, 1987), 203.
[19] Cf. Patrick Norris, ' The Movement Toward Physician-Assisted Suicide: A Step in the Wrong Direction' in *Linacre Quarterly*, 63(1995), 36.
[20] Ibid, 37.
[21] Luke Gormally, *Euthanasia, Clinical Practice and the Law* (London:Linacre Centre for Healthcare Ethics, 1994),46.
[22] Cf. Gormally, E*uthanasia, Clinical Practice and the Law*, 47.

The following is a treatment of the circumstances in which the withholding or withdrawal of means to sustain life is justifiable and does not constitute euthanasia.

4.1.1 Ordinary/Extraordinary Means

If a person is ill they are generally obliged to seek help to get better or if this is not possible, to minimise symptoms[23]. However, there are limits to the lengths we are obliged to go to sustain life. Catholic moral teaching uses the terms ordinary and extraordinary to describe treatments, which are morally obligatory or non-obligatory respectively[24]. In medicine, these terms have a different meaning. 'Physicians use "ordinary" to describe an accepted or standard medical procedure. A procedure or medicine that is new or untested or still in the experimental stage is called "extraordinary."'[25]The status of treatment as obligatory or optional, in Catholic moral teaching, depends on the patient's particular condition and sensibilities. Treatment, which constitutes a grave burden for one patient, may be quite tolerable for another[26]. Ordinary means to prolong life may be defined as 'all medicines, treatments, and operations, which offer a reasonable hope of benefit to the patient without excessive expense, pain or burden.'[27] Extraordinary means do not fulfil the above criteria and are thus optional. The terms 'proportionate' and 'disproportionate' are advocated by several ethicists such as McCormick who believe that the existing terms are circular. The terms they suggest are indeed apt to describe the underlying meaning of the traditional terms if

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[23] Cf. Luke Gormally, *Euthanasia, Clinical Practice and the Law*, 63.
[24] Cf. Ashley and O'Rourke, *HealthCare Ethics*, 420.
[25] Ibid.
[26] Cf. Luke Gormally, *Euthanasia Clinical Practice and the Law*, 63.
[27] Ashley and O'Rourke, *HealthCare Ethics*, 420.

properly defined. However, they carry 'the risk of succumbing to the proportionalist methodology on which the modernists rely, but which the encyclical the Splendour of Truth (John Paul II, 1993) has been rejected by the church[28].' The proportionalist theory, as outlined in the second chapter, permits the direct killing of innocent human beings if doing so serves to bring about a proportion of good over evil. The traditional terms retain the ethical principle, contrary to proportionalism, that euthanasia or any form of direct killing is always and everywhere wrong. At the same time they reflect the legitimacy of letting die when the benefits of treatment are disproportionate to the burdens[29].

4.2 KILLING/LETTING DIE DISTINCTION

The most obvious reason for rejecting treatment is if it is straightforwardly futile. Unfortunately, in discussing the legitimate refusal of treatment, it is necessary to make the point that no one is obliged to undertake useless treatments[30]. Society's denial of death is often carried into hospitals so that long after the possibility of cure has gone and focus should be on care, dying patients are offered potentially 'life-saving' treatment. It is a testament to realism, not fatalism, to reject such treatments. Few cases of burdensomeness are as straightforward as this. Assessing the burdens of most treatments involves consideration of risk, pain, suffering, strain on relatives, financial loss, time expended, medical resources[31]. Burdens can be personal and social; they can refer to the patient or those in attendance on the patient. The benefits of treatment must be assessed in the light of the above factors. A patient may reject treatment on the grounds that the proposed benefits are utterly disproportionate to the burdens. However, a patient may

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[28] Ibid.
[29] Ashley and O'Rourke, *HealthCare Ethics*, 421.
[30] Cf. *Gormally, Euthanasia Clinical Practice and the Law*, 63.

also legitimately refuse treatment, which promises great success but involves the burden of mutilation or a painful convalescence[32].

The intention of the patient is central to determining whether their decision to reject treatment is suicidal or ethically sound. For example, a patient in the final stages of a terminal illness may choose to forego treatment such as antibiotics, which is not in itself burdensome, but may no longer appear beneficial. This may be the result of a decision that life itself is no longer beneficial and that they're better off dead. Alternatively, it may be a manifestation of acceptance of their condition and the inevitability of death. The latter decision, unlike the former, is not a rejection of life because the patient does not seek to hasten death but believes treatment to be no longer worthwhile, being already dying[33]. A third patient may choose not to spurn what little time the antibiotics may afford. In both cases the patient's attitude is life affirming and their actions are good[34].

In a person's intention (what they are precisely aiming to achieve as distinct from motive which prompts us to action) lies the difference between killing and letting die. It is possible to kill someone or let them die for what are considered to be humane motives. However, whatever the motive, the intention/purpose/object to bring about death is opposed to respect for human life.[35] It is salutary to note that not seeking to prolong life can, at times, e.g. as in the circumstance outlined earlier, be compatible with respect for life or even a requirement of such respect. Unfortunately, some ethicists use the term 'letting die' as a euphemism for not allowing patients, such as neonates with a poor

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[31] Cf. ibid., 63.
[32] Cf. ibid.
[33] Cf. ibid., 65.
[34] Cf. ibid., 66.
[35] Cf.Iglesias, *Study guide to 'Euthanasia and Clinical Practice*, (London, The Linacre Centre, 1984), 89.

quality of life, to live. Others try to deny any moral difference between acts of omission aimed at bringing about someone's death and letting die when treatment is non - obligatory. The denial of a morally relevant distinction between killing and letting die is not the result of a desire to protect life or to promote an impossible moral concern. It is rather an attempt to muddy the waters i.e. break down the distinction between killing and letting die in order to gain acceptance for euthanasia[36]. James Rachels, the Hemlock Society and the Society for the right to die, take this approach[37].

Rachels's case against the killing/letting die distinction comes down to what he calls the 'bare difference' argument.[38] To make his point he tells a story about two characters called Smith and Jones who both stand to gain an inheritance if their respective young cousins die. Smith approaches his young cousin while he is bathing and drowns him. Jones approaches his cousin with the same intent but before he gets to him his cousin hits his head off the bath and begins to drown. Jones does nothing to save him. Rachels's attempt to discredit the traditional killing/letting die distinction doesn't work because the intent in both cases is to bring about death. Both characters have the same aim. Rachels's argument, however, is a powerful articulation of the fact that there is no morally significant difference between murder by commission or omission. Rachels doesn't prove the thesis he set out to prove.

Intention is crucial to the killing and letting die distinction. Yet in his example both Jones and Smith had the same wicked intention. He is right to say that their actions differ only in movement of bodily parts. The traditional view, which upholds the killing/letting

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[36] Cf. ibid., 17.
[37] Cf. J.P. Moreland, review of '*The End of Life*,' by James Rachels, *The Thomist*, 53 (1989), 714.
[38] Cf. ibid., 720.

die distinction, places great emphasis on the direction of the will. As outlined earlier, killing by commission or omission aims at death, the intent is to bring about death. In letting die the intent/aim is to avoid employing futile or excessively burdensome treatment. The motives in both cases can be what the agent considers humane, but a good motive cannot validate a bad intent [39]which, in this context, is to bring about death. Rachels fails to understand this distinction because he fails to understand the relationship between intention and action. He asks us to consider a second scenario.[40] Jack and Jill both visit their grandmother and cheer her up. However, what Jack intended to do was for its own sake whereas Jill's intent was to cheer up her grandmother in order to get a mention in her will. Jacks intent was good; Jill's wicked; yet Rachels believes they performed the same action. Motionally they did, but morally they did not. He fails to realise that physical movement is just part of an action. Our purpose forms our actions. Motivation moves us to action but intention is what we choose to do[41]. Motivation accompanies acts but intention constitutes them. The moral difference between the two cases for Rachels is reducible to Jack's having a good character and Jill a bad one. But, Jack and Jill's acts are morally different because of the intention. Jack's action was loving; Jill's action was mercenary. Rachels fails to debunk the traditional distinction between killing and letting die because he makes a poor case for intentions being separate from actions.

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[39] Cf. Iglesias, Study guide to Euthanasia, 17.
[40] Cf. Moreland, review of James Rachels, *The End of Life*, 719.
[41] Cf. Iglesias, Study guide to Euthanasia, 17.

4.3 AUTONOMY

Autonomy is the central argument in the moral defence of euthanasia.[42] In the prevailing climate of moral relativism, autonomy is seen as the one absolute. I suspect that the principle of autonomy which, has as its core value self-determination,[43] is revered in contemporary culture precisely because it is a panacea for modern society's failure to agree on a shared set of values. Autonomy gives everyone a licence to choose (their own concept of a good life)[44] thus allowing for what Engelhardt calls 'peaceable community'[45]. The interpretation of autonomy, which has gripped the popular imagination, is that of ethical liberalism.[46] The rights of individuals and free choice are absolutised. No one can deny that autonomy is of great good. Indeed, our human dignity is tied up with our common nature as beings bestowed with the twin-gifts of reason and freedom. However, popular culture believes that the 'sheer-fact' of choice is the sole right-making characteristic of an action.[47]. Choice has been detached from content and rights from responsibilities. The pro-choice movement's slogan "the right to choose" illustrates this. Choice must be respected even if it contradicts human welfare. In theory, ethical liberalism imposes limits on personal autonomy. One must respect the free choices of others and do no harm.[48] However, in practice we have undergone such a revolution in our self-confidence as human beings that we fail to consider or care how

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[42] Cf. Gula, *Euthanasia*, 8.
[43] Cf. ibid., 9.
[44] Cf. ibid.
[45] Stanley Hauerwas, *Suffering Presence. Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Edinburgh: T&T Clark, 1986), 9.
[46] Gula, *Euthanasia*, 8.
[47] Richard A McCormick, *Corrective Vision: Explorations in Moral Theology* (Kansas city: Sheed & Ward, 1994), 171.
[48] Gula, *Euthanasia*, 9.

our choices effect others. Abortion is perhaps the most blatant example of this. Even in less critical circumstances we view ourselves as radically individual, isolated and independent subjects rather than as relational and social beings. If we truly grasped that no man is an island we would realise that our autonomous choices have a ripple effect.

