

SANCTITY OF LIFE, A SENSE OF LIFE, AND GOOD ENDINGS

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Since the Terry Schiavo case the idea of sanctity of life has shown itself to be open to interpretations which seem too hard edged to be compatible with the kind of concern about human life that bioethics ought to be fostering. When we turn elsewhere for a concept that will do the work that is needed we find the phrase ‘a sense of life’ made famous by Martha Nussbaum. But what is meant by this? That it is linked to the sanctity of life seems inescapable but the link is problematic in a way that demands a closer inquiry, Nussbaum links it to a quasi-objective sense of a good life which raises issues of quality of life and not mere prolonging of life and yet seems to defuse the judgmental stance that is sometimes associated with the concept of quality of life. I settle on a reading in terms of subjectivity and the nature of the other (as encountered in the work of Levinas) such that an ethics of the subject as a being engaged with us in a distinctive way becomes the starting point of philosophical inquiry about human life and death. This then gives a sense in which the life of a human being is sacred but not in a way that favours its continuance in all circumstances but focuses our attention on the subjectivity at the centre of the life.

I INTRODUCTION

Since the Terry Schiavo case the idea of sanctity of life has shown itself to be open to interpretations which seem to have little to do with the kind of concern about human life that bioethics ought to be fostering. It is hard to escape the idea that hard-edged and absolute duties are being mobilised to support stances which lack a certain type of engagement with an unenviable human predicament. When we turn elsewhere for a concept that will do the work that is needed, we find the phrase ‘a sense of life’ made famous by Martha Nussbaum (in her work *Love’s knowledge*).¹ But what is meant by this? The link to the sanctity of life is inescapable and important but is problematic in a way that demands a closer inquiry. To pursue that inquiry we might explore the way the term is used by the author but also trace its resonances with other work in ethics and the contexts of that conversation. To that end we can begin with what surrounds the phrase in Nussbaum’s text so as to get some idea of its structural location in the author’s thought. In particular one wants to know how such an idea or feeling is related to the sanctity of life doctrine and the duties associated with it.

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¹ M Nussbaum, *Love’s Knowledge* (Oxford: University Press, 1990).

A sense of life is said to be required for reflective equilibrium, in the sense used by John Rawls to indicate the melding of ethical intuition with ethical principles in one's response to a given case. Ethical intuitions are, famously, linked to different conceptions of the good life (or orthodoxies) usually held to be irreconcilable and competing in a fragmented moral landscape, so that they are beyond rational argumentation.² Nussbaum, an Aristotelian, does not concede that point and asks how we might be able to evaluate the idea of 'the good life'. She remarks:

we notice and clearly describe the tensions among the views we find. Where there is inconsistency or irreconcilable tension ... we aim to revise the overall picture so as to bring it into harmony with itself, preserving, as Aristotle says "the greatest number and the most basic" of the original judgments and perceptions. There is no rule about how to do this. Individuals simply ask what looks deepest, what they can least live without – guided by their sense of life, and by their standing interest in consistency and community.³

She illustrates by exploring the case of Strether (in Henry James' *The Ambassadors*) who is sent to Europe to check on the scion of a solid New England family who has been sent to Paris for 'finishing'. He finds himself a little 'at sea' in relation to the values and duties sanctioned by New England society and that he is approaching his moral quest 'marked by a child's fresh delight in seeing and an undirected openness to the new concrete thing'. She comments:

This sense that life is an adventure, and that part of its joy precisely is the confrontation with the new – this is a sense of life already far removed from that where dignity is preserved by keeping down the new, acknowledging it only insofar as it exemplifies some law whose sense is already understood. ... heroically untouched by any horrible or wonderful aspect of life.⁴

She is clearly distancing herself from a contrasting morality 'solidly grounded' in an articulated set of duties and allegiances defined by a clear cut framework which one accepts as definitive of the good for those 'like me', that which is said to be irreconcilable with others of its ilk by thinkers like MacIntyre and Engelhardt.

