Dying in a technological society

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THE CARE OF the terminally ill in the United States has changed as the business of dying has shifted from the moral to the technical order. The moral order has been used to describe those bonds between men based in sentiment, morality, or conscience, that describe what is right. The technical order rests on the usefulness of things, based in necessity or expediency, and not founded in conceptions of the right.[1] The change of death from a moral to a technical matter has come about for many reasons based in social evolution and technical advance, and the effects on the dying have been profound.

One reason for the change has been the success of modern medicine in combatting death. For most, in the United States, premature death is no longer imminent. The death of infants is unusual, the death of children rare, and the death of young adults so improbable that it must be removed from the realistic possibilities of young life. Further, the nature of death has also changed. The degenerative diseases and cancer have become predominant. Lingering sickness in the aged is a less common event because medicine is able to combat the complications of chronic disease that so often in the past kept the sick person from functioning. Accompanying these changes brought about by technical advances, there has been a change in the place where death occurs. Death has moved from the home into institutions—hospitals, medical centers, chronic care facilities and nursing homes.

From the Moral to the Technical

There are other reasons for the shift of death in the United States from the moral to the technical order. One is the widespread acceptance of technical success itself. Because life expectancy has increased, the dying are old now. But, life expectancy is not an individual term, it is a statistical term. For individuals, what has changed is their death expectancy; they do not expect to die. They may use fantasies of early death or fears of death for personal or psychological reasons, but the reality belief is that death need not occur in the foreseeable future, that death is a reversible event. That belief in the reversibility of death, rooted in the common American experience of modern medicine, begins to move death out of the moral order. Death is a technical matter, a failure of technology in rescuing the body from a threat to its functioning and integ-

[1]Robert Redfield, *The Primitive World and Its Transformations* (Ithaca: Cornell University Press, 1953), pp. 20ff.

rity. For the moment, it does not matter that the death of a person cannot be removed from the moral order by the very nature of personhood; what matters is the mythology of the society. The widespread mythology that things essentially moral can be made technical is reinforced by the effect of technology in altering other events besides death; for example, birth, birth defects or abortion.

The fact that technology can be seen so often as altering fate nurtures an illusion that is basic to the mythology of American society—that fate can be defeated.

From the Family to the Hospital

Another reason why death has moved away from the moral order lies in the changes in family structure that have occurred over the past decades in the United States. The family remains the basic unit of moral and personal life, but with the passing of functionally meaningful extended families have come changes directly related to the care of the dying. The old, both the repository of knowledge about what is right and the major recipients of moral obligation, have left the family group. For many reasons, not the least their desire for continued independence in the years when previously material dependency would have been their lot, the aged frequently live alone. In retirement they may live far from their roots or their children, associating largely with others of their own age. An age-graded way of life has emerged that depends again on technical success and public responsibility (such as old age benefits) to solve problems for the aged that previously would have been the primary concern of the family. There is the belief, reinforced by the advantages of the change in family structure and geographic mobility, that essentially moral problems—obligations to parents, for example—have become part of the technical order amenable to administrative or technical solutions.

On the other hand, in his search for continued independence and comfortable retirement, the old person has allowed his family to separate, allowed the young to achieve their independence. In previous times and in other cultures, the mantle passed to the next generation only with the death of the old. Here it is voluntary. But, a problem is created for the dying patient. The old person who is going to die is already out of the family. To die amidst his family he must return to them—reenter the structure in order to leave it. Reenter it in denial of all the reasons he gave himself and his children for separation, reasons equally important to them in their pursuit of privacy and individual striving and in their inherent denial of aging, death and fate.

Thus, by reason of technological success and changes in family structure that are rooted in the basic mythology of America, death has moved from the moral order to the technical and from the family to the hospital.

The Context of Dying

It is interesting to examine some of the consequences and corollaries of the shift. In individual terms, moving the place of death from the home to the hospital, from familiar to strange surroundings, means changing the context of dying. The picture of the old person, independent and swinging free—promulgated as much by the old as by others—while part fact, is also a partial fiction dictated by the old person's love for, and nurturance of, the independence of the young. Becoming a burden is the great fear not only for what it may mean personally, but for the threat it poses to the fragile economic and personal structure of today's nuclear family. But part fiction or

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no, the hallmark of "golden age" is independence. With independence and its mobility, the belief arises that each person is the sole representative of his own beliefs, values and desires. In health that may seem to be true, but the fact is as fragile as the body. In health a person can struggle for his rights, pronounce his values and attempt their fulfillment. But the sick, bound to their bodies by their illness, are different. The values and desires dearly held during life give way in terminal illness. Pain and suffering erode meaning and deny dignity. The fiction of independence and the denial of fate give way to reality. In terminal illness, the individual must give over to others and to the context of his dying, the defense of his dignity and the statement of his values. But the context of dying and the people at the bedside have changed. The aged no longer die surrounded by their loved ones. An essentially private matter takes place in the public sphere surrounded by symbols of individual sameness, not personal difference. The family and its needs are the intruders. The patient's values, spoken by others, compete with the values of the institution. There is a final, ironic, independence as the person dies alone.

