On the sanctity of life

It is commonplace to pit the length of life against the quality of life. This happens in the sort of clinical discussion where the patient is nearly dead and seems to have little residual human functioning left. The typical situation GPs may face is the decision whether to send the patient to hospital for vigorous intravenous treatment of pneumonia or urinary infection, or leave them at home to survive or succumb under oral antibiotics alone. The resolution of the quandary generally depends more on the personalities involved than on rational debate. One of the more unfortunate consequences is where the family is called on to decide how energetically the doctors should strive to maintain the waning life. I say this is unfortunate because family members, albeit more familiar with the preferences of the patient, are also more liable to be in a state of conflict of interest, especially where they are the immediate caregivers bearing the personal cost and the day-to-day burden of the terminal stage of life, and even more so where they are the prospective inheritors of the patient's property.

I should like to unpick some of the terms we sometimes use only half-thinking. Underlying the discussion is a concept of a life not worth living, for it is only such a life that may be scrutinised as a candidate for termination, whether by benign neglect, passive euthanasia or assisted suicide. One may distinguish between early, middle and late lives that are not worth living. The early ones, severely damaged neonates, are clearly different from the late ones, the old person with advanced dementia in deep coma who has had what is often called a good and long innings. But it is the ones in the middle that are the most difficult to grasp. They have had their chances in life, but may have expected more. As well as terminally ill and suffering patients, this group could include others whose lives are not worth living, such as victims of prolonged violence —imprisonment in some regimes, domestic violence, sex slavery, and military occupation. Extreme poverty is often enough to make life not worth living. The key seems to be hope; where there is hope of a better tomorrow even the most unhappy life might be worth living. It is the absence of any hope that makes people give up.

The idea of a better tomorrow begs the question of the meaning of the quality of life. Whereas the existence of life may be observed objectively, and its days may be counted, its quality can only be judged subjectively. There can be no universally agreed criteria for the quality of life, for each person attaches different value to the various aspects of life, and this changes too with changing circumstances. Pain without hope of recovery may be judged differently from pain with the hope of recovery. The idea of averaging out different peoples' judgments to produce a conglomerate metric of the quality of life, ignores its essentially contextual nature and its intrinsic subjectivity. Life, with its joys and its suffering, its hope and its desperation, has a purely individual meaning for each person. Nobody can be a proxy for this sort of judgment, neither the family, nor social consensus, and certainly not the doctor.

Following this argument, doctors are led to conclude that quality of life is too fickle to use in making clinical decisions, and that all we can reasonably do is to concentrate on the countable and the measurable — to keep the physiological homeostasis going as long as we can, until entropy takes its inevitable toll and life ends. This gives us a usable endpoint whereby to assess the success or otherwise of our medical interventions, for the constant improvement of our science and our skills. This reductionist scientific attitude is also wholly consistent with the expressed and traditional commitment of our profession to save lives wherever possible.

The formulation I have given of the quality of life is essentially grounded in the western hedonistic tradition, where special value is ascribed to happiness and joy. Religious traditions promote other values. Religion attributes the quality of sanctity to human life, where life is not the property of man to use for his own entertainment, but rather a gift from God to use for higher purposes. This holy gift from God must be respected and maintained at all costs, say the religious fundamentalists. Since it does not belong to us, it is not for us to destroy — ever. In Helga Kuhse's definition — 'it is absolutely prohibited intentionally to terminate life because all human life irrespective of its quality or kind is equally valuable and inviolable.'[1] We arrive then, at a convergence of interest between reductionist medical science and fundamentalist religious doctrine. Both devote themselves to the maintenance of life — its salvage and its salvation.

However, many or most doctors, and many or most religious people, may find it difficult to identify with what I have just written. For there are other chords both in the secular[2] and the religious[3] worlds. It is not right to describe western society in purely hedonistic terms. Even using the simplest form of the 'golden rule' — behave towards others as you would have them behave to yourself — life has special value in itself. The ultimate thing that you do not want is to be killed, so do not kill others. From this special value of life derives a special duty to maintain and protect life, irrespective of what you think its value may be. This personal duty becomes subsumed as a social consensus and is enshrined in law. It also generates a right to life that each living person may demand of his fellows. It is this right to life that a person may chose of his own free will to forfeit, and in so doing relieve his fellows of their duty towards him. In this way a terminal and suffering patient, or any other person leading an intolerable life, may opt out of the efforts others make to save them. The doctor confronted with a patient who declines his best efforts to prolong life may, indeed should, withdraw and with no

pangs of conscience. If the duty to treat derives from the right to life, then it evaporates when those rights are not exercised. Where the person himself cannot express a wish, in practice it is extremely difficult to generate any valid proxy, and the dangers loom of the slippery slope of xenophobic euthanasia. It would seem wise to err on the side of caution.