Immediately we can say something that a sense of life is not – it is not wedded to absolutes narrowly conceived and defined in advance so that they can be applied *sans phrase* to the contexts in which they are to be discharged. Sanctity of life is often construed this way but, if Nussbaum is right, perhaps the relevant value should not be.

We can also follow a clue offered by Jean Paul Sartre⁵ in his discussion of the 'spirit of seriousness' which 'considers values as transcendent givens independent of human subjectivity' handed down to us as part of our essential being.

A sense of life seems to embody the idea that the ethics guiding our mortal judgments should be developed in the light of a finely attuned sensitivity to the human condition and a nuanced view of contested situations rather than seen as instancing and applying

² A MacIntyre, *After Virtue* (Notre Dame: University Press, 1984); T Engelhardt, *The Foundations of Bioethics* (Oxford University Press, 1986).

³ Nussbaum above n 2, 174.

⁴ Ibid, 179.

⁵ J P Sartre, *Being and Nothingness* (Methuen & Co, 1958) 626.

ethical truths laid down in an extra-human domain somehow immutable and impervious to the particularities of human predicaments.

II THE SANCTITY OF LIFE.

If that is true, then a sense of life is not, in any flatfooted way, committed to a doctrine of the right to life whatever the condition of the human being concerned, but rather regards the sanctity of life as something to be interrogated in the light of human subjectivity. But if that sounds a bit ‘woolly’ and an unlikely place to start real world ethical and legal thinking in the difficult context of the clinic or healthcare in general, we should notice that our intuitions are not nearly as clearcut in relation to life and death as some pronouncements make them out to be even if one holds a firm and widely accepted set of values. When we ask what is sacred about life we are immediately led to conclude that it cannot be mere biological life or what Helmut Thielicke⁶ calls ‘the empty shell of what once was human ... which can therefore no longer act as an independent subject’ ‘merely a biological culture’ but must rather be a subject who can be addressed as ‘you’. Thielicke, a protestant theologian, aims in this claim to agree with Pius XII who focuses on the person as a subject and gives supreme weight to ‘the presumed will of the unconscious patient’ in the provision of life prolonging measures.⁷ He is also in agreement with John Paul II in his 1995 encyclical *Evangelium Vitae* who affirms the value of human life as the setting where we meet God and enter into communion with God and others. Thus ‘the life of the body in its earthly state is not an absolute good’⁸ and:

euthanasia must be distinguished from the decision to forego so-called “aggressive medical treatment,” in other words, medical procedures which no longer correspond to the real situation of the patient either because they are disproportionate to any expected results or because they impose an excessive burden on the patient or his family.⁹

Notice that, in this Encyclical roundly rejecting both abortion and euthanasia, John Paul II makes a distinction between biological life and the life of a subject who can have meaningful relationships (with God or other human beings). It is worth noting that we are called, even by these traditionally conservative voices to consider the sanctity of life as involving a more nuanced principle than the principle of saving life in all circumstances and with whatever outcome, a view that seems sometimes to be the thrust of an absolute proscription against any medical or ethical complicity in accepting death as a natural end of life. The ‘gospel of life’ seems to regard death as something that, in the words of the hospice movement, should neither be hastened or unduly delayed so that we should aim for a ‘natural death’ in so far as that is possible in our medically technologized world.

In fact we are now in territory with which I feel distinctly familiar as a series of concepts come into view deserving close consideration in the light of a sense of life as a possible interpretative lens for the idea of the sanctity of life; they are:

⁶ H Thielicke, *The Doctor as Judge of Who Shall Live and Who Shall Die* (Fortress Press, 1970) 17.

⁷ Ibid 15.

⁸ Ibid 706.

⁹ Ibid 712.

- (i) Substantial benefit or an outcome which now or in the future the patient would consider worthwhile; and
- (ii) The RUB or the Risk of Unacceptable Badness.

These two concepts are more or less self explanatory and help spell out what we mean by respecting the life of a human subject in the context of decisions regarding limitation of treatment in end-of-life care.

III WHOSE LIFE IS SACRED?

