

## **Neither for love nor money: why doctors must not kill**

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**I**S THE profession of medicine ethically neutral? If so, whence shall we derive the moral norms or principles to govern its practices? If not, how are the norms of professional conduct related to the rest of what makes medicine a profession?

These difficult questions, now much discussed, are in fact very old, indeed as old as the beginnings of Western medicine. According to an ancient Greek myth, the goddess Athena procured two powerful drugs in the form of blood taken from the Gorgon Medusa, the blood drawn from her left side providing protection against death, that from her right side a deadly poison. According to one version of the myth, Athena gave to Asclepius, the revered founder of medicine, vials of both drugs; according to the other version, she gave him only the life-preserving drug, reserving the power of destruction for herself. There is force in both accounts: the first attests to

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This article is dedicated to the memory of my father-in-law, Kalman Apfel, M.D., physician extraordinaire (1907-1988), and my mother-in-law, Polly Apfel (1911-1987), who exemplified even with her last breath the noblest possibilities of the human soul. Earlier versions of this essay were presented as lectures delivered for the Program in Ethics and the Professions, Harvard University, March 16, 1988, and for the Kennedy Institute of Ethics, Georgetown University, May 6, 1988.

the moral neutrality of medical means, and of technical power generally; the second shows that wisdom would constitute medicine an unqualifiedly benevolent—i.e., intrinsically ethical—art.

Today, we doubt that medicine is an intrinsically ethical activity, but we are quite certain that it can both help and harm. In fact, today, help and harm flow from the same vial. The same respirator that brings a man back from the edge of the grave also senselessly prolongs the life of an irreversibly comatose young woman. The same morphine that reverses the respiratory distress of pulmonary edema can, in higher doses, arrest respiration altogether. Whether they want to or not, doctors are able to kill—quickly, efficiently, surely. And what is more, it seems that they may soon be licensed and encouraged to do so.

Last year in Holland some 5,000 patients were intentionally put to death by their physicians, while authorities charged with enforcing the law against homicide agreed not to enforce it. Not satisfied with such hypocrisy, and eager to immunize physicians against possible prosecution, American advocates of active euthanasia are seeking legislative changes in several states that would legalize so-called mercy killing by physicians. A year ago the editor of the *Journal of the American Medical Association* published an outrageous (and perhaps fictitious) case of mercy killing, precisely to stir professional and public discussion of direct medical killing—perhaps, some have said, as a trial balloon.<sup>1</sup> So-called active euthanasia practiced by physicians seems to be an idea whose time has come. But, in my view, it is a bad idea whose time must not come—not now, not ever. This essay is in part an effort to support this conclusion. But it is also an attempt to explore the ethical character of the medical profession, using the question of killing by doctors as a probe. Accordingly, I will be considering these interrelated questions: What are the norms that all physicians, *as physicians*, should agree to observe, whatever their personal opinions? What is the basis of such a medical ethic? What does it say—and what should we think—about doctors intentionally killing?

### Contemporary ethical approaches

The question about physicians killing is a special case of—but not thereby identical to—this general question: May or ought one kill people who ask to be killed? Among those who answer this gen-

<sup>1</sup>“It’s Over, Debbie,” *Journal of the American Medical Association*, 259: 272, January 8, 1988. See, in response, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, Mark Siegler, “Doctors Must Not Kill,” *Journal of the American Medical Association*, 259: 2139-40, April 8, 1988.

eral question in the affirmative, two reasons are usually given. Because these reasons also reflect the two leading approaches to medical ethics today, they are especially worth noting. First is the reason of *freedom* or *autonomy*. Each person has a right to control his or her body and his or her life, including the end of it; some go so far as to assert a right to die, a strange claim in a liberal society, founded on the need to secure and defend the unalienable right to life. But strange or not, for patients with waning powers too weak to oppose potent life-prolonging technologies wielded by aggressive physicians, the claim based on choice, autonomy, and self-determination is certainly understandable. On this view, physicians (or others) are bound to acquiesce in demands not only for termination of treatment but also for intentional killing through poison, because the right to choose—freedom—must be respected, even more than life itself, and even when the physician would never recommend or concur in the choices made. When persons exercise their right to choose against their continuance as embodied beings, doctors must not only cease their ministrations to the body; as keepers of the vials of life and death, they are also morally bound actively to dispatch the embodied person, out of deference to the autonomous personal choice that is, in this view, most emphatically the patient to be served.

The second reason for killing the patient who asks for death has little to do with choice. Instead, death is to be directly and swiftly given because the patient's life is deemed no longer worth living, according to some substantive or "objective" measure. Unusually great pain or a terminal condition or an irreversible coma or advanced senility or extreme degradation is the disqualifying quality of life that pleads—choice or no choice—for merciful termination. Choice may enter indirectly to confirm the judgment: if the patient does not speak up, the doctor (or the relatives or some other proxy) may be asked to affirm that he would not himself choose—or that his patient, were he *able* to choose, *would* not choose—to remain alive with one or more of these stigmata. It is not his autonomy but rather the miserable and pitiable condition of his body or mind that justifies doing the patient in. Absent such substantial degradations, requests for assisted death would not be honored. Here the body itself offends and must be plucked out, from compassion or mercy, to be sure. Not the autonomous will of the patient, but the doctor's benevolent and compassionate love for suffering humanity justifies the humane act of mercy killing.