4.3.1 Bioethics, Medicine and Autonomy

Almost from the outset bioethics gravitated toward an ethics of autonomy. This was a natural and necessary reaction to medical paternalism. It represented an attempt to humble the power of physicians and gain recognition for patient rights and the need for informed consent[49]. Autonomy started out as the battle cry of the oppressed but degenerated into a rallying cry for those who elevate personal choice above all other moral considerations and values.[50] The patients rights movement went into overkill and bioethics as a field neglected the concepts of moral responsibility and the common good.

An ethics of autonomy had as its model for the doctor-patient relationship the business contract.[51] The patient became an autonomous agent, which demanded a service to be provided by the doctor. Medicine has been transformed from a profession determined by an internal ethic, the Hippocratic oath and a profound commitment to care for the sick, to a consumer industry.[52]Engelhardt approves of an ethos of freedom in which the doctor becomes a high-powered mail carrier who delivers a medical journal or porn magazine

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[49] Cf. Daniel Callahan, 'Bioethics,' 7.
[50] Cf. Thomas H Murray, 'Communities Need More Than Autonomy' in *Hastings Center Report*, 24 (1994), 32.
[51] Cf. ibid.
[52] Hauerwas, *Suffering Presence*, 9.

with equal reliability.[53] In moral theory and medical practice, our ethics of autonomy reduces loyalty, integrity, solidarity and other such moral concepts to interesting curiosities or idiosyncratic preoccupation.[54] Unfortunately, there is nothing in his ethos of freedom, outside of market forces, to tell us why society should set aside some of its members to care for the ill. There is nothing in his theory to support a moral commitment to care for the sick, disabled and dying.[55] His freedom easily turns into tyranny of the powerful over the weak. Hauerwas believes that 'a peaceable community is finally possible, not when there is merely a willingness to live and let live, but only when freedom is supported by a profound commitment to the protection and care of each person's life.'[56] To sum up, in underwriting the demands of autonomy, bioethics has created a moral vacuum.[57] Autonomy does not counsel us to ask what is the right thing to do but rather asks is the decision free.[58] Attention is diverted away from the moral character or content of choice. Moral responsibility is overshadowed by freechoice. Bioethics as a field fails to capture or convey the idea that individual autonomous choices sooner or later create a culture. What of the common good?

4.3.2 The Common Good

The common good argument hasn't gained a foothold in the euthanasia debate because it is countercultural.[59] The slippery slope or thin edge of the wedge argument does not bear much resonance in the current climate of ethical liberalism. Individuals are encouraged

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[53] Cf. ibid.
[54] Cf. Murray, 'Communities need More than Autonomy', 32.
[55] Hauerwas, *Suffering Presence*, 15.
[56] Ibid., 14.
[57] Cf. Callahan, 'Bioethics', 29.
[58] Cf. Murray, 'Communities need More Than Autonomy', 32.
[59] Cf. Gula, *Euthanasia*, 18.

to pursue and satisfy their personal goals without regard for how it impacts on the well - being of society.[60] Moreover, rampant individualism has made people sceptical of the concept of the common good itself. Many people do not believe that there could be a good for the collective beyond that which each individual subjectively perceives to be good.[61] In a post-Christian culture, there is little sense of the human person as a social being. The Christian tradition has always affirmed that the good of the person emerges in relationship, not in isolation.[62] In any case, relationship is a given. It's not something we necessarily choose, it just *is*. The catholic moral tradition recognises limits to personal freedom in order to protect the dignity of every human being.[63] It rejects an individualist interpretation of rights.[64] Rights in the Christian understanding bind us together by fostering mutual respect in our common life. They look to the other person, not to oneself. To sum up, the principle of the common good is an integral part of the catholic tradition on social justice. It recognises the need to assess individual choices in the light of social responsibilities.[65]

Euthanasia is a profoundly social decision. Any death is not simply a personal matter. It effects the lives of many people. Euthanasia involves the one to be killed, the one doing the killing and hence his or her entire profession and a compliant society.[66] Autonomy hardly seems an adequate justification for a decision, which has far reaching

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[60] Cf. ibid.
[61] Cf. Gula, *Euthanasia*, 15.
[62] Cf. Canadian Bishops, 'Euthanasia', 394.
[63] Cf. ibid., 395.
[64] Cf. ibid.
[65] Gula, *Euthanasia*, 15.
[66] Ibid., 18.

social implications. Individuals have duties in justice to other members of society.[67] The suicide of an individual person affects the entire collective by discouraging others in their task of living.[68] The experience of euthanasia in the Netherlands shows the social effect of personal choice. What started as individual autonomous choice degenerated into an involuntary euthanasia for many of Holland's elderly?[69] Euthanasia is an area in which the interests of the individual simply cannot be separated from the common good.[70]

4.3.3 Human Freedom

In the encyclical Veritatis Splendour, John Paul II spoke of "an illusory freedom apart from truth itself".[71] He was referring to the current crisis in morality owing to the contemporary denial of the dependence of freedom on truth. (VS n.32.) Freedom itself becomes the source of values. (VS n.32.) A primacy of conscience is asserted over a primacy of truth. Conscience no longer judges the truth but decides "autonomously" according to subjective criteria what to call the truth e.g. "being at peace with oneself".(VS n.32.) The pope rejects such moral theories, which make the subject interpret the criterion for good and evil. He condemns utilitarian moral theories such as 'consequentialism' and 'proportionalism'.(VS n.75.) Moreover, he asserts against such theories that there are acts, regardless of intention and circumstances, which are intrinsically evil. (VS n.75.)

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[67] John Finnis, 'A philosophical case against Euthanasia' in John Keown (ed.), *Euthanasia Examined. Ethical, Clinical and Legal perspecitves* (Cambridge, NY: Cambridge University Press, 1995), 33.
[68] Ashley and O' Rourke, *HealthCare Ethics*, 420.
[69] John L Fleming, 'Euthanasia; human rights and inalienability' in *Linacre Quarterly*, 63 (1996),49.
[70] Canadian Bishops 'Euthanasia', 396.
[71] Pope John Paul II, Encyclical Letter *Veritas Splendor*, n. 1.Hereafter, VS and cited in body of text.

The Christian tradition does not equate freedom with control. True freedom rests in embracing the truth. (VS n.41.) The moral law is freedom. Moreover, the Christian tradition recognises 'that only the God of Creation has absolute dominion over creation and that creatures share in his dominion in a limited sense i.e. as stewards.[72] John Paul II sums up this freedom well when he says:

> The man is certainly free, inasmuch as he can understand and accept God's commands. And he possesses an extremely far-reaching freedom, since he can eat of every tree of the garden". But his freedom is not unlimited; it must halt before the "tree of the knowledge of good and evil" for it is called to accept the moral law given by God. In fact, human freedom finds its authentic and complete fulfilment precisely in the acceptance of that law. (VS n. 35.)

The forbidden fruit in the Garden of Eden symbolises a mastery of life and autonomy inappropriate for being human.[73] The reality of death itself points to our limited mastery over our own lives. To seek to control death through euthanasia is to seize for one-self a divine prerogative. Our freedom in death is the freedom we have in any situation in which we feel like we are not in control, namely the attitude we take to our situation. We can exercise our freedom in death by choosing to surrender to God in calm acceptance of our creaturehood. However, our freedom does not legitimately extend to absolute control over the time and manner of death.

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[72] Gula, *Euthanasia*, 13.
[73] Ibid.,12.

4.3.4 Autonomy and Human Dignity

The autonomous individual in control of his destiny has been glamorised to such an extent that dependency is seen as an intolerable indignity. This is why many people view death as preferable to disability and why many choose to take control of the precise time and manner of their death rather than suffer the vulnerability of dying. Euthanasia will always appear tempting if we see the individual as the centre of the universe. It's frightening to face death as an ego. The Christian faith encourages us to face death as a radically relational subject that is never alone but exists and is sustained in solidarity with fellow human beings and the trine self of the One God.[74]

The identification of human dignity with autonomy is pivotal in many pro - euthanasia arguments. John Harris advocates for euthanasia on the grounds that we respect human dignity only to the extent that we respect personal autonomy.[75] He believes that human life isn't intrinsically valuable. The value of our lives is subjective. If the individual doesn't value his or her own life then it isn't valuable! Euthanasia in such a case is perfectly legitimate because it destroys nothing of value. The problem with the understanding of human dignity as wholly dependent on autonomy is that the lives of those who, for whatever reason, do not possess or cannot exercise even minimal capacity for choice, are worthless. Human life itself, according to Harris is not valuable, only

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[74] Dermot A. Lane ' The Changing Experience of Death' in *Doctrine And Life*, 7(1996), 429.
[75] John Finnis, 'A philosophical case against euthanasia', 44.

certain individual lives.[76] He calls such human beings persons. According to Harris, belonging to the human family or 'species' does not qualify one for human rights. One has to be in possession of certain capacities or powers, namely intelligence and autonomy to warrant respect or protection. To sum up, Harris began by arguing for voluntary euthanasia on the grounds that we respect human dignity to the extent that we respect personal autonomy. He clearly identified human dignity with personal autonomy. This argument, taken to its logical conclusions, as Harris does, also justifies involuntary euthanasia. Non-autonomous human beings are defined as having no human dignity, as non-persons, as disposable.

