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Finitude, scarce resources, and end-of-life decision-making

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1. A collision of incompatible moral perspectives

To age is to come ever closer to death. To recognize the phenomenon of aging is to be pressed to reflect on end-of-life decisions. That one grows old invites one to plan for death. Yet how properly to approach aging, death, and end-of-life decision-making is a matter of no little dispute. End-of-life decision-making is a major area of bioethical controversy. The controversies are grounded in radically different views regarding the scope, content, and character of morality, including the moral significance of intending to kill a consenting, suffering person. On one side of the moral divide driving in these controversies, the moral account embraced recognizes that the character of an action, including an inaction, that willfully leads to the death of an innocent person is adversely determined by the actor's intention to expedite death, such that the consent of the persons killed does not cure the action of an immoral character nor save the agent from having acted immorally. On the other side of the moral divide are those who hold that in proper circumstances consent fully cures, such that killing a suffering, consenting patient will not count as murder, but as a properly beneficent act. The dominant secular culture, which supports this second view, is foundationally different from that embraced within traditional Christian moral understanding.

The dominant secular morality that emerged after the Enlightenment and the French Revolution has deflated, if not recast, the moral significance of major domains of traditionally moral choices. The secular understanding, which accepts the moral licitness of physician-assisted suicide and euthanasia, hopes to reduce the content of end-of-life decisions to matters of personal preference, affirm the cardinal role of self-determination or autonomy, and create claim rights to the assistance by health care providers with suicide and the provision of euthanasia. The secular culture seeks to shift the moral focus from the content of such decisions to the place of autonomy in the process of decision-making.[1] That such choices are made freely becomes more significant than the content of end-of-life decisions themselves. This autonomy-directed focus has proved cardinal in the move to establish physician-assisted suicide and/or euthanasia in the Netherlands (ten Have & Welie 2005), Belgium (Griffiths 2008), and elsewhere (Baezner 2008, Rothschild 2008), including the USA.[2]

Those in controversy are often separated by incompatible metaphysical appreciations of the human condition. The secular views are shaped by an atheistic methodological postulate[3] that invites one to approach reality as if everything, including human life, were without an ultimate defining significance, and as if there were no life after death. In contrast, the traditional Christian appreciation of end-of-life decision-making recognizes all to be set within a relation to God, Who is the source of ultimate meaning. End-of-life decision-making is then placed within a recognition of life after death. The gulf separating these two life-worlds is stark. Traditional Chris-

tians recognize that all comes from the creative act of God, and possesses an enduring significance in an after-life, while the secularists claim that all comes from nowhere, goes nowhere, and for no ultimate purpose, as well as holding that death is the end of personal existence. In the latter case, each individual within constraints that require the affirmation of liberty, equality, human dignity, and social justice is left to make his own final judgment regarding the purpose of his life. The loss of the recogition of a possible God's-eye perspective and of God as the enforcer of sanctions against the immoral involves a watershed change in the meaning of moral obligation (Engelhardt 2010a). The now-dominant secular morality that has developed in the West (Engelhardt 2010b) places end-of-life decision-making in a moral context different from that within which such decisions have traditionally been located.

End-of-life decision-making, as well as all that surrounds aging, is thus set within disparate moral-metaphysical visions. The result is that some will recognize no value in the suffering associated with dying or even with sustaining life in the face of the serious disease, disability, and loss of decisional capacity that often mark aging. For persons who live as if they were confined within the horizon of the finite and the immanent, it will make sense to establish advance directives for physician-assisted suicide and euthanasia. However, those who live authentically within the compass of a traditional Christian moral vision will regard the risk of disease, disability, and the loss of decisional capacity as offering for themselves as well as for those who may in charity come to their aid an occasion for humility, submission to the will of God, and repentance. Those who live within a traditional appreciation of the Cross of Christ as the door to resurrection will know that the humble acceptance of suffering and most crucially repentance, not dignity, are essential for a good death. The major downside risk of serious illness is not death, or even death with suffering, but dying unrepentant. This has the consequence that the worst death is one that comes without warning in one's sleep. For this reason, the traditional prayer is to be preserved from a sudden death for which one may not have adequately prepared: *a subitanea et improvisa morte, libera nos, Domine (Rituale Romanum* 1947, p. 106). Yet now, for many, the good death is a painless death in one's sleep without warning, but with good advance financial planning, though without the labor of spiritual preparation. In contrast, Orthodox Christians pray for „a Christian ending to our life, painless, blameless, peaceful; and a good defense before the dread judgment Seat of Christ".[4]

These profound metaphysical differences are reflected in the fragmented character of the cultures of Europe and the Americas. They give depth to the moral and bioethical disagreements about whether it is licit, forbidden, or obligatory to be involved in physician-assisted suicide or voluntary active euthanasia. The emerging post-Christian, post-traditional morality and its bioethics stand out in sharp contrast with, if not in opposition to, the Christian moral-theological position that lies in the background of contemporary European culture. This secular culture can but regard traditional Christian moral views, and the approach to law and public policy that they support, as wrongheaded and as an impediment to appropriate planning for the health care needed by finite, mortal beings who age. Of course, the traditional Christian understanding appreciates that the emerging secular view not only embraces vices as if they were virtues, but also trivializes the significance of proper end-of-life decision-making. These incompatible world-views frame the culture wars that underlie attempts to create general public policy to meet the needs of humans in general and of aging societies in particular.[5]

This presentation explores these core moral and metaphysical disagreements as they are reflected in disputes regarding:

1. the significance of life and death, which controversies are supported by disagreements regarding the existence of God and an after-life;

2. the moral significance of directly intending to expedite the death of a consenting patient, which significance for current debates is highlighted by the historical background of a Christian moral-theological perspective, which sustains a morality that historically undergirds contemporary European and American law and is at odds with the now-dominant secular morality;
3. the obligation to provide or accept life-prolonging treatment, as well as the scope of such treatment.