As I have indicated, these two reasons advanced to justify the killing of patients correspond to the two approaches to medical

ethics most prominent in the literature today: the school of autonomy and the school of general benevolence and compassion (or love). Despite their differences, they are united in their opposition to the belief that medicine is intrinsically a moral profession, with its own immanent principles and standards of conduct that set limits on what physicians may properly do. Each seeks to remedy the ethical defect of a profession seen to be in itself *amoral*, technically competent but morally neutral.

For the first ethical school, morally neutral technique is morally used only when it is used according to the wishes of the patient as client or consumer. The implicit (and sometimes explicit) model of the doctor-patient relationship is one of *contract*: the physician—a highly competent hired syringe, as it were—sells his services on demand, restrained only by the law (though he is free to refuse his services if the patient is unwilling or unable to meet his fee). Here's the deal: for the patient, autonomy and service; for the doctor, money, graced by the pleasure of giving the patient what he wants. If a patient wants to fix her nose or change his gender, determine the sex of unborn children, or take euphoriant drugs just for kicks, the physician can and will go to work—provided that the price is right and that the contract is explicit about what happens if the customer isn't satisfied.<sup>2</sup>

For the second ethical school, morally neutral technique is morally used only when it is used under the guidance of general benevolence or loving charity. Not the will of the patient, but the humane and compassionate motive of the physician—not as physician but as *human being*—makes the doctor's actions ethical. Here, too, there can be strange requests and stranger deeds, but if they are done from love, nothing can be wrong—again, providing the law is silent. All acts—including killing the patient—done lovingly are licit, even praiseworthy. Good and humane intentions can sanctify any deed.

In my opinion, each of these approaches should be rejected as a basis for medical ethics. For one thing, neither can make sense of some specific duties and restraints long thought absolutely inviolate under the traditional medical ethic—e.g., the proscription against having sex with patients. Must we now say that sex with patients is permissible if the patient wants it and the price is right, or, alternatively, if the doctor is gentle and loving and has a good bedside manner? Or do we glimpse in this absolute prohibition a deeper

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<sup>2</sup> Of course, any physician with *personal* scruples against one or another of these practices may "write" the relevant exclusions into the service contract he offers his customers.

understanding of the medical vocation, which the prohibition both embodies and protects? Indeed, as I will now try to show, using the taboo against doctors killing patients, the medical profession has its own intrinsic ethic, which a physician true to his calling will not violate, either for love or for money.

### Professing ethically

Let me propose a different way of thinking about medicine as a profession. Consider medicine not as a mixed marriage between its own value-neutral technique and some extrinsic moral principles, but as an inherently ethical activity, in which technique and conduct are both ordered in relation to an overarching good, the naturally given end of health. This once traditional view of medicine I have defended at length in four chapters of my book, *Toward a More Natural Science*.<sup>3</sup> Here I will present the conclusions without the arguments. It will suffice, for present purposes, if I can render this view plausible.

A profession, as etymology suggests, is an activity or occupation to which its practitioner publicly professes—that is, confesses—his devotion. Learning may, of course, be required of, and prestige may, of course, be granted to, the professional, but it is the profession's *goal* that calls, that learning serves, and that prestige honors. Each of the ways of life to which the various professionals profess their devotion must be a way of life worthy of such devotion—and so they all are. The teacher devotes himself to assisting the learning of the young, looking up to truth and wisdom; the lawyer (or the judge) devotes himself to rectifying injustice for his client (or for the parties before the court), looking up to what is lawful and right; the clergyman devotes himself to tending the souls of his parishioners, looking up to the sacred and the divine; and the physician devotes himself to healing the sick, looking up to health and wholeness.

Being a professional is thus more than being a technician. It is rooted in our moral nature; it is a matter not only of the mind and hand but also of the heart, not only of intellect and skill but also of character. For it is only as a being willing and able to devote himself to others and to serve some high good that a person makes a public profession of his way of life. To profess is an ethical act, and it makes the professional qua *professional* a moral being who prospectively affirms the moral nature of his activity.

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<sup>3</sup> Leon R. Kass, M.D., *Toward a More Natural Science: Biology and Human Affairs*, New York: The Free Press, 1985; paperback, 1988. See Chapters Six to Nine.

Professing oneself a professional is an ethical act for many reasons. It is an articulate public act, not merely a private and silent choice—a confession before others who are one's witnesses. It freely promises continuing devotion, not merely announces present preferences, to a way of life, not just a way to a livelihood, a life of action, not only of thought. It serves some high good, which calls forth devotion because it is both good and high, but which requires such devotion because its service is most demanding and difficult, and thereby engages one's character, not merely one's mind and hands.