There are so many holes in Harris's argument that it can't stand up. To suggest that human dignity is subjective is ludicrous. "Human dignity either means the same thing for all human beings or it has no moral meaning at all."[77] Moreover, "it is self-contradictory to make an objective claim about a subject that one asserts is not objective".[78] Thirdly, if human dignity is subjective, one can never ascertain when it is present and when it is not because it is dependent on the persons state of mind or mood which is ever changing.[79] Finally, it goes against our moral instincts, whatever the cultural biases, that those who are incapable of exercising autonomy or subjectivity are without dignity e.g. the severely disabled, the comatose or the mentally ill.[80] By Harris's definition, a charming pig would have more dignity than some of our fellow human beings. Harris is wrong to suggest that human dignity is purely subjective or to suggest that those who have lost control of certain functions or who have never had the freedom to make choices, have no dignity.

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[76] Ibid., 10.
[77] Daniel P. Sulmasy, 'Death and Human Dignity' in *Linacre Quarterly*, 61(1994), 27.
[78] Ibid.
[79] Cf. ibid., 29.

There is an alternative basis for human dignity which does not produce such awkward moral conclusions namely, human beings have dignity, simply because they are human.[81] Dignity rests in our common nature, not in our individual characteristics. In short, human dignity is not dependent on autonomy or subjective choice.

4.3.5 Is it really about autonomy?

'The plea "kill me: I need death but cannot kill myself", is a dubious example of self-determination.'[82] Is autonomy as the central argument in the moral defence of euthanasia, convincing? Far from returning control to the patient, euthanasia medicalises suicide thus granting control of dying to medicine and society.[83] Euthanasia does not demedicalise death. It involves medical intervention and in fact medicalises suicide. Therefore, euthanasia does not as its proponents suggest, enhance patient autonomy but rather turns what they propose is a private intimate moment into a clinical event.[84] This serves to empower doctors not patients. If proponents of euthanasia truly favoured autonomy, why do they not seek to end the physicians exclusive power to prescribe medication?[85] This would better serve their objectives, when one considers that euthanasia does not require skill.[86] Fear of botched attempts at suicide is not as

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[80] Cf. ibid.
[81] Cf. Sulmasy, 'Death and Human Dignity', 30.
[82] Gormally, *Euthanasia, Clinical Practice and the Law*, 42.
[83] Cf. Tania Salem, 'Physician -Assisted Suicide, Promoting Autonomy - Or Medicalizing Suicide?' in *Hastings Center Report*, 29(1999), 30.
[84] Cf. ibid., 32.
[85] Cf. ibid.
[86] Cf. ibid.

convincing an argument as the general public's desire to distance themselves from direct killing.[87] Suicide still has a stigma. Therefore, instead of empowering patients, proponents of euthanasia seek to draw on the physicians '*social and symbolic power already conferred on medicine and medical professionals in our societies*'[88] in order to legitimate suicide. The euthanasia debate is really about something beyond autonomy. It has to be when we consider that euthanasia requires the person to submit to medical surveillance. This constitutes 'an outrage to autonomy as this value is classically defined.'.[89]

Society, not the individual takes control. The modern project as outlined in chapter two, is based on control, in particular over the contingency of nature. Perhaps euthanasia, which involves death being "managed" by society, represents its best attempt to neutralise the threat death poses to high modernity itself, the cultural status quo. If euthanasia isn't about individual autonomy, it is clearly about the contemporary loss of meaning in suffering. I fear it also represents a denial of the human dignity of the suffering themselves. Otherwise, how could we justify the elimination of suffering at the cost of the sufferers?

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[87] Norris, The Movement Toward Physician Assisted Suicide', 33.
[88] Salem, 'Physician -Assisted Suicide, 33.
[89] Ibid.

4.4 ...SOME ARE MORE EQUAL THAN OTHERS

If euthanasia was about empowering people, then one would expect the groups representing those affected to be heading the change. However, of all the groups representing the terminally, few are pro-euthanasia. One is hard-pressed to find a pro-euthanasia position among groups representing senior citizens or among all the groups that represent those whom on a daily basis care for those in extreme circumstances of debility and illness.[90] Groups representing people with disabilities have been at the forefront of opposing legalised euthanasia around the world. They were instrumental in turning around the Canadian senate inquiry. They don't believe euthanasia is about autonomy but about human dignity, about who is considered valuable and who is considered disposable. The coalition of organisations for voluntary euthanasia has told them as much. 'It has, as one of its commitments that legalised euthanasia should apply to people with disabilities even if they do not have a terminal illness. You do not have to look far to find the slippery slope.'[91] Euthanasia is the solution offered to the people who proponents of euthanasia believe would be better off dead. The rest of society is protected against suicide. Legally we must not incite anyone to suicide and we certainly cannot assist him or her. Society puts support measures in place for such people because we believe their suicidal intention is irrational. Their request for death is treated differently. Their autonomy is not respected because they are believed to have a worthwhile life. It seems that society is quick to judge a life of sickness or disability as

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[90] Tony Burke, Executive Director of Euthanasia No! Address to the New South Wales Legislative Assembly, 16 October 1996.
[91] Ibid.

worthless. The following case example illustrates this point: a healthy person and a person with clear disability who is dependent on treatment to continue living and thus fulfils criteria for terminal illness both present to a physician with the same request for a lethal injection. They both possess the same autonomy, the same choice, and the same rights. Yet the physician will refuse the healthy person and fulfil the sick person's request. His actions say to the healthy "no, you're valuable. We can help you through this" and to the disabled or sick "yes, that's a logical choice".[92] The category currently en vogue at both edges of the spectrum of life, is sickness and disability. Today, discrimination on the grounds of race or religion is illegal. We have revamped one Nazi category and rejected two others. Shouldn't we reject all? Surely the same recognition of and respect for human dignity should apply equally to all human beings? Euthanasia is an assault on human dignity because it suggests that the patient's life has lost all meaning and value.[93] Disease and illness are an affront to human dignity. Medicine exists to serve the dignity of persons whose dignity is called into question by sickness. When it can cure, it should; when it can't, it should care. 'It is not easy to remind the dying of their dignity. But that is precisely what it means to comfort the dying.'[94] If the sick, the disabled or the dying feel worthless and request death, what is the compassionate response? Is it to confirm their fears, which they may have imbibed from wider culture, or to reaffirm their dignity. This question is taken up in more detail in the last chapter.

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[92] Ibid.
[93] Sulmasy, 'Death and Human Dignity', 31.
[94] Ibid., 32.

4.5 INAPPROPRIATE QUALITY OF LIFE JUDGEMENTS

Contemporary attitudes to suffering best find expression in quality of life judgements used as the basis of choices for actions or omissions intended to bring about or hasten death. Their quality of life judgements base the value of a person's existence on their quality of life. The value of the person's life is reduced to their particular condition[95]. Typically, lives that manifest extensive suffering or handicap are judged not worth living. At times, if someone dies after a long illness, we may say it was a 'mercy' because his or her suffering is over. But this isn't the same as a philosophy, which asserts that the quality of a person's life is an adequate basis for deciding to suppress his existence[96]. Because of our nature as spiritual beings, the meaning or value of our existence can never be known to anyone in this world. An agent may be acting from what he perceives to be humane or compassionate motives when he judges someone to be better off dead. But none of us can claim to be able to judge someone's life not worth living. Theories which advocate such judgements, are particularly worrying where incompetent patients are concerned. Babies do not have the capacity to consent to treatment decisions, therefore euthanasia of the newborn is necessarily involuntary[97]. It is salutary to note the comment of one paediatric surgeon that 'the immediate survival of the infant depends to a large extent on the attitude of those in attendance.'[98] If those in attendance take the popular attitude that suffering is an unmitigated evil and claim to be able to judge the value of a person's continued existence, the consequences can be drastic. There is weighty

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[95] Cf. Iglesias, *Study guide to Euthanasia*, 23.
[96] Cf. Gormally, *Euthanasia, Clinical Practice and the Law*, 43-44.
[97] Cf. ibid., 15.
[98] Ibid.

evidence to suggest that euthanasia by omission has become common in paediatrics. Euthanasia if it was practised in the 1950's was covert, but in recent decades it has become overt[99]. It is often 'a management option for children with spina bifida and those with Down's syndrome complicated by duodenal atresia'[100]. This new ethic' which imposes value-judgements on congenitally handicapped new-borns is in danger of usurping the traditional sanctity of life ethic. The traditional ethic maintains that a person's worth or value is not reducible to their particular condition, however damaged. It confines itself to evaluating treatment, not lives. Any assessment of treatment will involve consideration of how it impinges upon the patient's quality of life. However, decisions not to treat will be the result of a judgement that the benefits of a proposed treatment are utterly disproportionate to the burdens rather than an impossible calculation that a person's continued existence is not worthwhile. The traditional position acknowledges that physical life is not an absolute good, which outweighs all burdens, required to preserve it. However, it places all decisions concerning treatment in the context of respect for the inherent dignity of every human life. To sum up, the traditional ethic focuses on 'the advantages and disadvantages of specific possible treatments, given their effects, side effects and outcome. It does not enquire about, let alone focus upon the worth-whileness of the patient's being alive at all'[101]. The traditional ethic, which judges means to preserve life, requires us to ask; is the treatment effective?'or "Do its benefits

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[99] Cf. Gormally, *Euthanasia, Clinical Practice and the Law*, 16.
[100] Iglesias, *Study guide to 'Euthanasia and Clinical Practice'* 27.
[101] Gormally, *Euthanasia Clinical Practice and the Law*, 44.

outweigh its burdens?" And not as Richard McCormick advocates 'Granted that we can easily save the life, what kind of life are we saving?'[102]

