Diametros 45 (2015): 1–18
doi: 10.13153/diam.45.2015.793

THINKING ABOUT END OF LIFE IN TELEOLOGICAL TERMS

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Abstract. This brief paper presents an Aristotelian-inspired approach to end-of-life decision making. The account focuses on the importance of teleology, in particular, the *telos* of *eudaimonia* understood as the goal of human flourishing as well as the *telos* of medicine when a person's *eudaimonia* is threatened by serious illness and death. We argue that an Aristotelian bioethics offers a better alternative to a "fundamentalist bioethics" since the *telos* of *eudaimonia* (i) offers a more realistic conception of the self and the realities of frailty and mortality, (ii) provides a more objective basis for making decisions regarding end-of-life treatment and care, and (iii) is better able to resist the pull of the Technological Imperative. In addition, this teleological concept is flexible enough for it to be employed in multicultural and pluralistic societies.

Keywords: bioethics, Aristotelian, fundamentalist, end of life, *telos*, *eudaimonia*, death, illness, suffering, virtue.

> Every art and every inquiry, and similarly every action and choice, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim.[1]

Introduction: Contemporary Bioethics and the Challenges of End-of-Life Decision Making

Physicians have a difficult time coping with death, in large part because modern medicine is ill-equipped to cope with the fact that mortality for us (unlike for our ancestors) has become a medical experience, one in which medicine often

> [...] fails the people it is supposed to help. The waning days of our lives are given over to treatments that addle our brains and sap our bodies for a sliver's chance of

[1] Aristotle [1984] *Nicomachean Ethics* I, 1, 1094a1-3 (transl. W.D. Ross).

> benefit. They are spent in institutions—nursing homes and intensive care units—where regimented, anonymous routines cut us off from all the things that matter to us in life.[2]

And this fact has serious consequences: "Our reluctance to honestly examine the experience of aging and dying has increased the harm we inflict on people and denied them the basic comforts they most need."[3] However, while Gawande describes this state of affairs as "intolerable" for both physicians and patients, he is not sure how we should respond:

> Lacking a coherent view of how people might live successfully all the way to the very end, we have allowed our fates to be controlled by the imperatives of medicine, technology, and strangers.[4]

While this intolerable state of affairs raises questions that are fundamentally ethical in nature, it is arguably the case that a turn to bioethics as it is currently structured will also fail to provide adequate answers. Bioethics tends to deal with intriguing and sometimes exotic issues—such as whether wealthy individuals should be permitted to buy organs from the poor, whether frozen embryos should be considered property or persons, and whether selective abortion is morally wrong because it can be considered a form of eugenics—that arise in the context of medicine, and as a consequence of medical developments. Surprisingly, however, despite the contentious nature of the subjects with which it grapples, contemporary secular bioethics both spends little time considering, and is ill-equipped to explore, the more commonplace but nonetheless crucially important concerns that are an inherent aspect of the human condition, an unavoidable part of medical practice, and what ought to be a central concern of bioethics: how do we live well (and die well), given our embodiment, our frailty, and our inevitable mortality? That is to say, contemporary bioethics, like modern medicine (to use Gawande's phrase), also lacks "a coherent view of how people might live successfully all the way to the very end." In short, a striking feature of contemporary bioethics is that it offers little guidance when it comes to thinking about what it means to be human, and how we can live meaningful lives in the face of illness, suffering, and death.

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[2] Gawande [2014] p. 9.

[3] Ibidem.

[4] Ibidem.

We will argue that, given the ethical framework employed by contemporary secular bioethics, this omission is regrettable but not surprising, and that the great contribution Aristotelian ethics can make to bioethics is to provide a context for asking, and an approach to answering, deep questions about the meaning and purpose of our lives and the value of making particular choices as we approach the end of life. Moreover, our contention is that Aristotelian ethics can accomplish this work while still operating within a secular ethical framework, something that is of fundamental importance in the large multicultural and pluralistic societies in which many of us now live. We shall explore and defend these claims through an examination of the question of how an Aristotelian ethicist might address the "intolerable" state of affairs described by Gawande. Before we do this, however, we need to say more about the ethical framework that currently dominates in bioethics in order to make clear the ways in which an Aristotelian approach might shift the focus of bioethical deliberations.