The good to which the medical profession is devoted is health, a naturally given although precarious standard or norm, characterized by "wholeness" and "well-working," toward which the living body moves on its own. Even the modern physician, despite his great technological prowess, is but an assistant to natural powers of self-healing. But health, though a goal tacitly sought and explicitly desired, is difficult to attain and preserve. It can be ours only provisionally and temporarily, for we are finite and frail. Medicine thus finds itself in between: the physician is called to serve the high and universal goal of health while also ministering to the needs and relieving the sufferings of the frail and particular patient. Moreover, the physician must respond not only to illness but also to its meaning for each individual, who, in addition to his symptoms, may suffer from self-concern—and often fear and shame—about weakness and vulnerability, neediness and dependence, loss of self-esteem, and the fragility of all that matters to him. Thus, the inner meaning of the art of medicine is derived from the pursuit of health and the care for the ill and suffering, guided by the self-conscious awareness, shared (even if only tacitly) by physician and patient alike, of the delicate and dialectical tension between wholeness and necessary decay.

When the activity of healing the sick is thus understood, we can discern certain virtues requisite for practicing medicine—among them, moderation and self-restraint, gravity, patience, sympathy, discretion, and prudence. We can also discern specific positive duties, addressed mainly to the patient's vulnerability and self-concern—including the demands for truthfulness, patient instruction, and encouragement. And, arguably, we can infer the importance of certain negative duties, formulable as absolute and unexceptionable rules. Among these, I submit, is this rule: Doctors must not kill. The rest of this essay attempts to defend this rule and to show its relation to the medical ethic, itself understood as growing out of the inner meaning of the medical vocation.

I confine my discussion solely to the question of direct, intentional killing of patients *by physicians*—so-called mercy killing. Though I confess myself opposed to such killing even by non-physicians, I am not arguing here against euthanasia per se. More importantly, I am not arguing against the cessation of medical treatment when such treatment merely prolongs painful or degraded dying, nor do I oppose the use of certain measures to relieve suffering that have, as an unavoidable consequence, an increased risk of death. Doctors may and must allow to die, even if they must not intentionally kill.

I appreciate the danger in offering arguments against killing: even at best, they are unlikely to be equal to the task. Most taboos operate immediately and directly, through horror and repugnance; discursive arguments against, say, incest or cannibalism can never yield the degree of certitude intuitively and emotionally felt by those who know such practices to be abominable, nor are they likely to persuade anyone who is morally blind. It is not obvious that any argument can demonstrate, once and for all, why murder is bad or why doctors must not kill. No friend of decency wants to imperil sound principles by attempting to argue, unsuccessfully, for their soundness. Yet we have no other choice. Some moral matters, once self-evident, are no longer self-evident to us. When physicians themselves—as in Holland—undertake to kill patients, with public support, intuition and revulsion have fallen asleep. Only argument, with all its limitations, can hope to reawaken them.

### Assessing the consequences

Although the bulk of my argument will turn on my understanding of the special meaning of professing the art of healing, I begin with a more familiar mode of ethical analysis: assessing needs and benefits versus dangers and harms. To do this properly is a massive task. Here, I can do little more than raise a few of the relevant considerations. Still the best discussion of this topic is a now-classic essay by Yale Kamisar, written thirty years ago.<sup>4</sup> Kamisar makes vivid the difficulties in assuring that the choice for death will be *freely* made and adequately *informed*, the problems of physician error and abuse, the troubles for human relationships within families and between doctors and patients, the difficulty of preserving the bound-

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<sup>4</sup> Yale Kamisar, "Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation," *Minnesota Law Review* 42: 969-1042 (May, 1958). Reprinted, with a new preface by Professor Kamisar, in "The Slide Toward Mercy Killing," *Child and Family Reprint Booklet Series*, 1987.

ary between voluntary and involuntary euthanasia, and the risks to the whole social order from weakening the absolute prohibition against taking innocent life. These considerations are, in my view, alone sufficient to rebut any attempt to weaken the taboo against medical killing; their relative importance for determining public policy far exceeds their relative importance in this essay. But here they serve also to point us to more profound reasons why doctors must not kill.

There is no question that fortune deals many people a very bad hand, not least at the end of life. All of us, I am sure, know or have known individuals whose last weeks, months, or even years were racked with pain and discomfort, degraded by dependency or loss of self-control, isolation or insensibility, or who lived in such reduced humanity that it cast a deep shadow over their entire lives, especially as remembered by the survivors. All who love them would wish to spare them such an end, and there is no doubt that an earlier death could do it. Against such a clear benefit, attested to by many a poignant and heartrending true story, it is difficult to argue, especially when the arguments are necessarily general and seemingly abstract. Still, in the aggregate, the adverse consequences—including real suffering—of being governed solely by mercy and compassion may far outweigh the aggregate benefits of relieving agonal or terminal distress.

### **The “need” for mercy killing**

The first difficulty emerges when we try to gauge the so-called “need” or demand for medically assisted killing. This question, to be sure, is in part empirical. But evidence can be gathered only if the relevant categories of “euthanizable” people are clearly defined. Such definition is notoriously hard to accomplish—and it is not always honestly attempted. On careful inspection, we discover that if the category is precisely defined, the need for mercy killing seems greatly exaggerated, and if the category is loosely defined, the poisoners will be working overtime.