We should turn first to the investigation of the relation between subjectivity and a sense of life. A subject lives a life which forms a kind of a story and even though a life lived is more than such a story the discussion of the fitting end to a human life can usefully begin with the narrative view of human life.¹⁰

If an individual's narrative and life project determines what counts as doing the right thing for that person, certain conclusions follow that can be made vivid in a thought experiment (one I commonly use in our ethics course).

A young man, Nigel, is admitted to hospital to investigate headaches and epilepsy. He has a CT and an MRI scan that show a malignant brain tumour. He is told that his diagnosis and that he has a life expectancy of a few months. He is shattered so the neurosurgeon suggests he talk to a nurse or chaplain.

Two days later the neurosurgeon comes back saying he has good news. He says that they have been working on brain transplants for some years and that a young motorbike rider has been mangled in an accident with a train. They have kept his brain alive but the rest of his body is beyond saving. Nigel is told he can have a brain transplant so that he need not die from his malignant brain tumour. Nigel is, momentarily, overjoyed. However, just as the neurosurgeon goes to leave, he asks "Hold it, who is going to wake up from this operation?"

Now most people do not believe that Nigel will wake up which implies that most of us believe that the brain is the seat of the life of the person as a person. It is clear that an adequate level of brain function is required both to support conscious life and to keep a cumulative record so that a lived narrative can be inscribed in the person. And, as long as this lived experience can be activated, there seems to be a continuation of the life of the person as a person rather than merely a 'biological remnant of a person'.¹¹

Some prominent themes marking individual subjectivity emerge from the story including *personal identity* -a story of one's own, *conscious awareness* of the world around one, and *intentional interaction* with others.

Personal identity is, an autobiographical feature whereby an individual constructs a life story for him or herself, perhaps not very original or deliberate, but with a narrative structure and its own integrity. As the individual living this life among these people, the narrative may be more often edited rather than authored it is continually being updated in the light of everything that is happening and it is open-ended. Therefore (as Aristotle,

¹⁰ The next section condenses arguments to be found in my *Bioethics in the Clinic: Hippocratic Reflections* (Johns Hopkins University Press, 2004).

¹¹ Thielicke above, as in note 7.

Jean Paul Sartre, and many others have noted), one's life story is not finished until death because everything prior to that is part of the remembered (perhaps by self and definitely by others) story of a given the lived life.

Second, *conscious awareness or lived experience* is the person's response to the world and others (which may only be as a passive observer amongst others). Locked in Syndrome, for instance leaves the person in the position of a moral patient reliant upon others for the quality of their experiences. I have argued elsewhere that there are philosophical reasons to doubt that the Cartesian or purely inner self is a human possibility because consciousness essentially is an active, interactive, and exploratory cognitive function of whole subjects.¹²

Third, *intentional action and interaction* is the expression of an individual's conceptions and interests.¹³ Even where the individual concerned is severely disabled, there can be a quality of interaction that those who know the person discern and respond to in complex and nuanced ways. But once the possibility of any such action or interaction is irrevocably lost because of severe and widespread brain damage, the person's life as a person has ended.

We can, at this point, usefully revisit Aristotle (whose influence is felt in Christian thought through St Thomas Aquinas). Aristotle argued that the human soul is best thought of as a holistic set of functions and capacities realized in the human body through its interaction in rational and social/political (discursive) so that there is a close link between brain function and the integrity of a unique psychological being. Therefore, once that which supports the soul has been effectively destroyed, the life of the person *as a person* is ended. If bodily life as a 'biological remnant' of a fully human life is then continued, it cannot have the same significance as the life of a person as a subject, a fact with profound ethical implications.

IV ENDING THE NARRATIVE IN A FITTING WAY

A person can stop living the story of his or her life in the sense of experiencing it as a lived life and in such a situation those of us who know and love the person concerned need to try and ensure that the life story is ended in a way that is fitting. For that to be possible medical ethics and medical law have to work closely together.