Thus, there are personal or value problems created for the individual when death moves from the moral to the technical order. Characteristically our society seeks solutions to these problems not by reasserting the moral, but by attempting technical solutions for moral imperatives. We are seeing increasing attempts in the United States to find quasi-legal or legal means to reassert the rights of the dying—some technical means to give as much weight to the person who dies as the hospital gives to his body.

Mechanical Events in the Moral Sphere

In the process of the shift of death from the moral to the technical a basic confusion arises that confounds the usefulness of technical solutions in what are essentially moral problems. The mechanical events involved in a body becoming dead, which occur in the technical sphere, are confused with the process of dying, which occurs in the moral sphere. It is a natural error but one that we do not frequently make in health. That is to say that while we are aware that the mechanical event that is a beating heart is essential to life, we do not confuse ourselves with our heartbeat. As a matter of fact if someone becomes too conscious of his heartbeat, we consider it a symptom, or neurosis. But in the sick or the dying the confusion is rampant. There are two distinct things happening in the terminally ill, the death of the body and the passing of the person. The death of the body is a physical phenomenon, a series of measurable events that are the province of physicians. The passing of the individual is a nonphysical process, poorly defined, largely unmeasurable and closely connected to the nature of the dying person. It is the process by which he leaves the group and during which we take leave of him. Indeed, in the manner in which many act towards the newly dead body—as though it still contained some part of the person—the passing of the individual, at least for the onlooker, may not end with death. It is obvious that in sudden death, a person may pass away who was never dying; or conversely, in the depressed, the person may be dying with no evidence of impending death.

The passing of the individual is also part of the work of physicians, but of more importance, it is the province of family, friends, and clergymen—indeed the entire group. But in a technical era, the passing of the person, since it is unmeasurable and does not fit the technical schema, is not a legitimate subject for public discourse.

Those feelings within that relate to the dying person are difficult to organize, to deal with, or to speak about. The social rituals that previously enabled those confused meanings and feelings to spend themselves appropriately have diminished or disappeared along with the extended family. In the moral order, time slows down for those around the dying; but in the world of things, of necessity or expediency, time moves on relentlessly, making its case for those around the dying to return to that world. Furthermore, with decreasing practice in moral matters, even when social forms remain, the content becomes increasingly sterile. Men obscure the moral content of the passing of the person by using the facts and artifacts of the death of the body as the vehicle for their interchanges—much

as talk about the weather or sports draws the sting on other occasions.

The confusion of the mechanical events of the death of the body with the personal and social nature of the passing of the person confounds attempts to solve the essentially moral problems of the dying—problems of sentiment, conscience, or the knowledge of what is right. Thus, in matters such as when the respirators should be turned off, and by whom, essentially moral questions, the mechanical events loom so large that attention is diverted away from the moral, back to the technical. And this is the corollary problem to that raised earlier: the context of death no longer gives weight to the values of the dying person and forces a resort to legal or administrative protection of his rights.

Depersonalization of Care

The confusion of mechanical events for moral processes creates the further problem of depersonalization of care. And it is seen in the greater attention paid to diseases than to people by doctors and their institutions —a common complaint about physicians and particularly about physicians in their care of the dying. Frequently we explain this depersonalization by saying that it is the physician's psychological defense against the emotional burden imposed by the care of the dying. Though that may be true, it is only part of the truth. We have seen how the whole society has shifted its public focus from moral to technical in many areas of life: doctors are no exception to the trend. The problem cannot solely lie among physicians, or the society would not let them get away with it. Social forces would drive doctors back towards a more holistic view of their patients. Indeed, such a change is beginning to occur in response to the increasingly vocal dissatisfaction with medical care.

Because depersonalization is so much a part of the technical order, not only in medicine, and so antithetical to the values of personhood, let us further examine how depersonalization takes place. Each dying patient is not only a person, but also the container of the process or events by which his body is dying. By definition, since he is dying, these processes or events cannot be controlled by existing technology. Because of the inability of the technology to control such things—and cancer or heart failure are examples—they acquire independent meaning apart from the person containing them. From the viewpoint of caring for the terminally ill, such depersonalization may be justly deplored. But from the viewpoint of medical science the pursuit of the meaning of the resistant body process, apart from the person containing it, is a legitimate end in itself. That is to say, the heart as an abstraction, as a pump, an electrical system or what have you, is a proper object of technical concern and quite distinct from the fact that human hearts are only found in humans. Further, it is the nature of any system of abstract or formal thought not to be content with mystery, but to continue operating on any problem until understanding results. Mystery is a threat to the adequacy of the system of thought itself. Consequently, the disease process must be probed and probed, not only because of its relevance to the care of the sick and dying, but also because lack of a solution poses a threat to the entire logical construct of which the body process is thought to be a part. Thus, the depersonalization and abstraction of body mechanics is both necessary and legitimate within the framework of science, and understanding of the body-as-machine is impeded by consideration of human values.