The category always mentioned first to justify mercy killing is the group of persons suffering from incurable and fatal illnesses, with intractable pain and with little time left to live but still fully aware, who freely request a release from their distress—e.g., people rapidly dying from disseminated cancer with bony metastases, unresponsive to chemotherapy. But as experts in pain control tell us, the number of such people with truly intractable and untreatable pain is in fact rather low. Adequate analgesia is apparently possible in the vast



majority of cases, provided that the physician and patient are willing to use strong enough medicines in adequate doses and with proper timing.<sup>5</sup>

But, it will be pointed out, full analgesia induces drowsiness and blunts or distorts awareness. How can that be a desired outcome of treatment? Fair enough. But then the rationale for requesting death begins to shift from relieving experienced suffering to ending a life no longer valued by its bearer or, let us be frank, by the onlookers. If this becomes a sufficient basis to warrant mercy killing, now the category of euthanizable people cannot be limited to individuals with incurable or fatal painful illnesses with little time to live. Now persons in all sorts of greatly reduced and degraded conditions—from persistent vegetative state to quadriplegia, from severe depression to the condition that now most horrifies, Alzheimer's disease—might have equal claim to have their suffering mercifully halted. The trouble, of course, is that most of these people can no longer request for themselves the dose of poison. Moreover, it will be difficult—if not impossible—to develop the requisite calculus of degradation or to define the threshold necessary for ending life.

### From voluntary to involuntary

Since it is so hard to describe precisely and “objectively” what kind and degree of pain, suffering, or bodily or mental impairment, and what degree of incurability or length of anticipated remaining life, could justify mercy killing, advocates repair (at least for the time being) to the principle of volition: the request for assistance in death is to be honored because it is freely made by the one whose life it is, and who, for one reason or another, cannot commit suicide alone. But this too is fraught with difficulty: How free or informed is a choice made under debilitated conditions? Can consent long in advance be sufficiently informed about all the particular circumstances that it is meant prospectively to cover? And, in any case, are not such choices easily and subtly manipulated, especially in the vulnerable? Kamisar is very perceptive on this subject:

Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alter-

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<sup>5</sup> The inexplicable failure of many physicians to provide the proper—and available—relief of pain is surely part of the reason why some people now insist that physicians (instead) should give them death.

native of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves 'eliminated' in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

Even were these problems soluble, the insistence on voluntariness as the justifying principle cannot be sustained. The enactment of a law legalizing mercy killing on voluntary request will certainly be challenged in the courts under the equal-protection clause of the Fourteenth Amendment. The law, after all, will not legalize assistance to suicides in general, but only mercy killing. The change will almost certainly occur not as an exception to the criminal law proscribing homicide but as a new "treatment option," as part of a right to "A Humane and Dignified Death."<sup>6</sup> Why, it will be argued, should the comatose or the demented be denied such a right or such a "treatment," just because they cannot claim it for themselves? This line of reasoning has already led courts to allow substituted judgment and proxy consent in termination-of-treatment cases since *Quinlan*, the case that, Kamisar rightly says, first "badly smudged, if it did not erase, the distinction between the right to choose one's own death and the right to choose someone else's." When proxies give their consent, they will do so on the basis not of autonomy but of a substantive judgment—namely, that for these or those reasons, the life in question is not worth living. Precisely because most of the cases that are candidates for mercy killing are of this sort, the line between voluntary and involuntary euthanasia cannot hold, and will be effaced by the intermediate case of the mentally impaired or comatose who are declared no longer willing to live because someone else wills that result for them. In fact, the more honest advocates of euthanasia openly admit that it is these nonvoluntary cases that they especially hope to dispatch, and that their plea for *voluntary* euthanasia is just a first step. It is easy to see the trains of abuses that are likely to follow the most innocent cases, especially because the innocent cases cannot be precisely and neatly separated from the rest.

Everyone is, of course, aware of the danger of abuses. So procedures are suggested to prevent their occurrence. But to provide real safeguards against killing the unwilling or the only half-heartedly willing, and to provide time for a change of mind, they must be

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<sup>6</sup> This was the title of the recently proposed California voter initiative that barely failed to gather enough signatures to appear on the November 1988 ballot. It will almost certainly be back.

intrusive, cumbersome, and costly. As Kamisar points out, the scrupulous euthanasiasts seek a goal “which is *inherently inconsistent*: a procedure for death which *both* (1) provides ample safeguards against abuse and mistake; and (2) is ‘quick’ and ‘easy’ in operation.” Whatever the procedure adopted, moreover, blanket immunity from lawsuits and criminal prosecution cannot be given in advance, especially because of ineradicable suspicions of coercion or engineered consent, and the likelihood of mixed motives and potential conflict, post mortem, among family members.

### **Damaging the doctor-patient relationship**

Abuses and conflicts aside, legalized mercy killing by doctors will almost certainly damage the doctor-patient relationship. The patient’s trust in the doctor’s wholehearted devotion to the patient’s best interests will be hard to sustain once doctors are licensed to kill. Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so—even if only in some well-circumscribed areas—will make a world of difference.