Given the circumstance that these conflicting views are supported by divergent moral communities with foundationally disparate metaphysical and moral understandings, the strength of these disagreements will not likely abate.[6] The goal of this presentation is not to propose solutions or to advance a particular approach to end-of-life decision-making in aging societies. Instead, the goal is the more modest one of better appreciating the roots of the controversies in European and American societies that had once been Christian polities and that are now in many ways post-Christian, post-traditional, secular polities.

2. Finite, mortal, aging beings: Some of the challenges

Angels do not need to plan for their old age, for they neither grow old nor die. Such is not the case with fallen humans, who are not just finite, but mortal and face senescence. If humans do not die young, they will grow old, and with increased age there is an increasing likelihood of illness, disability, loss of decisional capacity, and the fate of living in circumstances that they may hold to be unacceptable. As a consequence, there are good grounds for humans as individuals as well as in families, communities, and governments to acquire and save resources for the treatment of infirmities, especially those of old age, as well as to establish advance directives for medical care and end-of-life decision-making, given the risks of loss of decisional capacity. Although over a quarter of health care resources is invested in the last year of life (Lubitz & Riley 1993), it is difficult to know for sure when one is in the last months of life. Given the certainty of death, the uncertainty of when death will occur and the unpredictability of how many resources one will need for the last years of one's life, one is invited by this state of affairs to defer the use of resources, which one could otherwise expend on the pleasures of youth, so as to have enough to support the medical and other needs of old age. Given a future possible period of significant disability, the uncertainties are considerable if one is unable to control the time of one's death.

If one is likely to oversave, given the risk of growing old and impecunious, and if one lives within a family structure that affirms familist values, then the bequest of excess unused resources to one's family will not be regarded as a loss but as an opportunity to support familial goals. However, if one lives as an atomic individual without close bonds to future generations, the oversaving of resources may more likely be negatively, not positively, regarded. One will have disproportionately saved for an old age one will not enjoy if one dies younger than one expected. The moral gulf separating those who live within a familist understanding of human flourishing from those who live within an individualist understanding of human flourishing compounds the other differences in approach to how one should regard and respond to the opacity of the risks of aging (Engelhardt 2007). Developments in biomedical technology, the costs of interventions to postpone death, and the resources needed to maintain acceptable function can exceed available resources. One usually lacks the ability to predict the costs in one's own case; this state of affairs requires individuals, families, and states to recognize that they cannot commit all the resources necessary to secure all possible benefits. Given competing goals, enough resources will not be available to provide for all interventions that could reduce morbidity

and postpone death. Faced with this defining character of the human condition, the finitude of human capacities and resources, one may conclude that the best choice under the circumstance is, as the Texan proverb goes, to "live fast and leave a good-looking corpse." More precisely, if one is able to give instructions via an advance directive for voluntary active euthanasia, so as to effect one's death when resources are exhausted, morbidities become excessive, and/or decisional capacities are lost, then one could better live within and up to the limits of one's budget. However, this choice collides with the background traditional moral and legal assumptions of Europe and the Americas.

These controversies are further compounded by the difficulties associated with social-democratic welfare approaches to providing funding for the care of aging populations. The commitment to a social entitlement approach to the funding of health care for an aging population confronts from four significant challenges: (1) the moral hazard that once entitlements to care are established, the entitlement holders will tend to exploit those entitlements; (2) the demographic hazard that there may be insufficient workers in the future to provide the level of care for aging non-workers now in place; (3) the political hazard that, in order to advance their political careers, politicians are tempted to promise benefits that will not in the future be financially sustainable; and (4) the ethical hazard that disparate moral and metaphysical views will bring into question the long-term sustainability of any public policy approach into question, given foundational moral disagreements regarding the proper character of such policies. A way free from the full weight of these difficulties is an approach such as Singapore's, which compels all to save for their own care so that they can choose what purchases to make, thus blunting the challenges posed by the moral, demographic, political, and ethical hazards besetting social-democratic welfare approaches. When end-of-life decision-making is nested within a Confucian, pro-familist ethos and policy structures such as Singapore's that supports transferring resources within a family, where resources can be passed to heirs and assigns, and where choices are set within a fabric of intra-familial responsibility shaped by a concern for one's own future generations, these challenges can be rendered less significant (Engelhardt 2008).

Western Europe and the Americas must frame policy for end-of-life decision-making in a dominant culture that is largely individualistic, non-familist, and non-Confucian, not to mention post-Christian. Within this dominant secular culture, the meaning of sex, reproduction, dying, and death are relocated within the horizon of the finite and the immanent and shorn of ultimate meaning. Nevertheless, a large dimension of these societies and their legal frameworks remain shaped by Christian understandings. In addition, Christianity has not evanesced but remains present and is joined by the contributions to this moral pluralism made by Jews, especially Orthodox Jews, and devout Mohammedans. The result is that there are foundational moral and metaphysical disagreements about how to face the circumstance that humans are finite, mortal beings who age. These disagreements sustain incompatible visions of proper moral decision-making in the face of the prospect of aging and death (Engelhardt 2000, chap. 6). Despite the salience of the contemporary dominant, post-Christian, post-familist, post-traditional culture of Europe and the Americas, one will need at the very least to appreciate the quite different historical background culture that still operates as a counter-culture to the culture dominant in the public forum and public spaces constituting a major source of much of the disputes of the contemporary culture wars.

