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Crito Revisited

Socrates: . . . [K]eep this one truth in mind, that a good man cannot be harmed either in life or death, and that his affairs are not neglected by the gods. . . .

Plato's Apology

Crito: . . . Socrates, I do not think that what you are doing is just, to give up your life when you can save it, and to hasten your fate. . . .

Socrates: . . . We must . . . examine whether we should act in this way or not, as not only now but at all times I am the kind of man who listens only to the argument that on reflection seems best to me. I cannot, now that this fate has come upon me, discard the arguments I used; they seem to me much the same. I value and respect the same principles as before. . . .

Plato's Crito

In the ancient Greek dialogue, *Crito*, Plato provides a portrait of his mentor, Socrates, only days before his death, and while the death scene itself is left to another dialogue, it is in *Crito* that Socrates explains why he would rather die in prison than live in exile (Plato 1997). The conversation is instructive on many levels, and one aspect that merits greater attention is the extent to which Socrates's cultivated character relates to the decision at hand. In particular, the dialogue raises issues concerning decisions at the end of life, decisions faced (in admittedly much different ways) by a multitude of patients,

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patient families, friends, and healthcare providers. In order to bring this out, let us begin, rather than with a simple recounting of the Platonic dialog, with a retelling of the story, updated and transformed from the prison cell to the hospital room.

Mr. S. is in his early seventies. He is a professor of philosophy and a war veteran who has earned commendations for bravery in battle, but is now confined to a bed in a hospital. According to his physicians, his cancer – a myeloma – is terminal, and so he simply awaits his fate. Though staring squarely into the abyss of death, his mind remains clear, even vibrant, and his mood is easily buoyed by visitations from his friends and loved ones.

One morning, Mr. S. awakens to see his friend and oncologist Dr. C., who has come not only to visit but to bring news and a proposition. The news is that Dr. C. has been investigating options, and clearly the hospital has reached the limits of what it can do to keep Mr. S. alive. In light of this, Dr. C. has looked into the possibility of employing alternative therapies at other centers around the world, and he wants to propose to Mr. S. some of these treatments that, while expensive and experimental, offer a small chance of success for extending life. However, being such a longtime and close friend, Dr. C. knows that Mr. S. will not be easily persuaded by some fly-by-night, desperate attempt to spare his life. Instead, Mr. S. will require of Dr. C. a careful accounting of this plan and a justification for following through with its recommended actions. In fact, Dr. C. is prepared to put forth several arguments on behalf of his proposition in the hope that Mr. S. might wish to prolong his life if possible.

According to his own evaluation of the situation, Mr. S. has been careful to cultivate the particular life he has led. He accepts the choices he has made, and most were quite deliberate. He has never been one to cling to life at all costs, and he does not jump at options simply because they are before him. He prefers to be reflective and to consider options in the context of his environment and character. As death approaches, then, he is confronted with the possibility, though perhaps remote, that he can stave off the abyss for awhile. Rhetorically, Dr. C. asks his friend, “Are you not acting ‘cowardly’ by taking the ‘easy way out,’ not fighting to extend your life (‘Where is

your rage against the dying of the light?’)? Would it not mean more time with family and friends, and Don’t you owe your family at least that much? Would you not be able to bring your unique insights to even more people as you continue to live? Would it not demonstrate a ‘manly’ defiance at the cruel fate that has befallen you?”

For Mr. S., none of the arguments is persuasive; in fact, Mr. S’s responses are quite clear and consistent: His family will understand, and his friends surely should. There is no way of telling whether his unique way of interacting with others will translate outside the community in which it was formed. Why be defiant against a fate that was neither of his own choosing nor of his own making? To “scramble” for life is inconsistent with his approach to life. He has never wanted to be too self-concerned, never feared death, never wanted more than his due, never wanted to be beholden to others. He has always tried to think through problems and choose wisely, not wildly. Though death will surely be an outcome of his choices on these matters, it is a death he is willing to embrace, for it is the most meaningful way for him to live unto death.

How We Die

Life – *living*, really – is the condition in which we all find ourselves, and though there might be a few who vainly argue the opposite, and regardless of the promises of a few geneticists or even some cryogenicists, *that we die* is a fate that most of us realize. However, these two facts taken together often lead to stress and frustration concerning our futures. Death is inevitable, whereas living is actual. Living is what we know; death is obscure. Eventually, though, it is possible to come to grips with one important fact: Even though death is the end point of our living embodiment, dying is a process within embodied living itself – that is, dying is part of our on-going life stories. Should this realization occur, the focus may shift from *that we die* to *how we die*.