And it will make a world of psychic difference too for conscientious physicians. How easily will they be able to care wholeheartedly for patients when it is always possible to think of killing them as a “therapeutic option”? Shall it be penicillin and a respirator one more time, or perhaps just an overdose of morphine this time? Physicians get tired of treating patients who are hard to cure, who resist their best efforts, who are on their way down—“gorks,” “gomers,” and “vegetables” are only some of the less than affectionate names they receive from the house officers. Won’t it be tempting to think that death is the best treatment for the little old lady “dumped” again on the emergency room by the nearby nursing home?

Even the most humane and conscientious physician psychologically needs protection against himself and his weaknesses, if he is to care fully for those who entrust themselves to him. A physician friend who worked many years in a hospice caring for dying patients explained it to me most convincingly: “Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.” The psychological burden of the license to kill (not to speak of the brutalization of the physician-killers) could very well be an intoler-

ably high price to pay for physician-assisted euthanasia, especially if it also leads to greater remoteness, aloofness, and indifference as defenses against the guilt associated with harming those we care for.

The point, however, is not merely psychological and consequentialist: it is also moral and essential. My friend's horror at the thought that he might be tempted to kill his patients, were he not enjoined from doing so, embodies a deep understanding of the medical ethic and its intrinsic limits. We move from assessing the consequences to looking at medicine itself.

### The limits of medicine

Every activity can be distinguished, more or less easily, from other activities. Sometimes the boundaries are indistinct; it is not always easy, especially today, to distinguish some music from noise or some teaching from indoctrination. Medicine and healing are no different; it is sometimes hard to determine the boundaries, both with regard to ends and means. Is all cosmetic surgery healing? Are placebos—or food and water—drugs?

There is, of course, a temptation to finesse these questions of definition or to deny the existence of boundaries altogether: medicine *is* whatever doctors *do*, and doctors do whatever doctors *can*. Technique and power alone define the art. Put this way, we see the need for limits: Technique and power are ethically neutral, usable for both good and ill. The need for finding or setting limits to the use of power is especially important when the power is dangerous; it matters more that we know the proper limits on the use of medical power—or military power—than, say, the proper limits on the use of a paint brush or violin.

The beginning of ethics regarding power generally lies in nay-saying. Small children coming into their powers must be taught restraint, both for their own good and for the good of others. The wise setting of boundaries is based on discerning the excesses to which the power, unrestrained, is prone. Applied to the professions, this principle would establish strict outer limits—indeed, inviolable taboos—against those “occupational hazards” to which each profession is especially prone. *Within* these outer limits, no fixed rules of conduct apply; instead, prudence—the wise judgment of the man on the spot—finds and adopts the best course of action in light of the circumstances. But the outer limits themselves are fixed, firm, and nonnegotiable.

What are those limits for medicine? At least three are set forth in the venerable Hippocratic Oath: no breach of confidentiality; no

sexual relations with patients; no dispensing of deadly drugs.<sup>7</sup> These unqualified, self-imposed restrictions are readily understood in terms of the temptations to which the physician is most vulnerable, temptations in each case regarding an area of vulnerability and exposure that the practice of medicine requires of patients. Patients necessarily divulge and reveal private and intimate details of their personal lives; patients necessarily expose their naked bodies to the physician's objectifying gaze and investigating hands; patients necessarily entrust their very lives to the physician's skill, technique, and judgment. The exposure is, in all cases, one-sided and asymmetric: the doctor does not reveal his intimacies, display his nakedness, offer up his embodied life to the patient. The patient is vulnerable and exposed; the physician is neither, or, rather, his own vulnerabilities are not exposed to the patient. Mindful of the meaning of such nonmutual exposure, the physician voluntarily sets limits on his own conduct, pledging not to take advantage of or to violate the patient's intimacies, sexuality, or life itself.

The reason for these restraints is not just the asymmetry of power and the ever-present hazard of its abuse. The relationship between doctor and patient transforms the ordinary human meaning of exposure. Medical nakedness is not erotic nakedness; palpation is not caressing; frank speech is not shared intimacy and friendship; giving out diets and drugs is not hospitality. The physician necessarily objectifies, reduces, and analyzes, as he probes, pokes, and looks for latent clues and meanings, while curbing his own sentiments and interests, so as to make a diagnosis and find a remedy. The goal that constitutes the relationship requires the detachment of the physician and the asymmetry of exposure and communication, and legitimates the acquisition and exercise of power. Yet it also informs the limits on how the power should be used and the manner in which the patient should be treated.

The prohibition against killing patients rests also on a narrower ground, related not only to the meaning of the doctor-patient relationship, but also, once again, to the potentially deadly moral neutrality of medical technique—the problem of the two vials. For this reason, it stands as the *first* promise of self-restraint sworn to in the Hippocratic Oath, as medicine's primary taboo: "I will neither give

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<sup>7</sup> For a fuller discussion of these prohibitions, both in relation to the Hippocratic Oath and to the meaning of the doctor-patient relationship, see my essays, "Is There a Medical Ethic? The Hippocratic Oath and the Sources of Ethical Medicine," and "Professing Ethically: The Place of Ethics in Defining Medicine," in *Toward a More Natural Science*.

a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. . . . In purity and holiness I will guard my life and my art." In forswearing the giving of poison, the physician recognizes and restrains the godlike power he wields over patients, mindful that his drugs can both cure and kill. But in forswearing the giving of poison *when asked for it*, the Hippocratic physician rejects the view that the patient's choice for death can make killing him right. For the physician, at least, human life in living bodies commands respect and reverence—*by its very nature*. As its respectability does not depend upon human agreement or patient consent, revocation of one's consent to live does not deprive one's living body of respectability. The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself, and, therefore, also what the Oath calls the purity and holiness of the life and art to which he has sworn devotion. A person can choose to be a physician, but he cannot choose what physicianship means.