3. Even Europe faces moral pluralism: Physician-assisted suicide and euthanasia

Those at dispute disagree not just regarding particular issues such as the morality of physician-assisted suicide and euthanasia, but regarding foundational moral premises and rules of moral evidence.[7] As a consequence, there is no neutral discursive moral rationality that can be invoked in sound rational argument to resolve foundational moral and bioethical disagreements, with the result that moral pluralism in bioethics is real, salient, and intractable.[8] There is no consensus on substantive issues in health care policy (Engelhardt 2006), nor is there consensus as to what should count as a consensus or why a consensus of any magnitude should be morally binding, although a consensus will surely possess political force (Engelhardt 2010c, 2010d). This post-modern state of foundational disagreement exists in the United States, Europe, and elsewhere, not just because of the presence in Europe of post-Christians who have entered into the secularized morality of modernity, who now confront those committed to traditional religious communities, but also and crucially because there is no one canonical account of secular moral rationality (Engelhardt 2002).

There is the further circumstance that traditional Christian understandings on these latter matters were recast in the West in the early second millennium into the idiom of natural law as Roman Catholicism emerged and embraced the project of embedding faith and morality within the demands of philosophical reason. This dialectic of faith and reason that engendered Roman Catholicism as a separate denomination between the 9th century and the early second millennium (Engelhardt 2003, 2006) also eventually produced a culture that through the Enlightenment and the ideological consequences of the French Revolution led to a secularization of Western culture and a further secularization of Roman Catholicism. The result is that, as Gianni Vattimo argues, one can regard this secularity as a continuity of Western Christianity (Vattimo 2002). This dialectic of philosophy and theology, which secularized traditional Christian concerns, severed moral intuitions (e.g., "there is something morally wrong with suicide, assisted suicide, and euthanasia") from the metaphysics that had sustained them, and undermined a range of the moral views that Western culture had from the fourth century embraced (i.e., there was no longer the recognition of the God Who forbids a set of consensual actions among competent adults, including physician-assisted suicide and voluntary euthanasia). For those who are secularized or are being secularized, these moral intuitions are slowly being eroded.

It is for this reason that many areas of life that were once considered to involve substantive moral choices (e.g., consensual sexual activity and the consensual expediting of death) have been reduced or are being reduced to matters of aesthetic or personal choice, set within complex, post-Enlightenment, moral side constraints regarding respect for oneself and others.[9] Given this cultural transformation, what is coming to be of importance is not the content of end-of-life decisions, but that such decisions be made freely, informed and directed by one's own values. Given a loss of a canonical understanding of the good life, a good old age, or a good death, the moral content of end-of-life decisions is deflated, and autonomy emerges not just as the source of authority for one's end-of-life decisions, whatever they might be, but as the cardinal source of the moral significance of such decisions. End-of-life decision-making becomes framed by Enlightenment concerns with autonomy not as merely free choice, but as a free choice reflecting a particular substantive view of liberty (Schneewind 1997)

Autonomy thus comes to serve not only as a source of authority for collaboration with others, but is valued in itself so as to be invoked as an overriding good to be pursued for its own sake. This lexical valuing of autonomy leads to advancing claims against others

for assistance in realizing one's own view of the proper ways in which one should end one's life. In this post-Christian account, where the moral significance of the content of end-of-life decisions is deflated (e.g., as to whether actively to end one's life), in the sense of being regarded as matters of personal preference, such choices are not merely to be tolerated in the sense of not being coercively interdicted, but are seen properly to be supported and abetted. The moral importance of autonomy is held to generate a claim on others to assistance and support in realizing one's own autonomous choices. Traditional adverse moral judgments of such autonomous choices (e.g., "physician-assisted suicide involves immoral collaboration in self-murder") also come to be regarded as improperly abusive instances of intolerance, if not hate speech. Terms such as "assistance in dying" come to be engaged in order to replace those terms that recognize the intentional expediting of death as killing or self-killing (e.g., "suicide"). Not only is the term "passive euthanasia" to be avoided, but even the terms active euthanasia and physician-assisted suicide are marginalized so as not to import a negative moral valence from the background traditional morality. As a result, there is a significant moral conflict between a view that regards physician-assisted suicide and voluntary active and passive euthanasia not only as licit but to be supported by health care institutions and professionals, versus the traditional Christian recognition of the immorality of intentionally expediting one's own death as well as of the immorality of aiding in the death of innocent consenting others, no matter how much they may be suffering.

Because Christianity has traditionally prohibited intentionally killing the innocent, even with their consent (Engelhardt & Iltis 2005), there remain in many European and American jurisdictions distinctions between foreseeing but not intending the possible consequences of actions and omissions. For example, within this traditional moral understanding and the legal frameworks they still sustain, it can be appropriate intentionally to engage in activities, or omit or cease particular actions that one foresees may hasten the death of a patient, as long as these acts involve no intention to kill, do not provide their benefits through expediting death, and are likely to cause more good than harm. Within these traditional moral constraints physicians are at liberty, and are often obliged, to act, omit actions, or cease actions, knowing that among the foreseeable consequences may be the earlier death of a patient. In contrast, as has already been noted, a post-tradtional secular morality has emerged within which the cardinal considerations are autonomy, equality, personal dignity, and social justice, such that traditional sexual, reproductive, and end-of-life morality, including the concern not to intend to expedite death, becomes at best a matter of personal preference. In many jurisdictions, these changes are recasting what is legally and professionally appropriate conduct. In contrast, within the traditional background Christian morality, one is required not just to abstain from any maleficent intention, but also from the intention to kill the innocent even when the innocent consents because of unbearable pain and suffering.[10] For those outside of this traditional moral framework, the side constraint of eschewing the intention to expedite death will seem unjustified, if not also precious.