Richard McCormick argues for the use of judgements on the quality of patients lives as the basis for decisions 'To Save or Let Die' in his essay of the same name. He believes that there comes a point at which life that can be saved is not 'meaningful life'[103]. He acknowledges that quality of life judgements pose a 'frightening task' and put this down to the fact that they cannot always be accounted for rationally.[104] Nevertheless, he argues for their necessity and says that if we err, we must err on the side of life. McCormick glosses over our fear of such judgements. They frighten us not because the task is difficult (it is in fact impossible) but because it is wrong. My generation likes to see itself as having only a future and no past, but the horror of the Nazi quality of life judgements on a massive scale in 1930's Europe is still deeply embedded in the Western psyche. Advanced technology allows eugenic decisions to be carried out discretely within that womb thus masking the horror. However, few embrace the frankness of Joseph Fletcher who argues that "it is wrong, immoral and irresponsible – not to back up abortion with the measures required postnatally to end damage in cases in which a child is born with Down's syndrome[105] The fact that many employ a regime of calculated neglect to achieve death for 'defective' infants and call it 'letting die' indicates that we are still not completely comfortable with the reality of judging some people better off dead. Perhaps this fear, which McCormick believes we ought to

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[102] Richard A McCormick, To Save or Let Die, Thomas A. Shannon (ed.), *Revised Bioethcis* (Mahwah,, New Jersey: Paulist Press, 1976), 164.
[103] Cf.ibid., 164.
[104] Ibid., 161.
[105] Joseph Fletcher, 'Abortion, Euthanasia and the Care of Defective Newborns' in Thomas A. Shannon (ed.), *Revised Bioethics* (Mahwah,, New Jersey: Paulist Press, 1976), 16, 17.

conquer, is the natural revulsion of our moral instincts to a wrongful judgement – the judgement of "lives not worth living." Moreover, I find it ironic that McCormick advises that we presume *in favorem vitae.* The latter rule of thumb is supposed to protect against the imposition of our value judgements upon incompetent patients[106]. Yet, McCormick invokes it as something to make value judgements safer. In another discussion, McCormick argues for quality of life judgements to determine the value of continued existence. He quotes approvingly Judson G Randolf, a chief surgeon in 'Children's' Hospital Medical Centre, Washington, D.C as follows:

> If a severely handicapped child were suddenly given one moment of omniscience and total awareness of his or her outlook for the future, would that child necessarily opt for life? No one has yet been able to demonstrate that the answer would always be 'yes'.[107]

This is an innovative way of imposing value judgements on a handicapped child from the entirely inappropriate perspective of normal adult experience. A normal healthy adult having known and lived all the benefits of health would naturally be appalled by the prospect of a life of severe handicap[108]. Yet, people with a disability from birth can oftentimes take it largely for granted having never experienced life without disability. The fact is, severely handicapped children don't get such moments of illumination as McCormick refers to, nor would if be to their advantage if they did. This hypothetical argument is not only irrelevant but dangerous because it gives us a vehicle to judge the

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[106] John Finnis, 'A philosophical case against Euthanasia' , 212-213.
[107] Richard A McCormick, *How Brave A New World? Dilemmas in Bioethics.* (London: SCM Press, 1981), 400.
[108] Iglesias, *Study guide to Euthanasia,* 103.

quality of a persons life from our own cosy standards while putting that judgement in the child's mouth so as to appear more reasonable and humane.

What is commonly referred to as the John Hopkins case brought the practice of euthanasia by omission in relation to defective new-borns into the open. The case occurred in 1963 in the John Hopkins University Hospital but was not publicised until later[109]. Since then it has been the subject of much discussion. A baby born with Down's syndrome was denied an operation to remove an intestinal blockage. The operation was minor, similar in scale to an appendectomy[110]. The baby could not be fed until the blockage was removed because to do so would kill the baby. The parents refused consent for the surgery and the hospital sought no court order to protect the baby's life[111]. The baby starved to death after fifteen days.

The benefits of the treatment clearly outweighed the minor burden of relatively easy and low risk surgery. Without the operation it was clear that the patient would die. A normal child would have been given the operation and no competent patient would have refused it for themselves[112]. The surgery was denied precisely because it would have preserved life, - a life judged not worth preserving[113]. McCormick believes that this quality of life judgement was incorrect because it didn't consider or else misjudged the child's capacity for relationship. He believes we need clearer criteria for making quality of life judgements. He still insists on their necessity but says we need to decide where to draw the line based on relational capacity.[114] He doesn't face up to the fact that it was a

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[109] G. Grisez and J. M. Boyle, *Life and Death with Liberty and Justice. A Contribution to the Euthanasia Debate*, (Notre Dame: University of Notre Dame Press, 1979), 16.
[110] Gormally, *Euthanasia Clinical Practice and the Law*, 45.
[111] Grisez and Boyle, *Life and Death with Liberty and Justice*, 16.
[112] Ibid., 272.
[113] Ibid.
[114] Cf. McCormick, 'To Save of Let Die', 164.

quality of life judgement that killed the child at the centre of the 'John Hopkins case'. The ordinary/extraordinary means approach could never have allowed it. It is quality of life language and the values it upholds, namely judging some lives not worth preserving, which incites such injustice. Are McCormick's quality of life judgements, based on relational capacity, any better? For a human being to lose a capacity, even one we prize as highly as 'relational capacity', is to lose a quality. It is not however, to lose one's life, the value of one's existence or one's dignity.[115] In his book 'Corrective Vision' McCormick argues against positive eugenics because 'We can begin to value the person in terms of the quality. In other words we reduce the whole to a part.'[116] Yet, isn't this precisely what McCormick advocates in 'To Save or Let Die?" In corrective vision he says, 'people who do that are on their way to doing other things civilised societies should abhor.[117]' I agree and I believe that euthanasia of newborn babies is a prime example of this. It fulfils postnatally what only Fletcher will publically advocate,, namely the widespread eugenic programme carried out in contemporary culture *in utero* and sanctioned by leaders such as Tony Blair who allows for restrictions on killing healthy babies in the womb but supports the abortion of disabled babies up to birth. That is the clearest revelation of all about how we chose to deal with the sick in our society.

McCormick makes the assertion that quality of life judgements are just a clarification on the traditional sanctity of life ethic. He argues that it is the quality of life after treatment that establishes the treatment as extraordinary. This isn't true. It is the relationship between the burdens of treatment and its proposed benefits, including those

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[115] Gormally, *Euthanasia Clinical Practice and the Law*, 45.
[116] McCormick, *Corrective Vision*, 168.
[117] Idem, 'To Save or Let Die' 168.

to quality of life, which establishes the treatment as ordinary or extraordinary.

In McCormick's ethic, the treatment is irrelevant because he has decided in advance the categories of life worth saving and worth what he calls 'letting die'. (McCormick believes that quality of life judgements should be made on the basis of relational capacity associated with certain medical conditions.)[118] Quality of life judgements are made in isolation from treatment considerations and are the final truth of the decision to treat or not to treat.

Once again McCormick claims to have common ground with the traditional ethic when he agrees that all lives are of incalculable value. However, he argues that in a certain condition such lives have 'reached their potential'[119] This is a euphemism for "they're better off dead." Such a calculation is an assault on their human dignity and at variance with his claim to recognise the incalculable value of every human life.

McCormick asserts that life should only be preserved as the basis of other values.[120] He believes that the Judaeo-Christian tradition supports his claim. He says that if we unpack the implications of the limits on the duty to prolong life in the Christian tradition this becomes clear. It is true that the Christian tradition does not see life as an absolute good. It can be an affirmation of human dignity to sacrifice one's life for a higher value or to forgo expensive medical treatment in order to spare one's family financial ruin. There are other examples mentioned in an earlier section, but none of them involve judging a life not worth living. The traditional ethic recognises the intrinsic value of the

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[118] Cf. McCormick, 'To Save or Let Die', 165.
[119] Ibid.
[120] Ibid.

human person as a being destined for good. Nothing can destroy the dignity of being made in the image of God. Life is not simply a *bonum utile.*

> Life is not only a condition which is necessary if a person is to achieve higher values. It is an intrinsic aspect of human flourishing; it directly contributes to the full dignity of the human person. Hence although human life is not absolute or superior to all other personal goods, neither is it instrumental'.[121]

This leads us on to our next question, namely the dualistic interpretation of human nature, at work in relation to patients who are severely brain injured.

4.6 A DUALISTIC INTERPRETATION OF HUMAN NATURE

The medicalisation of suffering effected our self-conception as human beings as outlined in chapter three. 'Deconstructing mortality' led to the body being divided up into component parts to be fixed. The body came to be seen as vehicle or place which was inhabited by the human person. Our response to patients in what is commonly termed persistent vegetative state (P.V.S.) reflects a dualistic interpretation of human nature. The treatment of these patients is a much disputed question in the euthanasia debate. It is a complex debate at the centre of which is the question of the artificial delivery of nutrition and hydration (ADNH). Some ethicists argue that it constitute medical treatment and may be withdrawn under the benefit versus burden test. Others maintain that it is part of normal or 'comfort care' and that its withdrawal amounts to euthanasia by omission.

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[121] Gormally, *Euthanasia, Clinical practice and the Law*, 379, 380.