The ethical issues in this area were raised by the case of Tony Bland injured in the Hillsborough stadium disaster. The judges ruled that we should respect the hypothetical wishes of Tony Bland himself (as we might say 'considered as a human subject not a biological organism'), and thus that his death should be fitting in the whole context of his life. Their reasoning about the removal of the gastric feeding tube keeping him alive is similar reasoning to that in the cases of Brophy and Quinlan;¹⁴

¹² Grant Gillett, 'Wittgenstein's Startling Claim: Consciousness and the Persistent Vegetative State' in C Elliot (ed), *Slow Cures and Bad Philosophers: Wittgenstein, Medicine and Bioethics* (2001) 70-88.

¹³ Sartre above n 6, 433; D Davidson, *Essays on Actions and Events* (Clarendon, 1980).

¹⁴ K Schrode, 'Life in Limbo: Revising Policies for Permanently Unconscious Patients' (1995) 81(5) *Houston Law Review* 1609-68.

if Anthony Bland were to be momentarily restored to consciousness with full knowledge that he would shortly revert to his PVS, and if he were to instruct those caring for him that he no longer wanted artificially to be kept alive, the doctors and nurses would be obliged to respect his wishes. ... The horror of his situation is such that few would not think it perfectly reasonable for him to decide that, as he has already lost all sense and consciousness, he would prefer to die. ...Anthony Bland is an individual human being and the principle of self-determination says he should be allowed to choose for himself and that, if he is unable to express his choice, we should try our honest best to do what we think he would have chosen.¹⁵

Notice the prominent place given to Tony Bland as a subject with consciousness and a sense of self-determination so that we ought to attend to the patient's life and attitudes, and do our best to respect the patient him or herself when we consider the provision of life-prolonging treatment. In fact, because it is a basic feature of the life of any person that he or she should live out his or her own life story, it is not just futile to keep an irreversibly comatose body alive in Persistent Vegetative State (PVS) but it is a certain kind of violence to (or disrespects the sanctity of) the subject as a self-determining human being.

A similar line of reasoning led a New Zealand court to decide that the termination of an Auckland patient's life would not be unlawful.¹⁶ Mr L, a man of 59 years, had been totally paralysed by Guillain-Barre Syndrome (which strips the coverings from nerves throughout the body) so that he had a type of 'Locked in Syndrome'. The specialists who saw him agreed there was no hope of recovery and his view was reliably said to be that he did not ever want to be left in such a state. His wife supported the medical team in their request to terminate his ventilator treatment and the court ruled that it would not be unlawful for the medical team in charge of Mr L to terminate his life support (that having been done, he died within 30 minutes an outcome deemed to be in accordance with his being *as a human subject*).¹⁷

Two further cases recommend the same conclusion but provide a conceptualization that also hinges on the idea of respect proper to a human subject. An Irish case concerned a woman aged 43 who had been severely brain injured at the age of 22 during a gynaecological operation. She was, at the time of the judgment:

spastic, her jaws were clenched, she could not swallow, she was incontinent and bedridden ... For 20 years she received nutrition and hydration through a nasogastric tube. This caused her some distress and she pulled it out on many occasions ... [she] was unable to speak and attempts by a speech therapist to establish some form of communication proved unsuccessful. [she] appeared ... able to recognise members of her nursing staff, and reacted to strangers by showing distress. She could follow people with her eyes and reacted to noise, although this appeared to be mostly by way of reflex action.¹⁸

The High Court, per Lynch J, consented to the withdrawal of artificial nutrition and hydration (upheld by the Irish Supreme Court). The main points of the judgment were that:

¹⁵ *Airedale NHS Trust v Bland* [1993] AC 789 (Hoffman LJ).

¹⁶ *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235.

¹⁷ G Gillett, L Goddard and M Webb, 'The Case of Mr L: A Legal and Ethical Response to the Court Sanctioned Withdrawal of Life-Support' (1995) *Journal of Law and Medicine* 3, 49-59.

¹⁸ *In the Matter of a Ward of Court* (1995) 2 ILRM 401-2.