As a result, there is a range of actions that in terms of the behaviors involved, but not in terms of the intentions embraced, could pass for either active or passive euthanasia, or as a proper intervention or a proper withholding or withdrawing of treatment. Within the contrasting moral perspectives, the same behaviors can have a quite different moral significance, given a different intention. Within traditional Christianity, it can be morally appropriate, absent the intention of expediting death, to provide aggressive comfort care that may have the unintended side effect of hastening death. So, too, it can be morally appropriate to withhold or withdraw diagnostic therapeutic interventions that will likely involve more harms, especially spiritual harms,

than benefits, as long as there is no intention to expedite death, even though death may come sooner. However, in the traditional account it will be morally prohibited to engage in any intervention with the intention of expediting death, as well as to withhold or withdraw treatment with the intention of expediting death. In contrast, in the emerging, secular, post-traditional moral view it is morally appropriate not only to provide aggressive comfort care with the intention of also hastening death of a suffering, consenting patient, but in addition it is held to be appropriate to withdraw and/or withhold diagnostic and therapeutic interventions that involve more harm than benefit, while also intending to effect an earlier death.[11] In this account, the presence of an intention to expedite death is no longer *per se* of moral significance. Instead, the focus is on the consent and the immanent well-being of the patient. The result is a conflict of incompatible views of the proper character of end-of-life decision-making.

4. Obligatory versus non-obligatory treatment

Beyond the matter of intending to expedite death, there is the question of what medical interventions, especially life-prolonging treatments, one is obliged to offer and/or accept, and when. As a matter of public policy, this is tied to the issue of what basic service package should be provided in general and in old age in particular. This in turn raises the question of rationing and the need to note at the outset three fundamentally different ways in which the term rationing can be engaged: (1) market rationing, where one has access to that for which one can pay; (2) service package rationing, where one buys or has purchased for oneself a particular package of services; and (3) prohibitive rationing, which renders illicit the purchase or sale of certain forms of better basic care or even of luxury care. Health insurance systems engage in service package rationing through the exclusion of experimental therapies and certain high-cost-low-yield interventions. In general, the issue is what package of services ought to be provided, leaving those who wish and can to purchase more than the ordinary package, including better basic care. All health care systems must engage in service package rationing.

The traditional Western moral understanding of the obligation to accept or out of charity to provide particular diagnostic and therapeutic interventions achieved much of its current character as a result of secularized reflections articulated within Roman Catholicism that hide their roots in traditional Christian concerns. The distinctions between ordinary and extraordinary care that came to be accepted in Roman Catholicism, and that have had wide secular influence, took shape in the 16th century and were articulated within a Western Christianity already substantively different from that of the Christianity of the first millennium.[12] The line between ordinary and extraordinary treatment focused on when a treatment involved an appropriate or inappropriate balance between likely benefits and harms, thus identifying extraordinary interventions as not obligatory in not enjoying an appropriate positive balance of likely benefits over harms, with the latter consideration including financial costs. Roman Catholicism came to frame this distinction in terms of when treatment is proportionate or disproportionate. The distinction between extraordinary or non-obligatory versus ordinary or obligatory treatment takes into consideration financial costs, psychological costs, social costs, dignity costs, and moral costs. This body of reflections also considers the likelihood of success in terms of the quality of life to be secured. Treatment is generally held to be obligatory only if there were hope of recovering health. This assessment also takes into account the quantity of life likely to be secured. Treatment that does not restore health or that secures only a minor postponement of death is not held to be obligatory.[13]

This account of obligatory versus non-obligatory treatment was set within the hope that a natural-law framework could be articu-

lated and made defensible within a mutually shared view of secular moral rationality. The supposition was that right reason could in principle lead all to common moral conclusions. Questions as to when it was permissible to withhold or withdraw possibly life-preserving medical interventions became equivalent to the question as to when in natural law the duty to maintain life had been defeated. That is, accounts of the norms for withholding or withdrawing medical interventions looked to the circumstances under which the duty to preserve life was out-balanced by the burden of the costs involved, or by the unlikelihood of restoring or maintaining health. This reformulation of Christian duties allowed a fully secular articulation of the norms for the proper use of resources to maintain life.[14] So articulated, the norms were held in principle to be expressible, absent specific Christian concerns.[15] Given these background assumptions, one could be optimistic regarding the possibility of creating a common approach in the area of health care in general, and with regard to end-of-life decision-making and care for the aged in particular.[16]

Appeals to futility, it should be noted, are not an adequate substitute for the traditional distinction between ordinary versus extraordinary care, in that most treatments about which there is a question as to whether they should be withheld or withdrawn are not truly futile, that is, absolutely without any benefit. Futility determinations usually mask under the term "futile" considerations of the likelihood of success, issues of the length of life likely to be achieved, the quality of life likely to be realized, and the amount of resources needed to engage the treatment in question. So-called futility determinations are multiform and include not only treatment that is truly futile in the sense of absolutely impossible, but more usually determinations as to when a treatment will provide an insufficient quality and quantity of life or involve unacceptable costs. Appeals to futility are thus really judgments as to when further treatment is obligatory or not obligatory, appropriate or inappropriate, ordinary or extraordinary, that is, regarding whether a treatment will involve more costs than benefits. The crucial problem is that common determinations of the line between appropriate and inappropriate care require a common understanding of how to compare death versus suffering, not to mention issues bearing on the purpose of living and the meaning of death, regarding which, as already noted, there is disagreement.

Contrary to the intentions of those involved, the discourses of ordinary versus extraordinary treatment, as well as of futility determinations, have not decreased the salience of moral pluralism in matters bearing on end-of-life decision-making. Instead, the character of the culture wars regarding end-of-life decision-making has been both obscured and intensified by Roman Catholicism's attempt to recast Christianity's traditional morality regarding end-of-life decision-making, through rearticulating religious commitments in the language of a secular morality expressed in natural-law considerations. First, there is no one common standard of moral rationality that can identify a canonical balance of morbidity, mortality risks, financial costs, and psycho-social distress, thus setting controversies aside. Second, a cleft in the culture wars emerges, separating natural-law approaches from traditional Christian approaches. In contrast, with the discourse of proportionate versus disproportionate interventions, concerns with regard to end-of-life decision-making in the Christianity of the first millennium, continued in traditional Christianity today, are not articulated within a natural-law framework supposedly open to persons as such. Instead, end-of-life treatment decisions are approached in terms of what is necessary for persons to turn rightly to the personal God, the Trinity.[17] By not being embedded in the more anonymous language of a natural-law ethics, but by instead being framed in the personal language of turning in repentance and love to one's Creator, this approach cannot be shared with non-believers, or even believers of another sort.