The Rise of "Fundamentalist" Bioethics and the Rejection of Teleology

Many scholars trace the origins of contemporary bioethics to the aftermath of the Second World War, and to the revulsion felt by many when it was discovered that physicians during the Nazi regime had conducted cruel experiments on human subjects, and that these physicians felt that their actions were justified because they were in accordance with the values that prevailed in their society at that time. What the early bioethicists sought to create was a form of bioethics that would be valid cross-culturally and cross-temporally, so that no one, anywhere or ever, would be able to justify unethical behaviour on the ground that what he did was considered ethically acceptable in his own culture. The type of bioethics that resulted has been built both on the idea that there are some fundamental ethical principles—such as a commitment to the concept of human rights and the informed consent of research subjects—which are shared by all civilized societies and endorsed by all reputable bioethicists, and that a commitment to this kind of universal bioethics necessarily precludes appeal to values that are not universally shared, such as those which arise out of particular religious or cultural perspectives.

Baker labels the beliefs on which contemporary bioethics is based as a species of "moral fundamentalism":

> As the label 'fundamentalism' suggests, the central tenet of this position is that certain basic or fundamental moral principles are accepted in all eras and cultures and thus are universally applicable to agents and actions in any era or culture.[5]

This form of bioethics is also thought by many bioethicists to be the only form that can work within the large pluralistic and multicultural societies in which many of us live today: because it purports to rely on principles and values that are held to be valid for everyone, everywhere, in any place or time period, it is also one that is applicable to all members of any given society, regardless of their cultural backgrounds or religious commitments.

This "fundamentalist" bioethics is primarily built on a three-part ethical foundation: it draws on Kantianism, utilitarianism, and the political philosophy of neutral liberalism that, in bioethics, operates as a moral, rather than as a political, theory. These theoretical contributions can be observed in the identification and application of the central principles of bioethics, namely, autonomy, justice, beneficence, and non-maleficence.

Autonomy and justice are usually understood to be Kantian in origin, but are now also given a largely liberal gloss: autonomy, in both theory and practice, means ensuring that individuals have the largest amount of freedom possible to pursue their own conceptions of the good; and justice means both that health care institutions should follow clear and transparent procedures when making decisions, and that most of the decisions that are made are ones that allow individuals, as much as possible, to make autonomous choices. Beneficence and non-maleficence are usually considered to be utilitarian in origin. They allow bioethicists to temper the scope of autonomous choice (as set out by the principles of autonomy and justice) with some consideration of what is best for large numbers of people. For example, it follows from the need to balance these principles that medical goods should be distributed so that they both support the exercise of autonomy, and ensure that the greatest amount of such goods are available for the greatest number of people. Thus, if physician-assisted suicide is legalized (in response to the demands of autonomous individuals), safeguards will be put in place to protect the weak and vulnerable (in response to the requirements of beneficence and non-maleficence).

What is striking about the ethical foundation of contemporary bioethics is its lack of any place for Aristotelian ethics in particular and virtue ethics in general. In large part, this lack rests on a misunderstanding: because Aristotelian vir-

[5] Baker [1998] p. 203 (italics in original).

tue ethics, like the ethical approaches endorsed in many religions (and, indeed, within many cultures) requires us to think in teleological terms, it is believed by many contemporary bioethicists, as well as by those who were instrumental in constructing bioethics in its current form, that to endorse any form of virtue ethics would be to create a partisan, religiously-oriented, and/or culturally specific kind of bioethics. We believe that this assumption is based on mistaken beliefs about the nature and form of Aristotelian ethics, and that this misunderstanding has an historical origin: during the Enlightenment period the rejection of religious authority along with its accompanying religiously-based teleology led to a rejection of all teleology, as a result of the mistaken belief that teleological thinking is necessarily religious in nature. The result of this rejection of teleological thinking has had a profound impact on contemporary ethics.

As MacIntyre argues, the ethical frameworks employed by the moral theories that emerged out of the Enlightenment and those that followed them (which are the theories employed in contemporary bioethics) are incoherent, because they jettison one part of a formerly-coherent three-part ethical scheme, one that connects (i) who we are now with (ii) who we could become if we realized our *telos* through (iii) the application of ethical judgment to our choices.[6] For the Aristotelian ethicist, moreover, the objective context by which we judge choices is identified not only by a consideration of our *telos* as a human being, but also located in the concept of a whole human life. An Aristotelian ethicist can ask, in a way that ethicists drawing on the other ethical traditions that currently prevail in bioethics cannot, not only what an individual desires when choosing among the options that are open to her, but also, whether what is desired is a good or bad thing with respect to human nature, and how our meeting it will contribute to, or detract from, that individual's capacity to develop and exercise the virtues and to live a life that (fully) realizes our human nature. In addition, because Aristotelianism connects ethics to our *telos*, Aristotle provides us with an objective reason to shape our characters so that we exhibit the virtues, since the possession of virtuous traits will make us happy. As a result, we will be living the kinds of lives that human beings ought to live.[7]

The Enlightenment and post-Enlightenment secular rejection of Christian theology (both Catholic and Protestant) and the rejection of Aristotelianism (in both science and philosophy) has produced an ethics in which we can talk about who we now are (part (i)), and about ethical principles (part (iii))—but in which

[6] MacIntyre [1981] p. 52 ff.