The main argument against ADNH as medical treatment is the simple fact that food and water are the basic necessities for life. 'Unlike medical treatment, all people require them whether they are well or ill'[122]. The provision of food and water is part of normal or comfort care afforded to all patients, like protection from exposure, or hygienic care. A few inches of plastic tubing do not magically transform food into medicine.[123] 'Nourishment and hydration are not in themselves medicines or treatments for any malady except their lack'[124]. It can be argued that the withdrawal of ADNH from patients in PVS constitutes aiming at their deaths. If one removes a respiration there is a possibility that the patient will begin to breathe spontaneously e.g. Karen Quinlan. Unlike air, we can't just start drawing in food. This leads some to say that the removal of food is tantamount to sucking the air out of the room.[125]

On the other hand, plastic tubing may not transform food into medicine, but plastic tubing itself is a treatment for a loss of function, namely the inability to digest food. Food is a universal need, but plastic tubing is not.[126]

Whatever one's position on the status of ADNH, the decision to suppress the existence of certain human beings on the grounds that it is merely biological, employs dualistic reasoning. ADNH is seen as useless and best removed because it treats a mere body, the real person having long since departed. This view fails to realise that 'the human being's

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[122] Robert Barry, 'Feeding the Comatose' in *The Thomist*, 53(1989), 30.
[123] Cf. Stephen J. Heaney 'You Can't Be Any Poorer Than Dead': Difficulties in Recognizing Artificial Nutrition and Hydration as Medical Treatment', in *Linacre Quarterly*, 61 (1994) 79.
[124] Ibid., 82.
[125] Cf. Ibid., 85.
[126] Cf. Ibid., 83.

life is not a vegetable life supplemented by an animal life, supplemented by an intellectual life; it is the one life of a unitary being.'[127]

Human bodily life is the life of a person until that person dies. Death occurs when an organism 'ceases to function as a specific unified homeostatic system and becomes disorganised into a mere collection of heterogeneous substances'[128]. Once the unifying life principle is present, so is the human person, no matter how damaged. Advocates of feeding patients in P.V.S. see this as caring for the embodied person. P.V.S. is a severe brain injury not a fateful disease.[129] Yet it seems that society would be a lot happier if such patients would just die. We seem to be particularly troubled by the 'biological tenacity'[130]of the 'cognitively compromised.'[131]Are we projecting our fear on to patients in P.V.S:

> Does the fact that they are cognitively compromised confront us with our deepest fears of our own fragile purchase upon the control that accrues to the cognitively powerful? Because we find their wounded plight troubling, have we explored sufficiently the reasons why we are troubled by their "biological tenacity?" Have we probed sufficiently our own fears of mortality, and our own discomfort in living with those who most acutely manifest our frail humanity?[132]

Christians reject death of the neo-cortex as a definition for death. "My identity is the identify of the whole organism, even if the higher functions of personhood are seated in the brain. How else could a man love a human and not merely her brains?"[133] The dignity of the human person, as an ensouled body, must be respected unto death as

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[127] Finnis, 'A philosophical case against Euthanasia', 31.
[128] Ashley and O' Rourke, *Health Care Ethics*, 400.
[129] Jeremiah J. McCarthy 'Caring for the critically Ill Patient in a Persistent Vegetative State: Must Nutrition and Hydration Support Always be Provided?' in *Linacre Quarterly*, 61(1994), 67.
[130] McCarthy 'Caring for the Critically Ill Patient...' 63. Quoting a phrase used by Daniel Callahan in his essay 'On Feeding the Dying, *Hastings Center Report*, 13(1983), 22.
[131] Ibid., 73.
[132] Ibid.
[133] Grisez and Boyle, *Life and Death with Liberty and Justice* , 71. (F.Robert Veatch's Analysis.)

defined earlier. Patients in P.V.S are still persons because they belong to the human family, not the animal kingdom. That kind to which they belong is characterised by rational nature[134]. Attacks on their humanity and personhood constitute and attempt to deprive them of their rights as human persons. We should stop using dehumanising language when referring to brain injured patients. Human beings cannot be in a 'vegetative' state. Humans, animals and plants all share certain functions. But biological life is specifically different in each of these species. That is not a speculative statement but a matter of fact which, even minimal knowledge of biology confirms.[135] Each of these species, while performing similar functions, perform them in a way proper to themselves. We perform our so-called vegetative functions i.e. assimilate food, grow, reproduce etc., in a human way, not in an animal or plant way. 'To be able to do some of the things a plant can do is not to be a plant; to be partly perfected by activities common to animals and plants is not to be partly a plant.'[136] Perhaps we should refer to the patients we are currently discussing as being in a *persistent non-responsive state.* At least this way we do not pre-empt the debate on the provision or withdrawal of ADNH by dehumanising the patients in question.

In the highly publicised case of Tony Bland, the Law Lords decision to approve the withdrawal of tube-feeling was based on a 'medical judgement that tube-feeding had become futile because continued existence in Tony Bland's condition was not a benefit; in other words, Tony Bland's existence was without worth or value.'[137] For starters, none of us created Tony Bland and us mere mortals are incapable of calculating his value.

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[134] Gormally, *Euthanasia, Clinical practice and the Law*, 41.
[135] Cf. Grisez and Boyle, *Life and Death with Liberty and Justice*, 373.
[136] Ibid.
[137] Gormally, *Euthanasia, Clinical Practice and the Law*, 143.

Secondly, if this judgement is accepted as a practical judgement for making life and death decisions, how would it be limited so as not to justify killing any patient whose life was full of pain and misery? Thirdly, the emphasis on patient autonomy in bioethics was a response to medical paternalism. In Bland, we have an example of court approved medical paternalism whereby a group of citizens, doctors, are deciding whether certain patients live or die based on their opinion that they represent lives not worth living. This is even more unjust than the medical paternalism which went before because '"their medical qualifications, experience ant ethos confer no standing to settle for the whole community such issues of meaning, consistency, humanity and justice."'[138]

It is not doctors alone, but all members of society that must debate and agree a shared set of values. I don't believe that we, as a society, should accept the kind of discrimination against the sick and the disabled based on an absolute rejection of suffering. Nor should we accept killing as a solution to any social problem. In order to counter this culture of death, value must be restored to the sick and the dying, and meaning restored to suffering. I believe that only the Christian vision of the dignity of every human being, the Christian concept of mercy and the Christian meaning of human suffering is capable of bringing about this change in attitudes.

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[138] John Finnis, Bland: *Crossing the Rubicon?*, (1993), 109, as reported by Dieter Giesen 'Dilemmas at life's end: a comparative legal perspective' in John Keown (ed.), *Euthanasia Examined. Ethical, Clinical and Legal Perspectives* (Cambridge, NY: Cambridge University Press, 1995), 210.

Chapter 5: A Christian Response

5.1 MEDICINE, CHRISTIANITY AND COMPASSION

Medicine and the Church have a centuries old history.[1] Western medical tradition has its roots in early Christianity and classical Greek civilisation.[2] The latter furnished the tradition with the two vital components of rational medicine and ethics, but only Christianity was capable of providing compassion.[3] It was a Christian concern for the sick that gave rise to the first hospitals.[4] Christians organised themselves to care for the sick. They were following the example of Christ. One third of Mark's Gospel is taken up with telling of how Jesus cured the sick. In Luke's Gospel, Jesus commands his apostles to do two things, namely to heal and to teach. The Church recognised that God usually works mediately, through secondary causes in the world, rather than through miracles, therefore it promoted care of the sick through medicine.[5] In the West, medical charity was shaped by the Christian understanding of the intrinsic, and equal value, of all human beings.

Today, we take compassion largely for granted, viewing it as an instinctive reaction to human suffering. However, like all ideas, it grew up at a particular time and place in history. Compassion for the sick was based on the doctrine of *imago dei* which held that all human beings were made in the image and likeness of God and therefore have equal dignity. It is argued that the Greeks did not have an ideological basis for valuing the

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[1] Cf. Russell E. Smith, 'Medical Ethics: An Offspring of the Church' in *Dolentium Hominum* 15 (1990), 39.
[2] Cf. Gary B. Ferngren, 'Medicine and compassion in early Christianity' in *Theology Digest* 26/4 (1999) 315.
[3] Cf. ibid.
[4] Smith, 'Medical Ethics: An Offspring of the Church', 40.
[5] Ibid.

equal dignity of all human beings.[6] This is because the Greeks did not believe that emotion was a desirable basis for action. They valued reason alone.[7] Therefore, they did not have an ideological basis for providing personal charity let alone corporate charity. Unlike the God of Christianity, the pagan gods were thought to favour the powerful rather than the poor. Greeks directed general beneficence at all citizens but they didn't have a preferential option for the marginalised. Early Christianity was changing the world, according to the esteemed historian Henry Sigerist, who said that Christianity introduced 'the most revolutionary and decisive change in the attitude of society toward the sick.' The sick person's position in society was utterly elevated.[8]

Christian ministry to the sick started out small and mushroomed. The Christian organised care of the sick was very extensive in the cities. Alms were collected and distributed to the poor. Care of the sick, at the outset, involved simple nursing rather than therapeutic medicine.[9]

The plague, which broke out in 251A.D, gave the Christian initiative added impetus. The civic authorities had no programme for the treatment of the sick and simply made supplications to the gods. Christians, who were being persecuted at the time, used their existing network to care for the sick and even branched out by caring for their persecutors.[10] The death toll was high among the cared for and the carers alike. The bishop of Alexandria lost his best brother to the plague. The plague, while devastating,

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[6] Cf. Ferngren, 'Medicine and compassion in early Christianity', 317.
[7] Cf. ibid., 316.
[8] Cf. ibid., 318.
[9] Cf. ibid.
[10] Cf. ibid.

saw the church extend its ministry of care to the sick who were not members of the Christian community. This marked a new departure in which there was no distinction made between strangers and Christians when caring for the sick. Christian persecution abated in 312A.D. with the conversion of the emperor Constantine to Christianity. The Church received large donations, which it channelled into the establishment of permanent hospitals. These were staffed by monastic orders. They began in the East around 350 A.D. and spread to the West around the end of the fourth century. They focused on alleviating human suffering of the poor and the indigent.[11] Rational or secular medicine had developed in Greek civilisation around the time of Hippocrates, in the fifth century.[12] The Hippocratic oath, which requires physicians to 'do no harm,' persisted into modern society. However, it has either been altered or ignored by physicians in countries or states where abortion and euthanasia are legal. The Christian virtue of compassion permeated through wider society and supplemented the Hippocratic tradition. But it too has been diluted. 'It is difficult to maintain a balanced relationship between the practice of scientific medicine and the duty to provide compassionate care.'[13] But compassion demands that the health care professional treat the patient not merely in a professional and medically competent manner but lovingly and tenderly as a human being of infinite worth and dignity. There is a danger, as outlined in the previous chapter, of treating diseases instead of persons. The increased use of technology is in part responsible for a shift away from a ministry of mercy in modern healthcare.