Illustrating what she calls the “cinematic” myth of the “Good American Death,” Nancy Dubler writes, “[The death scene often] includes the patient: lucid, composed, hungering for blissful release – and the family gathers in grief to mourn the passing of a beloved life. The

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murmurs of sad good-byes, the cadence of quiet tears shroud the scene in dignity” (Dubler/Nimmons 1992, 146). Unfortunately for many of us, our deaths will not be the spiritual, peaceful “passing” that we might envision or desire. As physician Sherwin Nuland explains, “To most people, death remains a hidden secret. . . . [T]he belief in the probability of death with dignity is our, and society’s, attempt to deal with the reality of what is all too frequently a series of destructive events that involve by their very nature the disintegration of the dying person’s humanity” (Nuland 1993, xv, xvii). For many, the hope is that they will die surrounded by loved ones (or quietly in the night), slipping away without pain after tying up all loose ends. The reality for the great majority of us, however, is that we will find ourselves ravaged by disease, struck down by illness, or tragically injured; we will be hooked up to machines, ingesting drugs. Nurses and physicians, strangers to us really, will be our most consistent contacts with humanity. Family and friends will find themselves without resort and at a loss to help if for no other reason than that we rarely give a clear account of our desires concerning end-of-life care before it is too late to give any account at all. We would like to think that these situations are at the margins, but if so, the margins are awfully wide and, either way, must not be ignored. Death, as William Gavin has argued, is a complex of historical and cultural as well as biological factors that do not present themselves for tidy packaging (see Gavin 1995; 2003). Crudeness and vagueness, frustration and mutilation are at play as much as scientific, technological precision in diagnosis and prognosis. Loneliness, pain, and bitterness are more common than peace and joy.

Mr. S, then, is a rare person – thoughtful, brave, and consistent in his character, able to move toward death with a calm, careful, considered disposition. In these respects, his case is easily idealized, hardly displaying the confusion, pathos, and tragedy of the hundreds of thousands of patients each year who find themselves confronting issues at the end of life. As such, there is only little we can glean from Mr. S’s situation. Tolstoy’s Ivan Ilych may be closer in sketch to many real-world deaths, with his pains and fears, concerns and insights, and yet his account also marks the death of only one man. What can

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we learn from any one death? Alone, maybe not much, but situated within a continuum of cases, we may be able to garner some insights.

To illustrate a particular continuum of dying patients, allow me to recount a few stories previously published by others.

Approximately forty years ago, then medical student Sherwin Nuland on his first night in the hospital encountered a dying patient, James McCarty. Recalling the situation, Nuland writes:

James McCarty was a powerfully built construction executive whose business success had seduced him into patterns of living that we now know are suicidal. But the events of his illness took place [at a time] . . . when smoking, red meat, and great slabs of bacon, butter, and belly were thought to be the risk-free rewards of achievement. He had let himself become flabby, and sedentary as well. . . .

McCarty arrived in the hospital's emergency room at about 8:00 p.m. on a hot and humid evening in early September, complaining of a constricting pressure behind his breastbone that seemed to radiate up into his throat and down his left arm. . . . The intern who saw McCarty in the emergency room noted that he looked ashen and sweaty and had an irregular pulse. . . . The electrocardiographic tracing. . . revealed that an infarction had occurred, meaning that a small area of the wall of the heart had been damaged. . . .

McCarty reached the medical floor at 11:00 p.m., and I arrived with him. . . . As I walked onto the division, the intern, Dave Bascom, took my arm as though he was relieved to see me. " . . . I need you to do the admission workup on this new coronary that's just going into 507 – okay?" . . .

McCarty greeted me with a thin, forced smile. . . . As I sat down at his bedside, he suddenly threw his head back and bellowed out a wordless roar that seemed to rise up out of his throat from somewhere deep within his stricken heart. He hit his balled fist with startling force against the front of his chest in a single synchronous thump, just as his face and neck, in the flash of an instant, turned swollen and purple. His eyes seemed to have pushed themselves forward in one bulging thrust, as though they were trying to leap out of his head. He took one immensely long, gurgling breath, and died. (Nuland 1993, 3–5)

In another story, James Buchanan discusses the circumstances surrounding Alzheimer's victim, Murray Wasserman.

The third stage of Alzheimer's is surely the most benevolent, the most understanding and merciful, of death's trimesters. All the confusion, embarrassment, and agony of self-observation are forfeited in favor of grateful amnesia.

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Family and friends become strangers while the familiar and foreign lose the elasticity of their boundaries and become one. . . .

For survival, only simple tools are needed: air, food, water. Life at its most basic and most elementary level has no need for anything unnecessary and burdensome. Murray simplified all that he had become for the purpose of concentrating what little he had on that which remained. Indeed, he was a child again. His bowels and bladder were liberated from social customs. . . . Rules and regulations . . . were abandoned in favor of more immediate concerns. He had become a child again.