[7] Aristotle [1984] *Nicomachean Ethics* I, chs. 1–8.

we no longer have a clear sense of what those ethical principles are designed to do, or how they might contribute to a life that is well-lived (part (ii)). As MacIntyre puts it,

> Since the whole point of ethics [in the Aristotelian scheme]—both as a theoretical and a practical discipline—is to enable man to pass from his present state to his true end, the elimination of any notion of essential human nature and with it the abandonment of any notion of a *telos* leaves behind a moral scheme composed of two remaining elements whose relationship is unclear.[8]

Moreover, the rejection of teleology not only generates a moral scheme that is incoherent, it also produces a moral scheme that is largely devoid of meaning and purpose, just as the rejection of teleology in science produces a materialist picture of reality that is devoid of meaning and purpose. While this may make a certain kind of sense when it comes to the consideration of scientific questions, it makes no sense when it comes to thinking about human lives, choices, and ethical judgments.

In other words, the rejection of teleology by contemporary bioethics has resulted in an ethics that is applied to actions rather than to persons. In contrast, the acceptance of teleology by Aristotelian ethics means that our ethical judgments are not simply applied to discrete actions ("Should we do another round of chemo?"), but to the larger question of whether or not the action will promote or inhibit an individual's *eudaimonia* ("Will this additional round of chemo help the patient live well, or might it mean they die badly?"). The term '*eudaimonia*' refers to the fulfillment of the *telos* appropriate to being human. Its rich meaning may be conveyed in English by expressions such as 'happiness' (understood as an abiding state of mind, not as a fleeting emotional state), 'well-being', and 'flourishing'.[9] Grounded in human nature, that is, our species-being as a "rational animal," *eudaimonia* would include the proper functioning of our biological life (the possession of healthy organs and their proper functioning as well as experiencing our characteristic pleasures and pains, that is, emotions), and of our social life (Aristotle's "political animal" that springs from our rationality).[10] *Eudaimonia* is rooted in human rationality, and is closely tied to the cultivation and possession of virtues,

[8] MacIntyre [1981] p. 54–55.

[9] Hursthouse [2001] p. 10–11; Aristotle [1984] *Nicomachean Ethics* I, 7, 1097b23-1098a20. In this passage, Aristotle defines *eudaimonia* as activity of the soul involving a rational principle and being in accordance with virtue.

[10] In understanding *eudaimonia* in these terms, we follow Hursthouse [2001] p. 147–183. For the human being as a political animal, see Aristotle [1984] *Politics* I, 2, 1253a8-38.

character traits that are necessary for the realization of human nature. Human flourishing in an Aristotelian sense, we should note, does not mean living a life in which someone is free from illness, suffering, danger, and temptation, but living well in the face of even these things.

In our consideration of the contribution Aristotelian ethics might make to contemporary bioethics, we shall focus on three distinct, but related concerns, all of which we have alluded to above, but which we will now make more explicit. First, the conception of the self that animates contemporary bioethical discussions is ill-equipped to deal with the significance of our biological life, the realities of human embodiment, and, in particular, with our frailty and mortality; second, ethical judgments based on the current bioethical framework tend to be made on the basis of subjective criteria, since there is no objective standard which can guide them; and, finally, because of these two features, bioethics, along with medicine, is ill-equipped to resist the pull of the Technological Imperative, which results in a high physical and psychological cost for dying patients, and a high financial cost for health care systems. We will consider each problem in turn, and show how an Aristotelian bioethicist might approach these concerns. In what follows, we shall distinguish the approach taken by what we will call a "fundamentalist bioethicist," that is to say, one following the ethical framework set out by fundamentalist bioethics, from the approach taken by an "Aristotelian bioethicist," someone whose attitudes and judgments are shaped by Aristotle's ethics.[11]

Contemporary Bioethics and the Reality of Sickness, Suffering, and Death

One question that bioethics professors like to ask their students is "Are you a body, or do you have a body?" The question is intended to get them to begin to notice the metaphysical underpinnings of their beliefs about themselves and about the world. The way in which the question is answered reflects deep and fundamental metaphysical assumptions about the nature of human beings and of our place in the world (both natural and social). Most students, shaped (usually unconsciously) by Cartesian dualism and mechanism, answer that they have a body. This question also provides a simple, but not simplistic, way of distinguishing be-