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[11] Cf. ibid., 320.
[12] Cf. ibid., 321.
[13] Ibid., 323.

Care has become all about doing rather than being. Do health care professionals actually have the time to be present to their patients anymore, short of a brief clinical consultation? Modern medicine is lacking a human face.[14] Today the Catholic Church is the single largest health care provider in the world. However, the religious sister, the traditional image of health care, is long since gone, due to a decline in vocations to religious life. Many argue that it doesn't matter if it's not a nun who takes your blood pressure as long as Christian values are upheld in the hospital. Upholding the ethos of a Catholic hospital of course means that immoral procedures such as abortion and euthanasia cannot take place on the premises but also that the experience of being a patient in a Catholic hospital be concretely different from that of a community hospital. 'To encounter a Catholic health facility must be an encounter with the healing touch of our Master, who said "What you do to the least of My own, that you do to me."'[15] They must realise that 'nobody, however sick, is beyond our compassion.'[16] They must experience that there are no limits to Christian compassion. This current secular age is hostile to any but private manifestations of Christianity.[17] We have witnessed in this century the removal of religious values from most public institutions, including those hospitals that have religious origins. [18]What medicine offers today grows from the values that the secular world encourages, such as medical research. This must not be

[14] Cf. Smith, 'Medical Ethics: An Offspring of the Church', 40, 45.
[15] Ibid., 46.
[16] Ibid.
[17] Cf. Ferngren, 'Medicine and compassion in early Christianity', 323.
[18] Ibid.

depreciated as it has provided us with our understanding of disease and its cure. Unfortunately, a by-product of secularisation has been to cut medicine off from its Christian roots and the well-spring of compassion.' The spirit of secularism whatever else may be credited to it, does not naturally foster compassion.'[19] The contemporary drive towards euthanasia reflects this. You cannot take care of someone by killing them. True compassion supports and sustains the sufferer. It doesn't make the judgement that he or she isn't worth preserving. 'Compassion is the missing element in modern medicine.'[20] Perhaps this is because it is not a quality that can be summoned at will. It has to be fostered. It is easy to recognise the dignity and humanity of every patient and treat them compassionately if you see them as someone bearing the image of God. However, without this transcendental basis to nourish compassion, it is likely to wither and die like seeds on rocky ground.[21] It is clear that 'the Christian ideals, which nourished the roots of medicine all those centuries ago, need to be reawakened in modern medicine.'

5.2 WHAT IT MEANS TO SHOW MERCY

'The word and the concept of "mercy" seems to cause uneasiness in man, who thanks to the enormous development of science and technology, never before known in history, has become the master of the earth and has subdued and dominated it.'[22] Perhaps our age

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[19] Ibid., 323.
[20] Ibid., 324.
[21] Ibid.
[22] Pope John Paul II. Encyclical Letter Dives in Misericordia, 30 November 1980. 1.2 . Hereafter, DM and cited in the body of the text.

does not feel it needs a merciful God, not being completely at the mercy of the forces of nature. Moreover, the contemporary mindset ' tends to exclude from life and to remove from the human heart the very idea of mercy.' (DM. I.2.) The previous section outlined how medicine no longer seems to be a ministry of mercy. With this in mind it is salutary to note that the only popular use of the word 'mercy' today, in this secular age, is in relation to euthanasia. The latter is commonly refereed to as mercy-killing. It is deemed merciful to put a human being out of their suffering by lethal injection. This understanding of mercy is very different to the Christian understanding of mercy. The latter is laid out in the encyclical letter of Pope John Paul II on the Mercy of God, *Dives in Misericordia.*

God's chosen people had a special experience of the mercy of God. Israel was in Covenant with God and broke that covenant many times. The prophets preached repentance and in their preaching linked mercy with God's love. Mercy signifies a special power of love, which is stronger than the sin and infidelity of the chosen people. (DM. III.4.)

Job, the subject of innocent suffering, after his rebellion, turned to God. The chosen people when in slavery turned to God and he delivered them from their oppressors. 'This is precisely the grounds upon which the people and each of its members based their certainty of the mercy of God, which can be invoked whenever tragedy strikes.' (DM. III.4.) Despite the idolatry of his people in the desert, God declares to Moses that he was a 'God merciful and gracious, slow to anger, and abounding in steadfast love and faithfulness.' (DM III.4.) This is why the psalmists sing of the God of love, tenderness,

mercy and fidelity. God is faithful to his own, but also to Himself, for he declared himself to be a God of mercy.

Mercy is the content of God's relationship with his people. It marks their life of intimacy with Him. In the Old Testament, the Creator has already linked himself to his creature with a particular love. God cannot despise anything that He has made. The mountains may fall but the love of the Lord will stand. (DM. III.4.)

Christ personifies the whole of the Old Testament's tradition about God's mercy. (DM. I.2.) Christ revealed the Father's mercy and in particular, his closeness to man when man is suffering, under threat at the very heart of his existence and dignity. (DM. I.2.) According to Luke's Gospel, Christ's first messianic declaration echoes the words of the prophet Isaiah : 'The Spirit of the Lord is upon me, because he has anointed me to preach good news to the poor. He has sent me to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord." (Lk 4:18-19.) God is a sign of love for broken people. (DM. II.3.) Jesus revealed that a love addressed to man is present in our world. It is a love that embraces everything in the human condition and is particularly present to the suffering, the poor or victims of injustice. This is God's mercy.

The parable of the Prodigal Son powerfully portrays God's mercy. The Son demanded his inheritance and proceeded to squander it 'in loose living' in a foreign land. (DM. IV.5.) A famine arose in that country and he was starving. He envied the pigs their pods but was denied even that. He decided that he would return to his father and ask to be treated as one of his servants because they had bread to spare. But the son is aware that he has lost the dignity of sonship. Under the norms of justice he no longer deserves

the rights of a son. However, the Father goes beyond the norms of justice and extends to his son merciful love. He restores his dignity as Son and the dignity of his humanity. "He had *compassion,* ran to meet him, threw his arms around his neck and kissed him." (DM. IV.6.) This parable tells us that God's love, like the Father's love in the parable, is able to reach down to every person no matter how miserable their state. 'When this happens, the person who is the object of mercy does not feel humiliated, but rather found again and restored to value.' (DM. IV.5.) Merciful love is by its essence a creative love. (DM. VII.14.) As already pointed out, it restores value. This point is also brought out in the parable of the Good Samaritan. On the outside it may appear that mercy belittles the recipient because the relationship seems unequal between giver and receiver. However, the relationship of mercy is based, as this parable illustrates, on the common experience of the dignity of the human person. Moreover, the relationship between giver and receiver is reciprocal because in reality the one who gives also receives. This is the testimony of many people who care for the sick. This point is brought out further in the next section, which deals with the meaning of human suffering. Lest there be any doubt about this, we only have to look at the Cross of Christ. (DM. VIII.15.) It is the most complete revelation of God's mercy, his selfless love for humankind. Yet the Father calls *us* to have mercy on his crucified Son who knocks at the door of every human heart. (DM. V.8.) The cross also demonstrates the creative nature of mercy because through it we are welcomed into God's family, the Trinity. (DM. V.7.) Mercy is the kind of love that does not allow itself to be 'conquered by evil', but overcomes 'evil with good.' (DM. IV.6.) Christ testified to this by his death and resurrection whereby he conquered sin and death. The Father, in his mercy for sinful humankind, does not recoil before the

extraordinary sacrifice of the Son. (DM. V.7.) The Son is in many ways mercy *incarnate* (DM. I.2) for despite fear expressed in the Garden of Gethsemane, he accepts the poisoned chalice. The actions of Father and Son alike teach us that:

> The true and proper meaning of mercy does not consist only in looking, however penetratingly and compassionately, at moral, physical or material evil: mercy is manifested in its true and proper aspect when it restores to value, promotes and *draws good from all the forms of evil* existing in the world and in man. (DM. IV.6.)

5.3 MEANING OF SUFFERING IN THE OLD TESTAMENT

'It is the experience of Israel that illness is mysteriously linked to sin and evil, and that faithfulness to God according to his law restores life: "For I am the Lord, your healer."[23](Ex 15:26.) However, Israel falsely identified all human suffering as a punishment for concrete sins. Proverbs, Tobit and Sirach all upheld the Deuteronomist's thesis of divine retribution. Good is rewarded in this life and evil punished, for there is no reward or punishment beyond the grave. Therefore, suffering, or misery, are due to unfaithfulness to Yahweh.[24] Proverbs, the purpose of which was to instruct the people in wisdom, saw suffering as a corrective i.e. God's way of disciplining sinful humanity and a sign of his love. [25] Any exceptions to the rule, such as cases of undeserved suffering, are merely ignored. The Book of Tobit doesn't debate the question of innocent suffering at all, despite the fact of the undeserved suffering of Tobit

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[23] Catechism of the Catholic Church , 1502. Hereafter, C.C.C. and cited in the body of the text.
[24] Cf. R.A Dyson, rev. by J. McShane, 'Proverbs' in A New Catholic Commentary on Holy Scripture (Nairobi: Nelson, 1975), 411g.
[25] Cf. Dyson, rev. by J. McShane, 'Proverbs' in New Catholic Commentary on Scripture, 412h.

and Sarah and the fact that this was a burning question in Jewish minds in the last centuries before Christ.[26]. The book of Tobit instead sets out the 'good' attitude to suffering and encourages the reader to have faith in Divine Providence, for virtue will be rewarded in the end. The book of Tobit is an exhortation to faith and patience.