Christianity traditionally recognizes medicine as a gift of God so that medicine's ap-

propriate use is considered not only good but obligatory. However, any use of medicine is rejected that is so all-encompassing for the patient or the family as to distract their focus from God. The point is that, if one tries to save life at all costs, one will turn this life and medicine into idols. It is for this reason that traditional Christianity forbids

Whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around solicitude for the flesh must be avoided by Christians. Consequently, we must take great care to employ this medical art, if it should be necessary, not as making it wholly accountable for our state of health or illness, but as redounding to the glory of God and as a parallel to the care given the soul (Basil 1962, pp. 331-332).

St. Basil (A.D. 329-379) in summarizing this point reminds his reader to avoid medical interventions that would involve an inordinate solicitude for the flesh. In addition, St. Basil reminds his reader to keep his central focus on his relationship with God, so that "we should keep as our objective (again I say it), our spiritual benefit..." (Basil 1962, p. 334). One is obliged to avoid, one is not simply at liberty to decline, treatment that involves an undue solicitude for the flesh and that is not supportive of the responsible care of one's soul. End-of-life decision-making, as a consequence, is placed within a very particular, highly theologically-freighted, very personal struggle of repentance, of turning from ourselves to God. For this reason, as St. Basil concludes:

Therefore, whether we follow the precepts of the medical art or decline to have recourse to them for any of the reasons mentioned above, we should hold to our objective of pleasing God and see to it that the soul's benefit is assured, fulfilling thus the Apostle's precept: "Whether you eat or drink or whatsoever else you do, do all to the glory of God (I Cor 10:31)" (Basil 1962, pp. 336-337).

Although in traditional Christian reflections, continued in Orthodox Christian reflections, there is a concern with using right reason in determining which treatment is appropriate or inappropriate, appropriateness and inappropriateness are articulated in terms of a content that is spiritual/therapeutic, not focused on appeals to natural-law, much less general secular moral philosophical concerns.

5. Agreeing to disagree: Forbearance rights and advance directives

The question then is whether one can sidestep these controversies through the use of advance directives. In the face of moral pluralism, advance directives developed in the United States as a practical means for resolving some of the bioethical controversies regarding end-of-life decision-making by appeals to forbearance rights and contractual agreement (King 1996, Ulrich 1999). In the face of substantive moral and metaphysical disagreement, advance directives can function as a default strategy that allows one to avoid directly addressing some substantive moral disagreements as to what amount of health care should be provided for the dying who have lost decisional capacity. For most advance directives, the accent is on forbearance rights expressed in the right not to receive treatment that one has not authorized, as well as the right to receive that treatment specified through agreement. Such approaches can often sidestep controversial issues such as whether a quicker death is being intended by a request to withhold or withdraw treatment by instead focusing attention simply on what medical interpretations have been authorized or refused.[18]

Advance directives in various forms in different jurisdictions across the United States and the world allow patients while competent to refuse specific medical interventions, should they become incompetent. Formal directives to physicians allow patients to direct what treatment they do or do not consent to

receive when terminal, or even in some jurisdictions, when suffering from the last stages of an incapacitating disease such as Alzheimer's. Policies that establish presumptive surrogate decision-makers usually recognize family members as the persons to report on behalf of the patient the patient's past wishes concerning treatment. Finally, other instruments formally appoint agents with a specific medical power-of-attorney who can make treatment choices, including withholding and withdrawing treatment. In most of these circumstances, the issues of intentionally expediting death can be avoided by focusing instead on not providing treatment in the face of the patient's refusal. Cases of *de facto* requests by patients for passive euthanasia can be treated as withdrawals of the consent for treatment.

Advance directives will not in the long run ameliorate but will instead likely contribute to the conflicts of the culture wars, in that by being used to request voluntary active euthanasia, they will engender conflicts with the forbearance rights of physicians, nurses, and particular health care institutions committed to avoiding any involvement in the provision of physician-assisted suicide or euthanasia. In addition, absent a health savings account approach to health care financing such as in Singapore, advance directives that generate a legal claim right for medical care generate claims against the resources of others for procedures that they may recognize as immoral. Approaches such as Singapore's, which rely primarily on health savings accounts (HSAs) can largely export such controversies regarding planning for aging and facing end-of-life decisions to the decisions of and the use of resources provided by particular individuals and families.[19] Absent a shift from health care being financed by taxes and/or by compelled insurance contributions to one supported primarily by a health savings account system such as Singapore's, one faces substantive public policy controversies regarding both the level of health care one should provide and which may be requested by the aged, as well as regarding compelled public support of physician-assisted suicide and euthanasia. Controversies regarding the character of appropriate end-of-life decision-making turn on controversies regarding the appropriate values, commitments, and side constraints that define the character of the good life and good death. These matters are deeply controversial.