[11] For a fuller account of these two approaches, see Haliburton [2014]. When considering Aristotelian responses to our contemporary situation, we should perhaps affix the prefix 'neo' as some contemporary Aristotelians do: we are of necessity compelled to engage in a certain degree of imaginative speculation when we apply Aristotle's thought to technological, social, and medical developments he had no way of anticipating. As 'neo-Aristotelians,' we try to draw on Aristotle's ethical insights, but must of necessity apply them in new ways and new contexts. Though nothing hangs on the distinction, the reader may understand 'Aristotelian' as 'neo-Aristotelian' throughout the paper.

tween a form of medicine and bioethics shaped by Cartesian assumptions, and a form of medicine and bioethics shaped by Aristotelian ones: most contemporary physicians (judging by their behaviours) and bioethicists (judging by their arguments) would likewise answer that they have a body; Aristotelians, in contrast, would arguably assert that they are a body.[12] These differences are reflected in the contrasting ways in which contemporary post-Enlightenment medicine and fundamentalist bioethics view sickness and death, compared to the way in which a medicine and a bioethics shaped by Aristotelian assumptions would grapple with these features of the human condition.

One of the unavoidable features of human life is that it ends. For ancient Greek philosophers like Socrates and Plato, this fact provided much of the impetus for philosophizing, and a context for deliberations about what it meant to flourish: for them, the purpose of wisdom is to prepare for death, and questions about what it means to live well (and to live badly) are meaningful, not in spite of the fact that we will all die, but because of it.[13] What is striking about contemporary technological medicine, however, is that it tends to view death, not as an unavoidable feature of human existence, but as a failure of medical technology or professional expertise. In medicine characterized by the development and use of powerful technologies, the death of a patient becomes less and less an act of nature, and more and more the result of a conscious decision made within a medicalized context to let someone die (for example, by choosing not to insert the feeding tube, or deciding to turn off the ventilator).

This sense that we have a body, and that death is a kind of medical failure, is dramatically illustrated by the recent proposal made by an Italian doctor to do a "head transplant." Even though someone's body has "died," he argues that there is no reason why that individual should cease to exist: they can simply have their head attached to a "donor body" and continue living.[14] The flight from our fragile embodiment and death is equally evident in the hope that, in the future, it will be

[12] MacIntyre [1999] p. 6. It is arguable whether Aristotle would say we are a body. This depends on how 'Platonic' one reads his views on the soul to be; however, his definition of the soul does stress the unity of the soul and the natural body it animates. See Aristotle [1984] *On the Soul* II, 1, 412a1-b9.

[13] Plato's dialogues *Apology*, *Crito*, *Phaedo*, and *Gorgias* portray a Socrates who is well aware that he could or will die for his philosophical pursuit of the virtuous life. See these dialogues in Plato [1989]. May ([2009] p. 115) remarks: "As important as the theme of death is, it is surprising how marginal a theme it is in philosophical literature after the ancients."

[14] Telegraph [2015].

possible (and desirable) to "upload" our brain patterns into a computer, thus achieving a kind of immortality.[15]

Contemporary bioethics, likewise, has a difficult time finding a place for human frailty, illness, and mortality in its deliberations. The model of the self—the understanding of what human beings are, how they choose, and what it means for such creatures to live well or live badly—that animates fundamentalist bioethics is shaped by the conception of persons as autonomous choosers, who have the mental capacity to consider the options open to them and to evaluate the likely consequences of making a particular choice among them, and the physical capacity to act on those choices. Given this figure of the autonomous chooser, bioethicists struggle to know how to respond to those whose ability to choose is affected by their cognitive incapacity, or whose ability to act is limited by physical frailty, illness, or handicap. Many of the ethical dilemmas with which fundamentalist bioethicists concern themselves in the context of health care (for example, how to treat those who are incompetent, or who make medical decisions that are medically questionable) are generated precisely because their standard model of the self is of a healthy, well-balanced, and autonomous decision maker.