The challenge to the theory of divine retribution comes from within the wisdom tradition itself in the form of Qoheleth and Job.[27] 'Qoheleth found the theory of divine retribution wanting because even if God did give the good person all the blessings of life, the key to happiness was not to be found among them.'[28] Qoheleth was disillusioned with life because death ends all life's pleasures and therefore spoils all enjoyment.

Job was a righteous man and, as the theory of divine retribution would suggest, rewarded accordingly[29]. God blessed him with a happy family and great wealth. Then tragedy struck his world. He lost his wealth, his children died and he became ill. His friends try to convince him that he must have overlooked some sin he committed and must confess it to God. But Job passionately protests: I clothed myself in righteousness, it was my clothing, in justice as a robe and turban. (Job 28:14.)[30] The whole point of the story is that Job suffers despite the fact that he committed no secret sin. 'In the course of his arguments, Job appeals again and again to the divine tribunal. He seems to feel that the hardest thing of all to take is the silence of God in the midst of his suffering.'[31] However, 'In the end, God himself reproves Job's friends for their accusations and recognises that Job is not guilty. His suffering is the suffering of someone who is

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[26] Cf. P. Giffin, 'Tobit' in New Catholic Commentary on Scripture, 339g.
[27] William Riley, *The Tale of Two Testaments* (Dublin: Veritas Publications, 1985), 65.
[28] Ibid., 66.
[29] Ibid., 67.
[30] Ibid., 68.
[31] Ibid.

innocent and it must be accepted as a mystery, which the individual is unable to penetrate completely by his own intelligence.'[32](SD. III.11.)

The old thinking denied the depth of the mysteries of death and suffering and the silence of God[33]. Job was revolutionary in that for the first time the question of suffering was directed at God instead of man. Job was not personally in the wrong but neither was God. The connection between sin and suffering is real but can only be understood within the context of original sin. Here the term 'sin' is used as an analogy because it is contracted not committed. It refers to our inheritance of a fallen human nature.

Suffering and death entered the world through our forefathers. (CCC. 400.) ' God created man in his image and established a relationship of friendship with Him but Man rebelled. The symbol of the tree of knowledge represents the limits appropriate to humans. The eating of the forbidden fruit of the tree symbolically evokes man's first sin, namely disobedience and claiming for himself what properly belongs to God. (CCC. 398.) This destroys original justice and creates disharmony in creation. Suffering and death enter the world.

During the Babylonian Exile, Second Isaiah saw in the miserable reality of the Israelites not a sign of Yahweh's failure, but of their own failure and of God's power. He saw it as God's way of purifying the people. In suffering, Israel would learn to truly serve the Lord.[34] Isaiah reveals that suffering can be an occasion for fidelity to God and an

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[32] Pope John Paul II. Apostolic Letter *Salvifici Doloris,* 11 February 1984. II.3. Hereafter, SD and cited within the body of the text.
[33] Cf. Reilly, *A Tale of Two Testaments*, 69.
[34] A. Penna, 'Isaiah' in New Catholic Commentary on Scripture, 66b.

opportunity for conversion. The positive value of suffering underlies his message of hope. Isaiah prophesies the time when God will pardon every offence and heal every illness. (C.C.C. 1502, Is. 33:24.) There is a major breakthrough in the problem of innocent suffering, which had painfully preoccupied Israel for many years in the fourth song of The Servant of Yahweh. (Second Isaiah: 52:13, 53:12.) It stresses suffering yet the tone is triumphant. (Is.52:15.) It has a strong theological message.

> The servant is chosen by God for the mission of establishing justice on earth, not only for Israel but for the world. He performs this task with humility and gentleness, but in spite of this he meets with neglect and opposition which develops into persecution. This is a situation familiar throughout Israel's history, in the experience of the prophets particularly. But the final song provides a dramatic and unexpected climax: the result of the Servant's suffeings is not failure but success, and **success not in spite of but precisely through his sufferings."** [Author's emphasis] [35]

The prophets did not suffer for their own sins but the sins of Israel. Therefore, suffering is not necessarily a sign of guilt but of attonement.[36]. Christ who bears the burden of the sins of humanity is the ultimate witness to innocent suffering.

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[35] Ibid., 481a.

5.4 THE CHRISTIAN MEANING OF HUMAN SUFFERING

Suffering and sickness are among the gravest problems confronted in human life. (CCC. 1500.) In an earlier section we mentioned that all sickness is an intimation of death. It is frightening also in that it makes us feel powerless and subject to forces that we cannot control. For these reasons, 'illness can lead to anguish, self-absorption, sometimes even despair or revolt against God.' (CCC 1501.) 'For, whereas the existence of the world opens as it were the eyes of the human soul to the existence of God, to His wisdom, power and greatness, evil and suffering seem to obscure this image, sometimes in a radical way'. (SD. III.9.) In chapter three we outlined that modern medicine aims to return us to the world status quo ante. However, that for many people who have been sick is impossible as a moral choice. Perhaps this is because illness 'can also make a person more mature, helping him discern in his life what is essential so that we can turn toward that which is. Very often illness provokes a search for God and a return to him.' (CCC. 1501.) This possibility for suffering leading to enrichment in our lives may be what the Arabs are getting at when they say "All sunshine makes a desert." Despite the fact that suffering may be an occasion for becoming, in itself it is not good. To suffer is to experience evil. (SD. 2.7.) God came that we may have life and have it abundantly (John 10:10).

> That Gospel does not call suffering a welcome thing in and of itself.
> But recognises that only through suffering accepted in love, do
> we truly come to grips with the real meaning and seriousness of life.[37]

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[36] Ibid., 481a.
[37] Raising the Stakes in the Euthanasia Debate, *Origins* 24(1994), 19.

5.4.1 What is suffering?

Suffering seems to be an exclusively human phenomenon. It is rooted in our nature as human being with an eternal destiny. (SD. II.3.) It belongs to our transcendence, is a mystery, and as such reveals the depth, which is proper to human beings. (SD. I.3.) Suffering is thus more complex a reality than sickness or pain. (SV. II.5.) Physical suffering constitutes the pain we feel when the body is injured of diseased, whereas moral suffering involves "pain of the soul." (SD. II.5.) Suffering can have a spiritual as well as a psychological nature, a reality that is often neglected in modern medicine, as outlined earlier. Sometimes we treat the loneliness of the dying with prozac or lethal injection.

The Old Testament is a powerful model for a holistic approach to the human person because it often links '"moral" sufferings with the pain of specific parts of the body.' (SD. II.7.) In the previous chapter we saw how a mind/body dualism encouraged by specialisation in medicine led to failure to recognise the dignity of brain-injured patients. "It is obvious that pain, especially physical pain, is widespread in the animal world. But only the suffering human being knows that he is suffering and wonders why; and he suffers in a humanly speaking still deeper way if he does not find a satisfactory answer." (SD. III.9.) This was evidenced in Job's case when the thing he found hardest to take about his miserable situation was God's silence. God's response to the 'Why' of human suffering is the Cross of Christ. (SD. III.13.)

5.4.2 SUFFERING CONQUERED BY LOVE.

'For God so loved the world that he gave his only Son, that whoever believes in him should not perish but have eternal life.'(Jn. 3:16, SD. IV.14.) Although this thesis is about suffering in its temporal form, Jesus came to save us from definitive suffering namely sin and death. (SD. IV.4.) But when Christ conquers eschatological suffering he also, at least indirectly, strikes at suffering in its temporal dimension because, as outlined earlier, suffering is linked to original sin. Christ conquered sin and death by his death and resurrection but does not blot out human suffering from our experience or the world. Nevertheless, the light of salvation sheds light on temporal suffering. The fact that God gave his only Son that we might be saved radically changes our situation in the world. God's love for us is so great that he draws near to us in our suffering. Firstly, in the Incarnation Christ takes on our human condition. He lived among us healing the sick and consoling the afflicted. (SD. IV.16.) 'He was sensitive to every human suffering whether of body or soul.' (SD. IV.16.) But ultimately Christ drew close to us in our suffering by taking this suffering upon himself. While living among us he grew weary, he felt misunderstood even by his closed friends, he experienced animosity toward him, he was aware of plans to put him to death. Christ was aware of the suffering he would go through, in the Garden of Gethsemane, and he shuddered before it. (SD. IV.18.) He was arrested, humiliated, mocked and crucified. (SD. IV.17.) Finally, he cries out in abandonment on the cross. The cry of forsakenness is paradoxical because it at once reveals the similarity and the difference between Christ's suffering and ours. Christ's sense of abandonment can only be understood within the context of the unique filial

relationship between Jesus and the Father. But whereas we could not experience the intensity of Christ's pain at being abandoned by the Father, 'there exists no pain, no darkness, no loneliness...no horror, no abandonment, no cry...nothing at all that is not found in him who has not refused anything of the misery he finds in us.'[38] Through Christ's perfect love for the Father and the Father's perfect love for sinful humankind not only have we been redeemed but so has human suffering. (SD. V.19.) It has been linked to that perfect divine love revealed on the Cross., 'to that love which creates good, drawing it out by meaning of suffering,' to a saving love. (SD. IV.18.)

5.4.3 Sharers in the Suffering of Christ.

Everyone who suffers can participate in Christ's redemptive suffering and "complete what is lacking in Christ's affliction." (Col 1:24.) This is because " in bringing about the redemption through suffering, Christ has also raised human suffering to the level of the redemption." (SD. V.19.) This does not mean that Christ has not accomplished the Redemption. The Redemption of the world has already been accomplished through Christ's suffering. However, Christ did not bring it to a close. It lives on through every human suffering that unites itself to Christ. (SD. V.24.) In this way it is analogous to the way the Church completes the redemptive work of Christ. In this way suffering united to Christ has a creative character. (SD. V.24.) This is because it is to suffer for the Kingdom of God. (SD. V.21.) Christ revealed the Kingdom of God through suffering and it is through sharing in Christ's suffering that those who suffer can enter this

[38] Gerard Rossé, *The Cry of Jesus on the Cross. A biblical and Theological Study* (NY: Paulist Press, 1987), 115.