6. End-of-life decision-making in post-Christian, post-modern societies

Despite desperate declarations of consensus, there is profound moral and bioethical disagreement. The controversies associated with end-of-life decision-making both with regard to the morality of willfully intending to expedite the death of consenting innocent persons and with respect to the amount of life-extending health care that ought to be provided or accepted are set within a much broader web of controversies, including controversies regarding the morality of third-party-assisted reproduction, human embryonic stem cell research, abortion, and the social-welfare state, as well as human sexual relations outside of the marriage of a man and a woman. These controversies are shaped and compounded by deep metaphysical disagreements about the existence of God, an afterlife, and the ultimate significance of reality. In an individualistic, secular culture often aimed at immanent self-satisfaction and self-fulfillment, where all is nested within the horizon of the finite, interests in extending life as long as it is on balance acceptable, concerns about controlling pain and suffering, and commitments to enhance autonomous self-determination (e.g., "I did it my way") will predominate in end-of-life decision-making and give content to claims regarding the characteristics of a death with dignity. Transcendent concerns will be discounted, if not rejected, and physician-assisted suicide and euthanasia will appear as an appropriate possible choice. Such affirmations of appropriate personal preference will be regarded as expressing the

dignity of self-control in the immanent self-constitution of meaning. Access to physician-assisted suicide and euthanasia will even be regarded as a claim right grounded in an evolving secular narrative that is moving from regarding autonomy as the source of authorization to affirming autonomy as a positive element of human dignity that generates morally compelling demands on others for support.

However, the secularization of the dominant culture has not led to the secularization of all communities that the societies of the Americas and Western Europe compass. Traditional Christians and their communities remain, as do those of Orthodox Jews and faithful Mohammedans, thus sustaining conflicting moral and metaphysical understandings. Moreover, in the absence of common moral premises and rules of evidence, even the secular debates about how to plan for aging and death will be intractable. The engagement of adverse directives in planning for aging and death will likely in the end compound the disagreements. End-of-life decisions and the project of planning for a life marked by aging will continue to be matters of which the battles in the culture war are made. Following the battles around abortion, a new fault line in the culture wars is thus now opening, bearing on decisions at the end of life, and with respect to care for the aged in particular.

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Footnotes

[1] The secular culture's deflation of the moral content in end-of-life decision-making and the general reduction of lifestyle and deathstyle choices to the issue of autonomy were appreciated in the old Texas legal position in the matter of assisted suicide, which had no prohibitions, no matter who did the assisting or abetting. "It may be a violation of morals and ethics and reprehensible that a party may furnish another poison or

pistols or guns or any other means or agency for the purpose of the suicide to take his own life, yet our law has not seen proper to punish such persons or such acts." Sanders v. State, 54 Tex. Crim. 101, 105, 112 S.W. 68, 70 (1908). This position has subsequently been changed by statute. See Engelhardt & Malloy 1982.

[2] In the United States, there have been moves to legalize physician-assisted suicide, as in Oregon (The Oregon Death with Dignity Act: Oregon Revised Statute 127.800-995) and then later in Washington (Revised Code of Washington 70.245) and Montana (Baxter v. State of Montana, http://compassionandchoices.org/documents/Baxter_complaint.pdf [accessed 1-15-2010]). At the national level in the United States, these issues fall within an area of profound moral disagreement and controversy. In the United States, on March 6, 1996, the United States Court of Appeals for the Ninth Circuit held that a liberty right exists regarding the choice of how and when one dies. In particular, the Appellate Court held that the provision of the Washington State statute banning assisted suicide when applied to competent terminally ill patients who wish to hasten their death by obtaining medication prescribed by their physician violated the due process requirements of the United States Constitution. Also, on April 2, 1996, the United States Court of Appeals for the Second Circuit declared unconstitutional two New York statutes penalizing assistance in suicide to the extent to which those statutes prohibit physicians from acceding to requests to hasten death for terminally ill, mentally competent patients. The position of these lower courts was not upheld by the U.S. Supreme Court, which recognized no constitutional right to physician-assisted suicide, but instead acknowledged that it was a matter for state legislation. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* Washington v. Glucksberg, 117 S. Ct. 2258 (1997); Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), rev'd, 117 S. Ct. 2293 (1997).

[3] Habermas, for example, speaks of how atheism has become salient since Hegel: "the *methodical* atheism of Hegelian philosophy and of all philosophical appropriation of essentially religious contents" (Habermas 2002, p. 68).

[4] This petition from the Litany of Supplication occurs in Great Vespers, Orthros, and Divine Liturgy (Liturgikon 1989, pp. 28, 149, 281, and 299)

[5] The term culture wars was popularized by James Davison Hunter (Hunter 1991). It identifies the conflicts regarding which moral perspective should shape law, public policy, and the discourse of the public square. The culture wars are by no means restricted to the United States.

[6] In the Americas and Europe, there are profound moral disagreements on many matters, including when it is licit, obligatory, or forbidden to have sex, reproduce, transfer private property without the permission of the owner (e.g., through taxes), and to take human life (e.g., through abortion and capital punishment). As already noted, underlying these disputes regarding particular moral and bioethical issues are foundational disagreements about the ultimate meaning of things. On the one hand, there are outspoken atheists who wish to erase the remaining public influence of theism in general and Christianity in particular. See Dawkins 2008, Harris 2005, and Hitchens 2007. On the other hand, one has figures such as the current and the previous pope of Rome who lament the deChristianization of the West, in particular of Western Europe (John Paul II 1998, Ratzinger & Pera 2006). For a short overview of some of the disputes in Europe, see Delkeskamp-Hayes 2008. Religious communities persist and secularity is far from triumphant; see Berger et al. 1999.

[7] There is no consensus about what constitutes a moral or bioethical consensus. This is the case because there is no adequate morally normative answer to the question as to what amount of agreement about what moral issues and by whom should be intellectually compelling or authoritative and why. Undergirding these unclarities is the challenge of determining who should count as moral and/or bioethical experts. See Bayertz 1994; ten Have & Sass 1998; Cambridge Quarterly 2002. Consensus as a moral notion, rather than a political notion indicating a politically powerful coalition, is highly problematic (Engelhardt 2010c, 2010d).