An Aristotelian bioethicist, in contrast, would begin his thinking about medical decisions at the end of life from a very different perspective. Far from assuming that human beings are most properly understood as free and autonomous decision makers (whose personal identity could be transferred from one body to another, or contained within a computer), an Aristotelian bioethicist would recognize that there is a clear and unavoidable connection between our personal identity and our embodiment, between our rationality and our animality, between our individual subjectivity and our social connections. Furthermore, what it means to pursue or achieve *eudaimonia* is necessarily shaped by the fact of our embodiment. While a contemporary fundamentalist bioethicist might take, as his central question, "How can we ensure that the autonomous choices of clients are respected?," MacIntyre argues that the central question an ethicist shaped by Aristotelianism would ask is "What difference to moral philosophy would it make, if we were to treat the facts of vulnerability and affliction and the related facts of dependence as central to the human condition?"[16] From the perspective of bioethics, we believe, it

[15] This view of personal identity is called informational patternism, which is a version of the Psychological Continuity Theory, a leading theory of the nature of persons in metaphysics. It is also closely related to the Computational Theory of Mind (CTM), the leading view of the nature of mind in both philosophy of mind and cognitive science. See Schneider [2009] p. 6–7; and for a set of articles on these views of personal identity, see also p. 55–102.

[16] MacIntyre [1999] p. 4.

would make all the difference in the world: rather than considering death a form of medical failure, we would begin to ask what it means to live well throughout our lives, including the period in which they are ending. The pursuit and achievement of *eudaimonia*, moreover, is important, not in spite of the fact that we will die, but precisely because that fact is an unavoidable feature of our embodiment. In addition, MacIntyre's question helps us identify objective criteria against which particular medical choices can be evaluated.

The Subjectivity of Ethical Judgments in Contemporary Bioethics

Contemporary bioethics tends to focus on individual rights, cost-benefit analyses, and procedural concerns, and to view patients, even those who are seriously ill and even dying, as independent and autonomous choosers. Moreover, this form of bioethics has been phenomenally successful in shaping the way in which the ethical practice of medicine is understood, and the health care institutions in which it is practiced. This is demonstrated by the fact that those who seek medical help are now often viewed as "clients," for whom the most important thing is to ensure that choices are respected, rather than as "patients," who can be expected to share certain goals with their health care providers, and who might, given the nature of their disease and their current condition, have very few options open to them—and perhaps none of them good. It is this framework, arguably, coupled with technological developments in medicine, that contributes to the difficulty in thinking about and acting in end-of-life situations because it provides no objective measure against which particular medical options can be evaluated, and no framework for determining when a life has reached a point at which it can be said to be complete. As Gawande observes, he no longer knows when a patient is truly dying:

> When there is no way of knowing how long our skeins will run—and when we imagine ourselves to have much more time than we do—our every impulse is to fight, to die with chemo in our veins or a tube in our throats or fresh sutures in our flesh. The fact that we may be shortening or worsening the time we have left hardly seems to register. We imagine we can wait until the doctors tell us that there is nothing more they can do. But rarely is there nothing more that doctors can do.[17]

[17] Gawande [2014] p. 173. Gawande's point seems to be confirmed by empirical studies that show that providing palliative care, rather than standard care or aggressive care, improves the patient's quality of life and mood as well as resulting in longer survival. See Temel, Greer, Muzikansky et al. [2010] p. 733–742.

Because there is no medical or bioethical framework for making objective judgments about when medical treatment should be stopped, the only basis for judgment is subjective: how the patient feels, how the physician feels, tempered, sometimes, by concerns about legal liabilities or financial costs. The result is two seemingly contradictory but actually connected trends: on one hand, physicians are uncomfortable talking about death and preparing patients for the fact that they are dying, which means many patients suffer from futile and painful treatments until the very end; on the other hand, many parts of the western world have seen an increasing push from citizens to legalize physician-assisted suicide, something which many people feel would at least give them some control over the timing and manner of their deaths. It is by providing just such an objective standard by articulating a conception of human flourishing that is rooted in our nature that Aristotelian ethics has a real, and even necessary, contribution to make. It also gives bioethicists (and physicians) the opportunity to think about the *telos* of medicine.

Determining the primary purpose of medicine can provide us with an objective measure against which particular medical choices can be judged, particular patient desires evaluated, and the appropriate use of medical technologies determined. While it might seem that the most obvious goal of medicine is simply to make sick people well, the picture is actually far more complicated, at least in modern medical practice which is shaped by the possibilities opened up by technological developments in medicine. We can ask whether

> [...] the overarching purpose of the health care professions [is] the prevention of death or the alleviation of suffering? If it is the alleviation of suffering, does this embrace not only a cure of the cause of the suffering, but also the comforting of the sufferer who cannot or will not be cured? Another possibility is that health care, in the context of a specific illness, is only the attempt to optimize the patient's chances for a happy and productive life.[18]

Clearly, these possible goals shape what we would understand to be the proper practice of medicine. But each possible goal is itself ambiguous: the alleviation of suffering might involve anything from curing the condition which causes the suffering to providing physician-assisted suicide which ends the life of the sufferer; and each falls in a different place on the subjective/objective continuum: what it means to live a happy and productive life in the face of illness might mean either

[18] Garrett, Baillie, and Garrett [1998] p. 15.

responding to the patient's subjective determination of what a happy and productive life looks like, or make appeal to an objective standard of human well-being, such as that offered in the Aristotelian account.