Kingdom. (SD. V.21.) It makes sense that if they share in his suffering they should also share in his glory. (SD. V.22.)

Suffering, as all ready mentioned can be creative. It can lead to spiritual maturity and is an opportunity for virtue. (SD. V.23.) If the individual shows bravery and perseverance in the face of suffering, he unleashes hope in the world by encouraging others in their task of living. It also makes the individual hopeful because he has responded courageously when faced with adversity. This will help maintain in him 'the conviction that suffering will not get the better of him, that it will not deprive him of his dignity as a human being, a dignity linked to awareness of the meaning of life.' (SD. V.24.) God has chosen to act through suffering in this world. This paradox is at the heart of the Gospel, namely that God revealed his glory in weakness and saved the world through suffering. Therefore, those suffering should never feel useless even if judged so by modern standards because to suffer is to be particularly susceptible to being a channel of God's salvific power. (SD. V.23.) Those in extreme situations of suffering may, at times, not feel very valuable but they are infinitely valuable to God and the world even if the world is blind to this truth. The Church recognises the special value of those who suffer and sees in suffering something good before which the Church bows down in reference with all the depth of her faith in the Redemption. (SD. V.24.)

'Down through the centuries and generations it has been seen that in suffering there is concealed a particular power that draws a person interiorly close to Christ, a special grace.' (SD. VI.26.) Many saints such as St. Francis of Assisi and St. Ignatius Loyola testify to this. (SD. VI.25.) When the body is gravely ill and movement becomes difficult and the person is severely confined, interior maturity and spiritual greatness are

revealed which constitute a touching lesson to those who are healthy. (SD. VI.26.) However, suffering being an evil, cannot be changed by grace from the outside, only from within. This is why Christ took suffering and death upon himself. Christ through his own salvific suffering is present in every human suffering and can act from within that suffering through His consoling Spirit. (SD. VI.26.)

Mary, the mother of God, is the epitome of a human being's contribution to the redemption of all. She knew that a sword would pierce her heart yet she accepted intense suffering with singular clarity. (SDVI .25.) She made a unique contribution to the Redemption. However, we are all called to suffer for Christ. Christ explicitly said 'If any man would follow me ... let him take up his Cross daily.' He warns his followers that they will be persecuted for following him but the Spirit will assist them and they will gain eternal life. (SD. V. 25.) Such persecution is a sign of union with Christ. He calls them to have courage and fortitude.

When the suffering person puts the question of suffering to God, God does not answer from an ivory tower but from the cross. Christ's answer however is no quick-fix. It isn't an abstract explanation but a call to discipleship, which takes time to be discerned interiorly. When the individual takes up his cross and unites his suffering to Christ, it is then that he finds inner peace. (SD. VI.26.) Moreover, he is carrying out an invaluable service for his fellow humans because his suffering opens the way for grace which transforms human souls. (SD. V.27.)

5.4.4 The Good Samaritan.

The parable of the Good Samaritan tells us that everyone is our neighbour. We should not turn our back on anyone who is suffering. We must stop and make ourselves available to care for them and express solidarity with them in their suffering. For Christ said "As you did it to the least one of these my brethren, you did it to me." (SD. VII.30.)

CONCLUSION

Pope John Paul II discerned that at the heart of the 'culture of death' lies the failure ' to perceive any meaning or value in suffering.'[1]. This thesis set out to examine contemporary attitudes towards death and suffering in the context of the euthanasia debate. The changes in attitudes towards death and suffering are inextricably linked, emerged under the same conditions and due to the pervading ideologies of modernity and postmodernity. The former's reliance on instrumental reason, and the latter's denial of truth, had the combined effect stripping the mysteries of suffering and death of all meaning and reducing them to biological processes, which were then subjected to human control and domination.

It is the Pope's judgement that much in contemporary liberal society is a 'veritable structure of sin.'[2] This crisis does not involve a mere corruption of the will but involves also 'the order of intelligence and thereby that which give institutions their inner logic or shape.'[3] This point is brought out in chapter three of this thesis in relation to medicine. It underwent radical changes in its inner logic. It cut itself off from its roots in Christian compassion and adopted a technological mentality. As a result medicine became a mechanistic-instrumentalist discipline instead of a ministry of mercy. Its primary focus was disease not patients. It became concerned with manipulating nature at the expense of caring for persons.

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[1] Cf. David L. Schindler, 'Christological aesthetics and *Evangelium Vitae*: Toward a definition of liberalism' in *Communio*, 22(1995), 193. See also Pope John Paul 11, Encyclical Letter *Evangelium Vitae* (25 March 1995) n. 12. Hereafter EV and cited in the body of the text.
[2] Ibid.
[3] Cf. ibid., 197.

The mechanistic model of medicine doesn't even have a category for much of what constitutes human suffering. It reduced suffering to physical pain and ignored moral suffering or suffering of the soul. It cannot recognise this kind of suffering because it no longer treats patients as persons but as mere biological entities. In chapter four, we see how the neglect of the human person as a unity of body and soul, coupled with an interpretation of 'quality of life' which places more emphasis on having and doing than actually being, leads to euthanasia. Modern medicine has no basis for caring for patients when the prospect of cure has vanished.

Chapter five advocates the return of medicine to its roots in Christian compassion. It challenges the notion of mercy which eliminates suffering by eliminating the one who suffers. It argues for the restoration of value to the sick and the dying based on the Christian concept of mercy. This chapter included a detailed treatment of the Christian meaning of human suffering. This was important because in the context of the euthanasia debate and the attitudes in society, which the euthanasia debate reflects, the sick and the dying are oftentimes made to feel a burden to society. The discovery of the salvific meaning of suffering in union with Christ overcomes this feeling of uselessness and worthlessness. The suffering person who shares in the suffering of Christ also shares in his redemptive work. In other words, they serve the salvation of their fellow members of society. In sharing in Christ's redemptive work they will also share in his glory. (SD.VI:27.) Through their suffering, like gold in the furnace, they are made worthy of his kingdom.

They are worthy in the eyes of God even if they feel worthless in the eyes of contemporary society. To comfort the sick and the dying is to offer them this hope. It is not to confirm their fears that they are better off dead and kill them.

Medicine has expressed itself in mechanistic-instrumentalist patterns of thought and action because of a separation of form (the meaning which gives shape to the culture's institutions and patterns of life) and love in the understanding of nature and of the severance of nature from grace. [4] 'Form abstracted form love becomes externalised, manipulative, and forceful.'[5] The entire thesis points to this fact. Christ, the incarnate God, as the *Logos* revealed the ultimate unity of form and love in his very self.[6] Nature will not be ordered by love unless it is reunited with grace. For only 'the blood of Christ, while it reveals the grandeur of the Father's love, [can show] how precious man is to God's eyes and how priceless the value of his life.'[7] (EV. n.22.)

In the introduction I argued for a communitarian bioethic because by the time we start discussing dilemmas there is often stalemate because attitudes to suffering and death, often unexamined, are already formed and predetermine life and death decisions. I argued that we must begin by examining cultural biases in order to understand the debate and tackle the culture of death at its rood causes. I began by doing this and ended in

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[4] Cf. Schindler, 'Christological aesthetics…', 200. See also double-dualism described by Hans Urs von Balthasar, *Love Alone* (New York: Herder and Herder, 1969), 114-115.
[5] Ibid.
[6] Ibid., 200.
[7] Ibid., 194.

chapter five with Christ. However, through out the course of this thesis I have learned that if we want to cultivate an unconditional choice for life in contemporary culture we must begin and end with Christ. Christ should not be the mere motivation or the source of our answers. He is the answer. We must engage the popular culture with the Gospel of Life. Some people will argue that this takes moral theology into a ghetto. I don't believe a specifically Christian message precludes dialogue with non-Christians. Pope John Paul II addresses *Evangelium Vitae* to all people of goodwill.

A case for God's place in society needs to be made because the source of our cultural crisis is living 'as though God did not exist.' (EV. n.22.) It emanates from 'the loss of contact with God's wise design.' (EV. n.22.)[8] It comes from a loss of 'the proper sense of creaturehood – of what it means to be one whose very being is a being-from.'[9] In not knowing God we do not know ourselves. We fail to realise that man is not first creative but first receptive-and obedient. A true culture of life:

> …arises from faith in the God of life, who has created every individual as a "wonder"(cf. Ps 139:14). It is the outlook of those who see life in its deeper meaning, who grasp its utter gratuitousness, its beauty and its invitation to freedom and responsibility. It is the outlook of those who do not presume to take possession of reality, but instead accept it as a gift, discovering in all things the reflection of the Creator and seeing in everyperson his living image (cf. Gen 1:27; Ps 8:5) (EV. n.83.)[10]

Only then will we open to the mysteries of suffering and death and learn to revere all human beings equally.

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[8] Cf. ibid., 200.
[9] Ibid., 217.
[10] Ibid., 205.

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Abbreviations:

DM Pope John Paul II. Encyclical Letter *Dives in Misericordia.* 30 November 1980.

SD Pope John Paul II. Apostolic Letter *Salvifici Doloris.* 11 February 1984.

VS Pope John Paul II. Encyclical Letter Veritatis Splendor. 6 August 1993. London:CTS Publication, 1993.

EV Pope John Paul II. Encyclical Letter *Evangelium Vitae.* 25 March 1995. London: CTS Publication, 1995.

CCC Catechism of the Catholic Church. Dublin: Veritas, 1994.