In the religious world, too, there are other voices. Although life is indeed the gift of God, it is not merely a biological gift, and morally neutral. Its holiness is to be defined not by its origins but by its dedication to the ends it was intended for — the service of man and God. If a life cannot be used for its intended purpose, it is not a sanctified life. This is the basis for the death penalty in religious legal systems, for otherwise the penalty would be sacrilegious. The life of a deliberate murderer, whose actions negate the very nature of God's purpose in the world, loses its protected status. Judaism, a religion that delights in encapsulating everything possible in codes and laws, specifies two more categories of sin where the duty to maintain life is suspended —incest and adopting pagan rituals and beliefs.[4] A life essentially contradictory to God's wishes is not a holy life. There is no intrinsic sanctity of life, rather life is given by God to man in order to sanctify it.

So here we arrive at another convergence of the secular and the religious. In both systems there are circumstances where the duty to save life is not absolute, but contingent on the value of that life. In secular terms, where the sane and competent patient ceases to value his own life, the doctor is relieved of the duty to maintain it. In religious terms, where it is not possible to use the life for its God-given purpose, it loses its status of holiness. This convergence is in marked contrast to the sanctity-of-life/right-to-life coalition which typifies the fundamentalist periphery of religious thinking, as well as the more conservative and narrowly scientific sections of secular society.

I suggest that the term 'sanctity of life' confuses rather than clarifies the debate. It should be replaced by 'value of life', which exposes the individual case to critical scrutiny. Medicine can better cope with its current and future ethical dilemmas by a case-by-case approach[5] rather than by adopting a series of dogmas, such as the sanctity of life.

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Neville Goodman

SCHADENFREUDE

English has many imports. Many of our words have evolved from or are related to words in other languages, especially from Latin via French, or from German and Old Norse. Some, though, are more or less direct imports. One of my favourite words is serendipity, which comes from the old name for Sri Lanka. It's such a jolly word, and means such a jolly thing: something nice that happens by accident. Which, until we understood the exact structure of drug receptors, is how many of our drugs were discovered. Pethidine was intended as an atropine-like compound, until someone noticed that it made mice's tails stick up in the air — the Straub tail response, indicative of what we now call opioids.

Other imports are darker. Schadenfreude sounds dark, and it is. My dictionary defines it as 'the malicious enjoyment of another's misfortunes'. The Barefoot Doctor sullied the pages of the *Observer* for some years with his mixture of touchy-feely psychobabble, which was annoying but harmless, and irrational explanations of medical problems, which was infuriating and possibly dangerous. My correspondence with Barefoot was unsatisfactory, and soon ignored. The *Observer* was concerned only with his popularity which, judging from the books and potions sold under his name, was considerable.

Imagine my malicious enjoyment then, on reading a front page story in the *Observer* (the very same) titled 'Crackdown on the therapists who abuse vulnerable', and discovering that Barefoot was the subject of allegations of sexual misconduct, highlighted by an investigation by the *Observer* (the very same). The allegations are not without foundation: Barefoot has admitted to having sex with ex-patients, and now no longer practises.

So I was looking in the wrong direction. It was his nonsensical explanation of physical illness ('the ears are the flowers of the kidney') that most perturbed me, but it was the touchy-feely stuff that got him into trouble, when vulnerable women came to him for help. On his website, he wrote that his relationship with one woman whom he had met at a healing workshop was 'not as a healer … but as a man in great need of solace'.

His columns — more correctly, that his columns appeared in a serious newspaper — annoyed me. But I cannot help feeling a little sad. In my first piece about Barefoot (January 2001) I said that, judging from his general statements about health, he wrote sensibly, had a good sense of humour, and probably helped many people. It turns out that he did indeed know, first hand, about the weaknesses of human flesh.