In defining the goals of medicine in a modern context, we believe that an Aristotelian bioethicist would, as much as possible, strive to articulate those goals by appeal to as many objective criteria as possible. This task could be accomplished by, on one hand, locating our thinking about the goals of medicine in a recognition of our existence as an embodied and frail species-beings whose lives are finite, and, on the other, thinking about what role medicine can play in facilitating the pursuit and achievement of *eudaimonia* throughout our lives, and, in particular, in the face of illness, suffering, and death.

It is important to note that illness and suffering are commonly distinguished from one another in the following way: illness is a condition that afflicts the body, while suffering is a condition that afflicts the person—not simply in terms of how they feel physically, but in terms of their psychological, emotional, social, and even spiritual state. What contemporary technological medicine excels at is treating illness (even if doing so sometimes prolongs the dying process rather than restoring the patient to health), but is not very good at treating suffering, as first-person accounts of illness reveal. For example, Frank describes his suffering, when treated for a serious illness, as the loss of a sense of who he was, and where he belonged:

> The loss of a life's map and destination are not medical symptoms. The scope of modernist medicine—defined in practices ranging from medical school curricula to billing categories—does not include helping patient's learn to think differently about their post-illness worlds and construct new relationships to those worlds.[19]

Likewise, Carel notes that, in her experience, medical treatment was both frightening and alienating:

> I quickly learned that when doctors ask 'How are you?' they mean 'How is your body?'; that when an X-ray of my lungs is on screen and several doctors stand around it discussing my 'case', they will not include me in the discussion; that they will not want to know how my life has changed because of my illness, how they could make it easier for me.[20]

[19] Frank [1995] p. 6.

[20] Carel [2008] p. 39.

Fundamentalist bioethicists, likewise, have done little to alleviate patient suffering, as these first-person accounts of illness attest. The ethical practice of medicine, described simply in terms of facilitating and responding to patient choices about how their illnesses might be treated, leaves patient suffering almost entirely unaddressed.

We believe that an Aristotelian bioethicist would be more able than their fundamentalist bioethics counterparts to take the suffering of patients seriously. First, Aristotelian bioethicists would endorse the distinction between treatment and care, and would make it a central part of their approach. Treatment can be understood as the application of medical procedures directed towards illness with the goal of restoring health and eliminating disease, while care can be defined as the process of looking after the patient by focusing on treating the suffering (in all its forms) of the patient. Aristotelian bioethicists would propose that the goal of medicine is the treatment of illnesses which can be cured in the hope of restoring health and normal functioning to the greatest extent possible (with 'normal functioning' understood in species-based terms); however, when treatment cannot be expected to restore health (even though it might be able to prolong the dying process), the goal would shift to that of providing care, especially in the form of palliative care. (We should note that the one area of medicine that comes closest to approximating what we take to be the Aristotelian ideal is palliative care.)

Second, an articulation of the *telos* of medicine also provides a basis for an examination of the virtues that ought to be demonstrated by both physicians and patients: their virtues will respond to (and correspond with) the goals of sound medical practice, and the place of medical practitioners and patients within it. In part because he would not see the body being treated as somehow separate from the person being treated, and in part because he would take seriously the question of what virtues should be exhibited by those who are ill and by those who care for them, an Aristotelian bioethicist would be well-placed to take the suffering of patients seriously. He would not ask (as a fundamentalist bioethicist might), "What does this client want, and how can we provide it to her?," but, instead, "What suffering is this patient experiencing, and how can the medical team help make this experience less alienating and frightening for her?"

In short, within an Aristotelian framework, both medicine and bioethics should be focused on the person, not merely on the illness: it should try to alleviate suffering, which often includes, but is not limited to, physical pain, since it also has an emotional, relational, psychological, and sometimes spiritual dimension. An Aristotelian bioethicist would take seriously the question of how to promote an ill or dying person's *eudaimonia*, through helping that patient develop or culti-

vate virtues, maintain relationships, and find closure on important life projects, while suffering through the experience of illness and coming to grips with her own mortality. An Aristotelian bioethicist would also help physicians cultivate the appropriate virtues that allow them to best treat patients as they go through this process. For example, they would help physicians recognize that good medical care includes paying attention to the person they are treating, not just to their bodies, and that providing treatments that are futile is not good medical practice. In short, helping physicians and other medical practitioners know when to stop treating an illness and start responding to suffering would be an important part of an Aristotelian bioethicist's role. He would assist medical practitioners in understanding death as not only an inevitable part of life, but also as providing the context which makes our choices meaningful, and thereby no longer in seeing its occurrence as primarily a fundamental failure of medicine.