### The essence of medicine

One way to define medicine—or anything else—is to delimit its boundaries, to draw the line separating medicine from non-medicine, or its ethical from its unethical practice. Another way to define medicine—or anything else—is to capture its center, to discern its essence. In the best case, the two kinds of definitions will be related: the outer boundary will at least reflect, and will at best be determined by, what is at the center. Some practices are beyond the pale precisely because they contradict what is at the center.

To seek the center, one begins not with powers but with goals, not with means but with ends. In the Hippocratic Oath, the physician states his goal this way: "I will apply dietetic measures *for the benefit of the sick* according to my ability and judgment. I will keep them from harm and injustice." In a more thorough explication of the Oath in my book, I have argued that this little paragraph, properly unpacked, reveals the core of medicine. For example, the emphasis on dietetics indicates that medicine is a cooperative rather than a transformative art, and the physician an assistant to the immanent healing powers of the body. And because a body possessed of reason is a body whose "possessor" may lead it astray through ignorance or self-indulgence, the physician, as servant of the patient's good, must teach, advise, and exhort to keep him from *self-harm*

and injustice. Here I focus only on the modest little phrase, “the benefit of the sick.”

The physician as physician serves only the sick. He does not serve the relatives or the hospital or the national debt inflated due to Medicare costs. Thus he will never sacrifice the well-being of the sick to the convenience or pocketbook or feelings of the relatives or society. Moreover, the physician serves the sick not because they have rights or wants or claims, but because they are sick. The benefit needed by the sick qua sick is health. The healer works with and for those who need to be healed, in order to make them whole.

Healing is thus the central core of medicine: to heal, to make whole, is the doctor’s primary business. The sick, the ill, the unwell present themselves to the physician in the hope that he can help them become well—or, rather, as well as they can become, some degree of well-ness being possible always, this side of death. The physician shares that goal; his training has been devoted to making it possible for him to serve it. Despite enormous changes in medical technique and institutional practice, despite enormous changes in nosology and therapeutics, the center of medicine has not changed: it is as true today as it was in the days of Hippocrates that the ill desire to be whole; that wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire, move, and maintain itself; and that the relationship between the healer and the ill is constituted, essentially even if only tacitly, around the desire of both to promote the wholeness of the one who is ailing.

### Human wholeness

The wholeness and well-working of a human being is, of course, a rather complicated matter, much more so than for our animal friends and relations. Because of our powers of mind, our partial emancipation from the rule of instinct, our self-consciousness, and the highly complex and varied ways of life we follow as individuals and as members of groups, health and fitness seem to mean different things to different people, or even to the same person at different times of life. Moreover, departures from health have varying importance depending on the way of life one follows. Yet not everything is relative and contextual; beneath the variable and cultural lies the constant and organic, the well-regulated, properly balanced, and fully empowered human body. Indeed, only the existence of this natural and universal subject makes possible the study of medicine. The cornerstone of medical education is the analytic study of

the human body, *universally* considered: anatomy, physiology, biochemistry and molecular biology, genetics, microbiology, pathology, and pharmacology—all these sciences of somatic function, disorder, and remedy are the first business of medical schools, and they must be learned before one can hope to heal particular human beings.

But *human* wholeness goes beyond the kind of somatic wholeness abstractly and reductively studied by these various sciences. Whether or not doctors are sufficiently prepared by their training to recognize it, those who seek medical help in search of wholeness are *not to themselves* just bodies or organic machines. Each person intuitively knows himself to be a center of thoughts and desires, deeds and speeches, loves and hates, pleasures and pains, but a center whose workings are none other than the workings of his enlivened and mindful body. The patient presents himself to the physician, tacitly to be sure, as a psychophysical unity, as a *one*, not just as a body, but also not just as a separate disembodied entity that simply *has* or *owns* a body. The person and the body are self-identical. To be sure, the experience of psychophysical unity is often disturbed by illness, indeed, by bodily illness; it becomes hard to function as a unity if part of oneself is in revolt, is in pain, is debilitated. Yet the patient aspires to have the disturbance quieted, to restore the implicit feeling and functional fact of oneness with which we freely go about our business in the world. The sickness may be experienced largely as belonging to the body as something other; but the healing one wants is the wholeness of one's entire embodied being. Not the wholeness of *soma*, not the wholeness of *psyche*, but the wholeness of *anthropos* as a (puzzling) concretion of *soma-psyche* is the benefit sought by the sick. This human wholeness is what medicine is finally all about.

### Wholeness and killing

Can wholeness and healing ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead? There is, of course, a logical difficulty: how can any good exist for a being that is not? "Better off dead" is logical nonsense—unless, of course, death is not death at all but instead a gateway to a new and better life beyond. But the error is more than logical: to intend and to act for someone's good requires his continued existence to receive the benefit.