[8] The impossibility of resolving content-full moral disagreements by sound rational argument, and why such attempts beg the question, argue in a circle, or engage an infinite regress, is explored at length in Engelhardt 1986, chapters 1-4.

[9] The emerging morality is a post-Enlightenment morality in that the Enlightenment, in particular Kant, sought to maintain Christian morality on matters ranging from sexuality to suicide. The contemporary dominant secularity affirms the Enlightenment and French Revolution affirmations of autonomy, equality, human dignity, and social justice, while explicitly deflating the significance of choices bearing on maters such as sexuality and end-of-life decision-making.

[10] The traditional Christian condemnation of intentionally expediting the death of an innocent person focuses on the intrinsic wrongness of such an intention and its consequences for the moral status of the agent from intending, not just foreseeing, that the agent's actions will lead to a person's earlier death. For example, providing ade-

quate and appropriate pain management, not so as to kill the patient, that is, without an intention to expedite the death of a patient, is recognized as a beneficent act, even if this proper pain management may increase the likelihood of an earlier death. However, the physician is not to provide pain relief in a fashion such that the relief of pain follows from killing the patient. So, too, withholding or withdrawing morbidity-producing medical interventions that produce significant morbidities has traditionally been considered not just morally and professionally acceptable, but appropriate, as long as there is no intention to kill the patient, but where instead there is an intention to avoid significant morbidities, even if the withholding or withdrawing increases the likelihood of an earlier death. This traditional approach to the practice of medicine reflects an appreciation that the pursuit of the good within medicine is not without risk of some harms. There is always some risk of an foreseen (indeed, of unforeseen), albeit unintended, adverse outcome. To take a non-medical example, driving a car always involves the risk of a fatal car accident, however remote the risk and however unintended. The possible adverse outcomes are not to be intended.

This appreciation of the risk-laden character of medical decision-making in general, and of end-of-life decision-making in particular, achieved a special articulation in the Roman Catholic moral-theological account of double effect, which account developed out of just-war theory, and which came to influence much of European and American law and policy. Summarizing what has already been laid out, this account holds that one may without moral fault engage in an action that has two effects, one good and the other evil, as long as (1) the evil outcome is not intended but only foreseen (this requirement avoids the agent's affirming the evil outcome); (2) the good outcome that is intended does not issue directly from an evil outcome (this requirement is not just a view about how the effects of an act that is willed define the character of an action, but how intentionally affirming an evil act in order to achieve the good adversely changes the character of the agent); (3) the act is not evil in itself, because directly willing evil adversely changes the character of the moral agent (this requirement reflects the circumstance that certain acts by their very character have a feature that renders the act per se evil and therefore the agent vicious – a Christian recognition of such an act would be adultery); and (4) it is likely that a proportionate good will be achieved, that is, more benefit is likely to be realized than harm (this requirement excludes reckless acts). This moral account is aimed at avoiding intentionally killing the innocent or recklessly being involved in producing harm. In this account, stopping artificial hydration and nutrition in order to expedite death constitutes a direct involvement of the agent in willing the death of another. In such a case there is an intention to accelerate death, rendering the withholding and withdrawing an element of achieving an evil end, which end the agent wills.

[11] It is important to note how intention bears on the definition of active and passive euthanasia. First, intention is a necessary element of the definition of physician-assisted suicide and euthanasia, so that active euthanasia or active assistance in suicide involves in the very definition of the act both some active intervention and an intention to expedite death, while passive euthanasia involves some withdrawal of treatment, as well as an intention to expedite death. The prevention of terminal suffering and distress, or even the prudent use of resources, that might also lead to an earlier death is not an instance of active euthanasia unless the prevention involves an active intervention productive of death combined with the intention to cause death. In particular, the withholding and withdrawing of treatment that might lead to an earlier death is not an instance of passive euthanasia or passive suicide unless it involves some withholding or withdrawing of treatment productive of death, along with an intention to expedite death, not merely the intention to avoid suffering or other costs. Within traditional Christian morality, which came to be a taken-for-granted morality framing medicine in Western culture, it has been accepted that one may never directly intend to take the life of an innocent person, thus ruling out both active and passive euthanasia. In contrast, within the post-traditional morality now becoming dominant, the legal prohibition of physician-assisted suicide and active euthanasia appears to many to be immoral, as well as the refusal of physicians to refer to those who would provide physician-assisted suicide and active euthanasia. The result is the genesis of significant battles in the culture wars.

[12] The mid-second millennium in the West, in which the Roman Catholic distinction between ordinary and extraordinary care was articulated, was characterized by rapid cultural change. These changes, driven by the fall of Constantinople on Tuesday, May 29, 1453, and the subsequent acceleration of the Renaissance of the West, were followed by the dramatic 16th- and 17th-century Western European progress in science and medical knowledge, ranging from Copernicus (1543) to Vesalius (1543) and Harvey's *de motu corde* (1628). Thomas de Vio Cajetan (1480-1547), the person who examined Martin Luther on behalf of the pope, also addressed issues of medical experimentation in his

Summula peccatorum. In this atmosphere of scientific progress, medical innovation, and cultural change, the question arose as to the extent to which medical interventions one was obliged to accept, leading to reflections on the line between ordinary and extraordinary, obligatory and non-obligatory treatment.

[13] In the traditional account of the character of extraordinary treatment, no distinction was made between withholding and withdrawing treatment, which position has the advantage of allowing for a trial of treatment. It was correctly appreciated that in withholding and withdrawing treatment in order to avoid inordinate costs, one was not seeking to expedite death. Instead, the choice regarding treatment was made in order to avoid engaging in an activity where the harms would likely outweigh the benefits, and where therefore the moral obligation to accept or offer treatment was defeated. Relatively little attention was given to the propriety of extraordinary treatment. The distinction between foresight and intention in the account of double effect established norms that allowed physicians and patients to pursue a good effect or avoid serious harms while foreseeing the possibility of concurrent adverse effects, as long as the adverse outcomes were not intended, and as long as the good pursued did not come from the evil foreseen, the act engaged in was not evil in itself; and the benefits of the choice outweighed the harms. It is this last consideration that forms the primary focus of reflections on the border between ordinary and extraordinary treatment.