Resisting the Technological Imperative

Many of the ethical issues that arise in bioethics are driven by developments in technology. In the western world, at least, the practice of medicine has become highly technological, and it is arguably primarily developments in technology that have transformed death from an unavoidable natural event to one that results from human choices and actions. Winston defines technology as "a systematic and rational way of doing things; it is, in general, the organization of knowledge, people, and things to accomplish specific practical goals."[21] Often, these goals are not themselves evaluated on ethical grounds, but, instead, respond to social expectations and financial considerations. For example, technology can help us design more efficient factories that produce goods more cheaply and quickly, but which cause high rates of illness in the factory employees. It is important to note that, while we often think of technology simply in terms of the machines that we use, Winston's definition makes it clear that technology encompasses expertise, artifacts, and information. In the context of health care, for instance, when we think of technology, we should think not only of equipment like ventilators and feeding tubes, but also of medical knowledge, techniques, and medications: chemotherapy drugs are as much a manifestation of technology as are the machines that insert them into the bodies of patients. In addition, as Postman observes, technological change is "ecological" rather than "additive": new technologies do not simply add new options to existing ones; rather, they transform the societies in which they appear.

[21] Winston [2003] p. 1 (italics in original).

> A new technology does not add or subtract something. It changes everything. In the year 1500, fifty years after the printing press was developed, we did not have old Europe plus the printing press. We had a different Europe.[22]

Modern medicine, likewise, has been transformed by technology; as a result, we are no longer constrained by what used to be considered inescapable natural features of our existence. As a result of medical technology, post-menopausal women can give birth to children who have no genetic connection to them, cell lines can achieve a kind of immortality, and an analysis of our DNA can give us a picture of where our ancestors were from and what diseases we might develop in the future.

Not only is technological change transformative, but, in addition, technology often takes on a life of its own: we use technology because it is there. Moreover, we often want to advance our technological capabilities because we can, without asking whether we ought to use them, and why we want to develop them further. This feature of technology and of our relationship to it has been termed the Technological Imperative, and its presence in medicine generates many of the issues that arise in end-of-life care and treatment. It means, on the one hand, that if the technology exists to extend life (which often means merely to prolong the dying process), patients, their families, and health care professionals, will all feel compelled to use it. This can come at a high personal cost for patients, and a high financial cost for the health care system. For example, we have been told by a physician we know that it can cost as much as $60,000 (in Canada) to extend a dying cancer patient's life by two or three weeks, with little or no quality of life resulting from this treatment; however, he says, it is very difficult for both physicians and patients not to proceed with treatment, no matter how clearly futile, if the possibility that it might prolong life exists.

On the other hand, as noted above, it is these very developments in medical technology that have largely spurred the push for the legalization of physician-assisted suicide and euthanasia: once at least some individuals come to understand that their dying is likely to be painful and prolonged because the existence of medical technologies means that "there is always something more that can be done," they decide that they would rather die at a time and in a manner of their own choosing.

A fundamentalist bioethicist is largely powerless to resist the push of the Technological Imperative as it manifests itself in the practice of medicine, because

[22] Postman [1992] p. 18. Postman examines how medical technologies have transformed the practice of medicine in ch. 6.

she has no objective natural norms to which she can appeal. Given the emphasis on autonomy in fundamentalist bioethics, a bioethicist is likely to assert both that patients should be given access to any treatments they desire, and that they have a right to physician-assisted suicide, if that is what they choose. An Aristotelian bioethicist, in contrast, is well-placed to resist the Technological Imperative as it operates in medicine, and to help physicians and patients know when to cease treatment and focus on care, because he can draw on precisely those natural norms that the Technological Imperative challenges in medicine for guidance. For example, he would not think that head transplants, even if technically possible, would be advisable. He would observe that menopause places a natural limit on a woman's fertility. He would recognize that the dying process is something that human beings need to find ways to make meaningful, not something that they can avoid through the rigorous use of technological medicine. Unlike fundamentalist bioethicists, an Aristotelian bioethicist would be able to ask not only whether a particular treatment is desired, but also whether or not it should be desired: does it contribute to the pursuit or maintenance of *eudaimonia*? Is it a treatment a virtuous patient would desire, or a virtuous physician would offer? Would a virtuous first world patient buy an organ from an impoverished inhabitant of the third world? Would a virtuous patient expect $60,000 to be spent on him for two extra weeks of life, and would a virtuous physician provide such costly, painful, and expensive treatment? Or would they arrange for exceptional palliative care instead? Notice not only that, once these questions are posed, it seems relatively clear how those working within an Aristotelian framework would answer them, but also that they are almost impossible questions for a fundamentalist bioethicist to even ask, let alone answer.