Certain attempts to benefit may in fact turn out, unintentionally, to be lethal. Giving adequate morphine to control pain might



induce respiratory depression leading to death. But the intent to relieve the pain of the living presupposes that the living still live to be relieved. This must be the starting point in discussing all medical benefits: no benefit without a beneficiary.

Against this view of healing the whole human being, someone will surely bring forth the hard cases: patients so ill-served by their bodies that they can no longer bear to live, bodies riddled with cancer and racked with pain, against which their “owners” protest in horror and from which they insist on being released. It is argued that it just isn’t true that we are psychophysical unities; rather, we are some hard-to-specify duality (or multiplicity) of impersonal organic body plus supervening consciousness, what the professionals dub personhood: awareness, intellect, will. Cannot the person “in the body” speak up against the rest, and request death for “personal” reasons?

However sympathetically we listen to such requests, we must see them as incoherent. Strict person-body dualism cannot be sustained. “Personhood” is manifest on earth only in living bodies; our highest mental functions are held up by, and are inseparable from, lowly metabolism, respiration, circulation, excretion. There may be blood without consciousness, but there is never consciousness without blood. The body is the living ground of all so-called higher functions. Thus one who calls for death in the service of personhood is like a tree seeking to cut its roots for the sake of growing its highest fruit. No physician, devoted to the benefit of the sick, can serve the patient as person by denying and thwarting his personal embodiment.

To say it plainly, to bring nothingness is incompatible with serving wholeness: one cannot heal—or comfort—by making nil. The healer cannot annihilate if he is truly to heal. The boundary condition, “No deadly drugs,” flows directly from the center, “Make whole.”

### Analogies

The reasonableness of this approach to medical ethics is supported by analogies with other professions. For example, we can clearly discover why suborning perjury and contempt of court are taboos for lawyers, why falsifying data is taboo for a scientist, or why violating the confessional is taboo for a priest, once we see the goals of these professions to be, respectively, justice under law, truth about nature, and purification of the soul before God. Let me expand two other analogies, somewhat closer to our topic.

Take the teacher. His business: to encourage, and to provide the occasion for, learning and understanding. Recognizing this central core, we see that the teacher ought never to oppose himself to the student's effort to learn, or even to his prospects for learning. This means, among other things, never ridiculing an honest effort, never crushing true curiosity or thoughtfulness; it also means opposing firmly the temptations that face students to scramble their minds through drugs. And even when the recalcitrant student refuses to make the effort, the teacher does not abandon his post, but continues to look for a way to arouse, to cajole, to inspire, to encourage. The teacher will perhaps not *pursue* the unwilling student, but as long as the student keeps coming to class, the true teacher will not participate in or assist him with his mental self-neglect.

Now consider the parent. These days only a fool would try to state precisely what the true business of a father or mother is, *qua* father or mother. Yet it must be something like protection, care, nurture, instruction, exhortation, chastisement, encouragement, and support, all in the service of the growth and development of a mature, healthy, competent, and decent adult, capable of an independent and responsible life of work and love and participation in community affairs—no easy task, especially now. What will the true parent do when teenagers rise in revolt and try to reject not only the teachings of their homes but even the parents themselves, when sons and daughters metaphorically kill their parents as parents by un-sonning and un-daughtering themselves? Should fathers acquiesce and willingly unfather themselves; should mothers stand against their life-work of rearing and abandon the child? Or does not the true parent “hang in there” in one way or another, despite the difficulty and sense of failure, and despite the need, perhaps, for great changes in his or her conduct? Does not the true parent refuse to surrender or to abandon the child, knowing that it would be deeply self-contradictory to deny the fact of one's parenthood, whatever the child may say or do? Again, one may freely choose or refuse to become a parent, but one cannot fully choose what parenthood means. The inner meaning of the work has claims on our hearts and minds, and sets boundaries on what we may do without self-contradiction and self-violation.

### When medicine fails

Being a physician, teacher, or parent has a central inner meaning that characterizes it essentially, and that is independent both of the demands of the “clients” and of the benevolent motives of the practi-

tioners. For a physician, to be sure, things go better when the patient is freely willing and the physician is virtuous and compassionate. But the physician's work centers on the goal of healing, and he is thereby bound not to behave in contradiction to that central goal.

But there is a difficulty. The central goal of medicine—health—is, in each case, a perishable good: inevitably, patients get irreversibly sick, patients degenerate, patients die. Unlike—at least on first glance—teaching or rearing the young, healing the sick is *in principle* a project that must at some point fail. And here is where all the trouble begins: How does one deal with “medical failure”? What does one seek when restoration of wholeness—or “much” wholeness—is by and large out of the question?