[14] The late-Christian approach to end-of-life decision-making framed by Roman Catholicism took on a secularized character through being embedded in natural-law discourse. Moral issues came to be considered to be able to be recognized as morally binding by natural reason alone. For example, John Cardinal De Lugo (1583-1660) held that one is not held to the extraordinary and difficult means...the 'bonum' of his life is not of such great moment, ..., that its conservation must be effected with extraordinary diligence: it is one thing not to neglect and rashly throw it away...: it is another however, to seek after it and retain it by exquisite means as it is escaping away from him, to which he is not held; neither is he on that account considered morally to will or seek his death (Cronin 1958, pp. 63-64).

It is not that the Roman Catholic bioethical account of proper end-of-life decision-making became fully disconnected from any reference to the pursuit of salvation. It is rather that, because the concerns regarding ordinary versus extraordinary, proportionate versus disproportionate treatment were set within a natural-law framework, the logic of their articulation and appreciation was progressively recast in an intellectual moral framework, which was considered at least in principle to be understandable without a recognition of God, much less of Christ and of the requirements of an authentic Christian life. The result was a significant secularization of end-of-life decision-making. Undoubtedly, this shift towards a secular natural-law idiom was not generally recognized as misdirected, as it would have been by the Church of the first half millennium.

Articulating moral matters within a secular idiom of argument even came to be regarded as offering an advantage from the perspective of Roman Catholic bioethics, in that the secular idiom, which was a consequence of a natural-law turn in medical-moral reflection, was taken to support the hope that one could bring others to the content of Christian morality, independently of their having to recognize Who Christ is. This approach is tied to the view that it is important and indeed possible to shape a society in terms of Christianity's morality, even if the morality is articulated in terms that are held to be understandable apart from a recognition of Christ. The Christian moral life in the process became disengaged from preaching the Gospel and from the task of converting the general society into a Christian society. Benedict XVI while still a cardinal for this reason argued that ultimately the only weapon is the soundness of the arguments set forth in the political arena and in the struggle to shape public opinion. This is why it is so crucial to develop a philosophical ethics that, while being in harmony with the ethic of faith, must however have its own space and its own logical rigor. The rationality of the arguments should close the gap between secular ethics and religious ethics and found an ethics of reason that goes beyond such distinctions (Ratzinger & Pera 2006, pp. 130-131).

Commitments to natural-law discourse and to a general secular moral rationality are invoked to shape society through a philosophically defensible common morality and bioethics, which does not exist.

The natural-law turn has had an impact on the character and content of Roman Catholic end-of-life decision-making, leading it, given its background commitments, to be further disengaged from the traditional Christian discourse of the first millennium, as well as from that of the emerging secular culture. As a consequence, Roman Catholic reflections on end-of-life decision-making are now set within a paradigm different from the thought-style of the Church of the first millennium. The result is that many of the original Christian concerns are obscured.

[15] The general position of Roman Catholic medical-moral theology is that one is obliged to use medical treatment only if there is hope of health *(si sit spes salutis).* The manual by H. Noldin and A. Schmitt held, for example, that medical treatment is required only when there is hope of recovery *(ubi spes affulget convalescendi)* (Noldin & Schmitt 1938, §325.3.a , p. 308). Also, when great exertion (i.e., *dures labor*) is involved, one is excused from such interventions (Noldin & Schmitt 1938, §325.2, p. 307).

[16] The secularization by Roman Catholicism of traditional Christian understandings of medical interventions required to extend life is reflected in the address of these issues by Francisco de Vitoria (1486?-1546), who as a member of the Second Scholasticism made a major contribution to reflections on international norms of justice. For his reflections on medical treatment, see in particular Vitoria 1997, pp. 103-107, §33-37; for his reflections on international law, see Vitoria 1991.

[17] His All-Holiness, the Ecumenical Patriarch Bartholomew I, is among those who have commented on the widening moral and metaphysical gulf separating the Christianity of the first millennium from the Christianities of the West (Bartholomew 1997).

[18] Among the problems besetting advance directives is that it is difficult in advance to give directions that can adequately envision all important future medical decisions. Also, it has been known for a long time that most proxy decision-makers usually do not have a good knowledge of the wishes of the persons for whom they are making decisions (Suhl et al. 1994). Not only do most proxies have inadequate information, but they may not fully share the same values as the patient. In addition, physicians often appear reluctant to discuss advance directives (Morrison et al. 1994), and many seriously ill turn out to be much happier with their lives than might have been anticipated by healthy third parties or by patients while relatively well (Tsevat et al. 1995). The situation is made even more difficult by the circumstance that families are often made up of moral and religious strangers. In addition, patients and their caregivers are often separated by quite different moral and metaphysical understandings of life and death. The moral of this state of affairs is not just that one should give clear instructions, but more importantly one should thoughtfully appoint trustworthy agents who share one's own moral and metaphysical commitments. It is best to live in an intact moral community or family such that one shares with one's spouse and children a common view of the significance of life and death. Also, it is important insofar as possible to have physicians and nurses who are not moral strangers.

[19] Contemporary concerns about equality are a function of moral views that became salient following the Enlightenment and the French Revolution and that now require asserting and defending the equality of persons. Depending on how this equality is understood, it will be held to be improper to provide less health care to the aged because they are aged. Within this moral framework, one might attempt to escape from charges of ageism by considering all persons as equally charged with creating a reasonable budget for their health care over time. However, given value pluralism, there will be disagreement regarding the character of a reasonable budget.

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