Conclusion

This brief paper presented an Aristotelian-inspired approach to end-of-life decision making. The account focused on the importance of teleology, in particular, the *telos* of *eudaimonia* understood as the goal of human flourishing and well-being as well as the *telos* of medicine when a person's *eudaimonia* is threatened by serious illness and death. We argued that an Aristotelian bioethics offers a better alternative to a "fundamentalist bioethics" since the *telos* of *eudaimonia* (i) offers a more realistic conception of the self and the realities of frailty and mortality, (ii) provides a more objective basis for making decisions regarding end-of-life treatment and care, and (iii) is better able to resist the pull of the Technological Imperative. In addition, this teleological concept is flexible enough for it to be employed in multicultural and pluralistic societies. Finally, we acknowledge that

> [o]ur discussion will be adequate if it has as much clearness as the subject-matter admits of; for precision is not to be sought for alike in all discussions, […] We must be content, then, in speaking of such subjects and with such premisses to indicate the truth roughly and in outline.[23]

References

Aristotle [1984] – Aristotle, *The Complete Works of Aristotle, The Revised Oxford Translation*, 2 vol., Bollingen Series LXXI, J. Barnes (ed.), Princeton University Press, Princeton, NJ 1984.

Baker [1998] – R. Baker, "A Theory of International Bioethics: Multiculturalism, Postmodernism, and the Bankruptcy of Fundamentalism," *Kennedy Institute of Ethics Journal* 8 (3) 1998, p. 201–231.

Carel [2008] – H. Carel, *Illness,* Acumen, Stocksfield, UK 2008.

Frank [1995] – A.W. Frank, *The Wounded Storyteller*, The University of Chicago Press, Chicago, IL 1995.

Garret, Baillie, Garrett [1998] – T.M. Garrett, H.W. Baillie, and R.M. Garrett, *Health Care Ethics: Principles and Problems*, 4th Ed., Prentice-Hall, Upper Saddle River, NJ 1998.

Gawande [2014] – A. Gawande, *Being Mortal: Illness, Medicine, and What Matters in the End*, Doubleday Canada, Toronto 2014.

Haliburton [2014] – R. Haliburton, *Autonomy and the Situated Self: A Challenge to Bioethics*, Lexington Books, Lanham, MD 2014.

Hursthouse [2001] – R. Hursthouse, *On Virtue Ethics*, Oxford University Press, Oxford 2001.

MacIntyre [1981] – A. MacIntyre, *After Virtue*, University of Notre Dame Press, Notre Dame, IN 1981.

MacIntyre [1999] – A. MacIntyre, *Dependent Rational Animals: Why Human Beings Need the Virtues*, Open Court Publishing Company, Chicago and La Salle, IL 1999.

May [2009] – T. May, *Death*, Acumen, Stocksfield, UK 2009.

Plato [1989] – Plato, *The Collected Dialogues of Plato, Including the Letters*, Bollingen Series LXXI, E. Hamilton and H. Cairns (eds.), Princeton University Press, Princeton, NJ 1989.

Postman [1992] – N. Postman, *Technopoly: The Surrender Of Culture To Technology*, Vintage Books, New York 1992.

Schneider [2009] – S. Schneider (ed.), *Science Fiction and Philosophy: From Time Travel to Superintelligence*, Wiley-Blackwell, West Sussex 2009.

Telegraph [2015] – Agency, "Frankenstein-style human head transplant 'could happen in two years'," *The Telegraph*, Feb. 26, 2015, URL = http://www.telegraph.co.uk/

[23] Aristotle [1984] *Nicomachean Ethics* I, 3, 1094b11-13 and 19-21 (transl. W.D. Ross).

news/science/science-news/11436319/Frankenstein-style-human-head-transplant-could-happen-in-two-years.html [18.06.2015].

Temel, Greer, Muzikansky et al. [2010] – J.S. Temel, J.A. Greer, A. Muzikansky, et al., "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *The New England Journal of Medicine* 363 (8) 2010, p. 733–742.

Winston [2003] – M. Winston, "Children of Invention," [in:] *Society, Ethics, and Technology*, 2nd Ed., M. Winston and R. Edelbach (eds.), Thomson Wadsworth, Belmont, CA 2003, p. 1–20.