There is much that can and should be said on this topic, which is, after all, the root of the problems that give rise to the call for mercy killing. In my book I have argued for the primacy of easing pain and suffering, along with supporting and comforting speech, and, more to the point, the need to draw back from some efforts at prolongation of life that prolong or increase only the patient's pain, discomfort, and suffering. Although I am mindful of the dangers and aware of the impossibility of writing explicit rules for ceasing treatment—hence the need for prudence—considerations of the individual's health, activity, and state of mind must enter into decisions of *whether* and *how vigorously* to treat if the decision is indeed to be for the patient's good. Ceasing treatment and allowing death to occur when (and if) it will seem to be quite compatible with the respect that life itself commands for itself. For life is to be revered not only as manifested in physiological powers, but also as these powers are organized in the form of *a* life, with its beginning, middle, and end. Thus life can be revered not only in its preservation, but also in the manner in which we allow a given life to reach its terminus. For physicians to adhere to efforts at indefinite prolongation not only reduces them to slavish technicians without any intelligible goal, but also degrades and assaults the gravity and solemnity of a life in its close.

Ceasing medical intervention, allowing nature to take its course, differs fundamentally from mercy killing. For one thing, death does not necessarily follow the discontinuance of treatment; Karen Ann Quinlan lived more than ten years after the court allowed the “life-sustaining” respirator to be removed. Not the physician, but the underlying fatal illness becomes the true cause of death. More important morally, in ceasing treatment the physician need not *intend* the death of the patient, even when the death follows as a result of

his omission. His intention should be to avoid useless and degrading medical *additions* to the already sad end of a life. In contrast, in active, direct mercy killing the physician must, necessarily and indubitably, intend *primarily* that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death.

### Being humane and being human

Yet one may still ask: Is killing the patient, even on request, compatible with respecting the life that is failing or nearing its close? Obviously, the euthanasia movement thinks it is. Yet one of the arguments most often advanced by proponents of mercy killing seems to me rather to prove the reverse. Why, it is argued, do we put animals out of their misery but insist on compelling fellow human beings to suffer to the bitter end? Why, if it is not a contradiction for the veterinarian, does the medical ethic absolutely rule out mercy killing? Is this not simply inhumane?

Perhaps inhumane, but not thereby inhuman. On the contrary, it is precisely because animals are not human that we must treat them (merely) humanely. We put dumb animals to sleep because they do not know that they are dying, because they can make nothing of their misery or mortality, and, therefore, because they cannot live deliberately—i.e., humanly—in the face of their own suffering or dying. They cannot live out a fitting end. Compassion for their weakness and dumbness is our only appropriate emotion, and given our responsibility for their care and well-being, we do the only humane thing we can. But when a conscious human being asks us for death, by that very action he displays the presence of something that precludes our regarding him as a dumb animal. Humanity is owed humanity, not humaneness. Humanity is owed the bolstering of the human, even or especially in its dying moments, in resistance to the temptation to ignore its presence in the sight of suffering.

What humanity needs most in the face of evils is courage, the ability to stand against fear and pain and thoughts of nothingness. The deaths we most admire are those of people who, knowing that they are dying, face the fact frontally and act accordingly: they set their affairs in order, they arrange what could be final meetings with their loved ones, and yet, with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can. Because such conclusions of life require courage, they call for our encouragement—and for the

many small speeches and deeds that shore up the human spirit against despair and defeat.

Many doctors are in fact rather poor at this sort of encouragement. They tend to regard every dying or incurable patient as a failure, as if an earlier diagnosis or a more vigorous intervention might have avoided what is, in truth, an inevitable collapse. The enormous successes of medicine these past fifty years have made both doctors and laymen less prepared than ever to accept the fact of finitude. Doctors behave, not without some reason, as if they have godlike powers to revive the moribund; laymen expect an endless string of medical miracles. It is against this background that terminal illness or incurable disease appears as medical failure, an affront to medical pride. Physicians today are not likely to be agents of encouragement once their technique begins to fail.

It is, of course, partly for these reasons that doctors will be pressed to kill—and many of them will, alas, be willing. Having adopted a largely technical approach to healing, having medicalized so much of the end of life, doctors are being asked—often with thinly veiled anger—to provide a final technical solution for the evil of human finitude and for their own technical failure: If you cannot cure me, kill me. The last gasp of autonomy or cry for dignity is asserted against a medicalization and institutionalization of the end of life that robs the old and the incurable of most of their autonomy and dignity: intubated and electrified, with bizarre mechanical companions, helpless and regimented, once proud and independent people find themselves cast in the roles of passive, obedient, highly disciplined children. People who care for autonomy and dignity should try to reverse this dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate goodbye-to-all-that contained in one final plea for poison.

The present crisis that leads some to press for active euthanasia is really an opportunity to learn the limits of the medicalization of life and death and to recover an appreciation of living with and against mortality. It is an opportunity for physicians to recover an understanding that there remains a residual human wholeness—however precarious—that can be cared for even in the face of incurable and terminal illness. Should doctors cave in, should doctors become technical dispensers of death, they will not only be abandoning their posts, their patients, and their duty to care; they will set the worst sort of example for the community at large—teaching **technicism and so-called humaneness where encouragement and**

humanity are both required and sorely lacking. On the other hand, should physicians hold fast, should they give back to Athena her deadly vial, should medicine recover the latent anthropological knowledge that alone can vindicate its venerable but now threatened practice, should doctors learn that finitude is no disgrace and that human wholeness can be cared for to the very end, medicine may serve not only the good of its patients, but also, by example, the failing moral health of modern times.

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