Of course, his friends and family saw none of this. Rather, they saw an old, emaciated man who wore diapers and wept to himself alone, and sometimes cried in grateful acceptance of the slightest things. . . .

Murray was engaged in a desperate struggle for his life, for his existence, for some shred of solidity against the possibilities of death and nothingness. . . . [E]very minute, every hour, every day was a desperate struggle to remain something against forces that sought to make him nothing. . . .

In the end, all death comes from anoxia. . . . One tries not to breathe, to end it all quickly, but the body is too desperate to obey such intellectual suicide. It wants to live even if the brain desires to die. And so like a heaving straining animal, the frightened lungs continue again and again their futile effort until coma and unconsciousness discontinue this malice of self-observation and self-torture.

Murray died in such a way; he died wrapped about himself – actually holding on to himself for dear life – in a fetal position. Were it not for the gray hair, the wasted six-foot body, the wrinkled and puffy face, one might have thought him a child who died of crib death. . . . But Murray Wasserman was not a child but rather an old – very old – man who died before his time and looked far more ancient than his sixty years could ever foretell. (Buchanan 1989, 45–50)

Finally, author and physician Richard Selzer tells of his encounter with an AIDS patient and his partner in 1990.

At precisely 4 P.M., as arranged, I knock on the door. It is opened by . . . let him be Lionel, a handsome man in his late thirties. . . . He is an ordained minister. . . . In the living room Ramon is sitting in an invalid's cushion on the sofa, a short delicate man, also in his thirties. Ramon is a doctor specializing in public health – women's problems, birth control, family planning, AIDS. He is surprisingly unwasted, although pale as a blank sheet of paper. . . . He and Lionel have been lovers for six years. . . .

For a few minutes we step warily around the reason I have come there. All at once, we are engaged. I ask him about his symptoms. He tells me

of his profound fatigue, the mental depression, the intractable diarrhea, his ulcerated hemorrhoids. He has Kaposi's sarcoma. Only yesterday a new lesion appeared in the left naso-orbital region. He points to it. Through his beard I see another, larger black tumor. His mouth is dry, encrusted from the dehydration. He clutches his abdomen, grimaces. There is the odor of stool.

"I want to die," he announces calmly without the least emotion. (Selzer 1992, 284)

The common thread among these three stories is simply that death is rarely clean, hardly ideal; as Gavin points out, "death – or more *non*-precisely speaking, dying – remains at least somewhat wild-game flavored" (Gavin 2003, 107). Also, the character of each person's death is shaped by her history and community. Furthermore, these cases illustrate a continuum present among specific acts of dying, a continuum that ranges from deaths where control is not a factor to those where controlled manipulation is not only possible but preferable.

James McCarty killed himself through his own extravagant living, an unintended "suicide" as Nuland put it. He died in one powerful instant, alone with an inexperienced medical student left to fend for himself. In a very important sense, we can also say that there is no way his death could have been otherwise. Though he may have had control over his eating and living habits before his heart gave out, once McCarty found himself in the hospital, it was simply too late. Control over his death was clearly not at issue.

Murray Wasserman, on the other hand, reveals the very real distance between one's situation and the perceptions of others. An old man dies like a child, while his relatives find him pathetic and decrepit. Fighting for a self he long ago lost, however, Murray dies as alone as McCarty, lost in a world of his own. And here one could argue that so much more could have been done. The progressive nature of Murray's disease allowed for the possibility of proactive measures aimed at determining the dying process on a personal level. Advance directives and communication among health care professionals, family, friends, and of course Murray himself during the early stages of the disease might have helped with care in the later stages.

Finally, Ramon's situation illustrates a desire to avoid the emptiness of the previously described deaths. Influenced by the nature

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of his profession and the character of his relationships, Ramon was keenly aware of the issues involved in his own disease. Committed to a loving relationship, his desire to die also was concerned with his partner, the burdens involved in care, and the embarrassment of continued existence in this state. Ramon seized the opportunity to exercise his agency, wishing to participate in his own dying process.

With this continuum – ranging from an utter lack of, to an expressed desire for, control over dying – squarely in our minds, let us return briefly to Mr. S. More clearly than most, Mr. S's situation demonstrates a fundamental position taken in the pages of this book: The dying process is part of lived experience. Of course, every death demonstrates this in its own way, but for some, taking charge of the process in a *meaningful* way is possible.¹ Furthermore, the choices and actions that are sought (if not enacted) in pursuit of meaningful dying are morally charged, and significant. Finally, the ability to engage one's own dying process, to make it not simply anathema to living but constitutive of one's character, in short, to embrace it as part of one's life story, may result in a morally appropriate choice to die even in the face of alternative ways to continue living.