The problem of depersonalization depends in part on the degree to which the dying person's disease process is understood. For example, in the care of the patient with bacterial pneumonia, easily treated with antibiotics, depersonalization poses little difficulty. The abstractions necessary for understanding microbes, antibiotics and so forth, are so much a part of the physician's thinking that he or she is able to integrate them back into a total concept of man, patients, etc. Withdrawal and depersonalization are not frequent, I think, when experienced doctors and nurses care for the dying, if the cause of death is something acceptably inevitable, such as pneumonia in the very old, or stroke. If it is correct that persons dying of a poorly understood process are more likely to be depersonalized by their physicians, we can better understand why the accusation of depersonalization is

most often brought against young physicians. To the inexperienced doctor almost everything about the dying person is unfamiliar or poorly understood thus requiring the abstraction that leads to depersonalization. Effective integration of the learned technical material with human needs, values, and desires comes only at a later stage of learning.

Temples of the Technical Order

In the United States, the modern medical center is the very temple of the technical order, revered both by medicine and the public. As medical science, in its effort towards understanding, has taken the body apart system by system, it has departmentalized the intellectual structure of the hospital. By that I mean not only the well known division of medicine into specialties, but the further subdivisions that represent specific body functions. The corridors of any American medical center reveal rooms whose doors bear titles such as pulmonary function laboratory, cardiographics laboratory, nuclear medicine, sonography and so forth. Each of these specialized functions has contributed immeasurably to the diagnostic and therapeutic power of the modern physician, and no doctor who has grown accustomed to their use will feel wholly comfortable in their absence. They are unlike the traditional clinical or research laboratory which when examining a function of the patient's body takes the whole patient along; it is not his blood or urine that goes to the laboratory, it is the patient. But it is not the person who holds the interest for the specialized laboratory; instead the interest centers on the person's lungs, or heart, or whatever. A good coronary arteriogram is not necessarily a good patient or even good for the patient, it is merely a technically good example of coronary arteriograms. Patients are usually not aware or interested in those distinctions and all too frequently, but in an opposite sense, neither is the physician who performed the test. One can see the hospital, thus compartmentalized, as the concrete expression of the depersonalization resulting from the abstract analytic thought of medical science. Thus, the dying patient in the modern hospital is in an environment ideally suited for the pursuit of knowledge and cure, but representing in its technology and idealized representative—the young doctor—technical values virtually antithetical to the holistic concept of person. This does not imply that the most personal and humane care cannot be and is not given in such hospitals, but rather that those who do give such care must struggle against their technical depersonalized thinking about the body, and against the structure of the hospital that such thought has produced.

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No discussion of the care of the terminally ill in the United States can avoid the problem of the nursing home. Whereas the modern hospital represents the positive strivings of medical science and the technical order—the belief that nature, disease, and fate can be conquered—the nursing home represents the tattered edges of that philosophy. Medicine and medical care are seen primarily as the application of medical science to disease: if science fails the body, medicine fails the person. Nursing homes contain the failures and frustrations of medicine, as well as the homeless or unwanted sick. They are a place to linger and to die. Walking their halls is deeply depressing because hopelessness is overwhelming. It is the hopelessness one experiences whenever one sees the sick completely overtaken by their sickness, forever apart from the comfort of group. None of the many reasons for their proliferation and crowding explains why they are the hopeless places that they usually are. We know they can be better be-

cause of the success of the occasional institution given over to the care of the terminally ill in a positive sense. Such successful nursing homes are often run by religious orders or by others whose belief in their mission is deeply moral. Thus, what we see in the usual American nursing home is by no means inevitable in the way that death is inevitable, but rather a vacuum of care. The promise of science and technology has failed here. The old family solutions to the problems posed by the care of the terminally ill have been altered past utility by social change. No new solution has come forward to fill the void.

We have seen how the care of the terminally ill has changed in the United States. They are older now and die more frequently in institutions. But that bare frame of facts conceals increasing distress within the society over the quality of their dying. When death occurs in the modern hospital there seems to be more concern for the disease than for the dying person, more concern for life as a succession of heartbeats, than life as meaning. When death occurs in nursing homes it is as if life just dribbled out—custodial care seemingly inconvenienced by individual difference or tenacity for life.

A Balance of Moral and Technical

We have seen that the problem is larger than widespread insensitivity which might be corrected by new educational programs. Rather, there has been a shift of death from within the moral order to the technical order. The technical, the expedient, the utilitarian that has worked so well in so many material ways seemed to promise easier solutions to the problems previously seen as matters of conscience, sentiment, or obligations between men. But the promise has not been fulfilled; not in the United States nor elsewhere where the technical order spreads its dominance.

Even if it were possible, the solution is not a return of American society to technical innocence. I do not believe that men were inherently more moral in the past when the moral order predominated over the technical. The path seems to lie in the direction of a more systematic understanding of the moral order to restore its balance with the technical. Understanding the body has not made it less wonderful, and the systematic exploration of the moral nature of man will not destroy that nature but rather increase its influence. In the care of the dying, it may give back to the living the meaning of death.