Engaging the Dying Process: Meaningful Life Stories

Engaged dying brings meaning to what may seem to be otherwise meaningless acts and choices. Such meaning-making is grounded

¹ The case of Mr. S. is surely a glorified account, but a meaningful death need not be one of peace and ease (though our myth of the "good death" may suggest as much). The death of Susan Sontag, as recounted by her son David Rieff, is one of pain and agony while battling cancer. And yet her death did have meaning for her, as she determined to fight for every last minute of life she could. As Rieff recounts, her doctor said, "If you want to fight, if what matters to you is not quality of life . . ." And my mother said, "I'm not interested in quality of life." (interview in Salon.com; http://www.salon.com/books/feature/2008/02/13/david_rieff/index1.html). In his book, Rieff discusses Sontag's earlier successful bout with stage-4 breast cancer: "For as the years went by, my mother began more and more to think of her survival . . . as the result of medical progress and also of her willingness to have the most radical, mutilating treatment. . . . As she understood her own story, choosing the milder version . . . would have meant not making the commitment to survival that was required. Real commitment for her was always radical" (Rieff 2008, 38; emphasis mine). And later, he notes about her final struggle with cancer, "[S]urvival was her goal, and that never changed from the moment of her diagnosis to almost the hour of her death" (82).

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in the recognition that living continues unto death. That is, lived experience continues for those who are dying, and like all other moments in life, the lived experience of dying can, at times, be shaped by our own hands.

The approach to living and dying assumed in this book is itself grounded on what philosopher William James calls “radical empiricism.” While the next chapter is dedicated to elucidating this concept, in brief we can say here that “radical empiricism” accepts as “real” any and all experience, and thus requires that all experience be taken seriously. Furthermore, “experience” is characterized as a flowing, fluctuating stream. Both this continuity of experience and need for serious attention to relationships that arise in experience require a view of our lives that, while noting those moments of discontinuity and the possibility of novel, radical change, also attends to connectedness of our memories, histories, choices, and actions. Value, itself, arises in experience, not imposed upon experience from some transcendent realm of value. Our lives range from birth to death, and everything in between is what we call *living*. Radical empiricism is a philosophy that focuses simply on *that*. As such, it is well suited (if not uniquely so) to approach issues in the care of dying patients. It is not unimportant, but often forgotten, that the dying process is part of living. This fact is often de-emphasized or misplaced when we are confronted with a dying patient, because our attention so quickly turns to the end of the process – namely, death – without significant attention to the intervening living that goes on until the end is reached. However, as Gavin points out, “[J]ust as one would not identify a melody with the last note in the score, so too one should not focus on the last moment of dying, that is death, at the expense of the entire process of dying.” (1995, 123) This is no trivial observation. Such a view demands an attitude toward dying that treats it as continuous with the rest of our living. In fact, the end itself is part of the context set forth by what comes previous to it. In another use of a musical example, Erich and Roberta Loewy (2000) note that

If the preceding movements [of Beethoven’s ninth symphony] had been less majestic, if they had failed to prepare the ground properly, our perception of the last movement would have been quite different. . . . In dealing with

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issues at the end of life, then, we cannot take that life out of the context of its history, of its social setting or its existential being. (5–6)

Mixing metaphors, though death and dying do mark the “final” chapter of our life stories, it is still part of the book – a situated and significant part, at that – and it gains meaning from the chapters that precede it.

The goal of health care itself is often colloquially defined as avoiding death, preserving life, but surely this focus is far too narrow. Such a take on the aims of medical practice is not only doomed to failure, since we shall all die someday, but is far too negative to prove practically helpful in the daily lives of physicians and patients. Thus the end of medicine must first and foremost be positive and progressive, attaching to the reality of active engagement in the world. Elsewhere, I have proposed that “living healthily” should be medicine’s primary goal for the patients it serves, since this goal not only captures the historical calling of physicians, but also the needs and desires of patients (Hester 2001). Furthermore, living healthily taken as a positive, contextually sensitive goal can be achieved with patients at any point along life’s spectrum. In fact, it is not only possible but morally significant that dying patients can live healthy lives unto death. If this sounds oxymoronic, then we must develop a stronger understanding of what is meant by “living healthily.”

While I refer the reader to the more robust explanation of this position in the work *Community As Healing* (Hester 2001), briefly here, living healthily constitutes a person’s active engagement in the world, in the decisions that affect her life, in the communities of which she is a part and are part of her. Such an engagement is participatory, when a person’s interests and values find expression and are infused into the environment. Living healthily does not demand that a particular individual’s interests and values always hold sway, but that they be taken seriously by the community because that individual participates as a member of the community. None of us is an atomic creature, insularly independent. We are, in fact, social products, our very selves arising from the communal interactions in which we take part. For medicine to take this seriously requires an expansive and flexible view of the goals of medicine in order to