- 1) the ward's best interests should prevail over other considerations;
- 2) the court exercised a *parens patriae* jurisdiction to ensure that those interests were protected;
- 3) the right to life includes a right to a dignified death;
- 4) the provision of nourishment through a gastric tube was intrusive;
- 5) the right to self-determination means that a competent adult has the right to refuse any medical treatment whatsoever;
- 6) this right should not be denied a person who did not have the mental capacity to exercise it; and
- 7) in this case the ward should be allowed to die a natural death.

The reasoning and its obvious links to the Bland case are clear. The link between a right to life and the right to a dignified death is, however, novel and striking but in deep accord with the present discussion of a sense of life and a framework for ethical decisions informed by what is profoundly worthwhile in a human life. Absent this connection we can use life prolonging treatments without adequate ethical or juridical constraints (appropriately sensitive to the concerns of a human subject) on that use. The Irish court invokes a 'right to a dignified death' but an appeal to the idea of substantial benefit (as defined) or a sense of what is fitting in the whole context of the person's life story delivers the same conclusion.

The New Zealand case, Mr G, concerned a 69 year old man who had suffered a severe brain injury in a road accident 16 months previously.¹⁹ The judge noted:

He is totally immobile, is unable to talk or otherwise communicate in any meaningful way and is incontinent of urine and faeces. His CT scans and EEG show severe brain damage. Every effort has been made to rehabilitate him but to no avail. He has remained in the same state and there is no prospect of recovery. He is kept alive by food and fluids through a gastrostomy tube and is provided with all necessary and appropriate medical and nursing care.²⁰

Judge Fraser consented to the removal of gastric food and fluid, taking note of the cases of Mr L, Tony Bland, and the Irish Ward of court already described, and of:

1. Mr G's injuries and his present condition;
2. specialist opinions that artificial feeding and fluid be withdrawn;
3. the fact that the prospect of meaningful recovery was 'virtually nil';
4. the Ethics Committee's unanimous decision that they had no objection to withdrawal of treatment;
5. the application for withdrawal by Mr G's family
6. the evidence that Mr G's wishes if they could be ascertained would be to have treatment withdrawn; and
7. the fact that withdrawal of treatment would not cause pain and suffering.

¹⁹ *Re G* [1996] NZFLR 362.

²⁰ *Ibid* 2 (Fraser J).

He ruled that those measures should be used which would allow Mr G ‘to end his life and die peacefully with the greatest dignity and the least distress’²¹ again implicitly appealing to something like the fuller sense of life that we are currently interrogating.

The thought that the life of a human subject implies that there is a link between the right to life and the right to a dignified death (or, alternatively, that respect for the sanctity of life turns on a conception of human life that is something more than a mere biological life), we notice that there are conditions in which we can (and should) decide on somebody's behalf that he or she would not want his or her present existence to continue (states of unacceptable badness). We ought to be able to reassure any patient that if such a state eventuated, then health care professionals would not keep him/her alive by intrusive medical means but would respect the human subject at the heart of the issue and a sense of life proper to that conception resulting in an ethical basis for the maintenance and withdrawal of life prolonging treatment that respects the dignity and integrity of the patient (as a human subject).

V THE RUB: THE WORST POSSIBLE END TO THE STORY

A similar point can be made when the life of a human being is under mortal threat. Consider the decision to withhold or withdraw life saving treatment if, for instance, a patient is admitted acutely and rescue treatment or Cardio-Pulmonary Resuscitation (CPR) is required. Two alternatives are commonly mentioned – life and death; but there is another significant category: survival in an unacceptably bad state for the patient concerned. Here we confront the RUB (the Risk of Unacceptable Badness). ‘To sleep, perchance to dream, Aye, there’s the RUB’.

Hamlet is contemplating suicide. He has been told by a ghost (purporting to be that of his father, the recently deceased king of Denmark) that his Uncle (who has since married his mother) murdered that same beloved father. Should he take revenge on his uncle or just exit? If his uncle is innocent, killing him is a mortal sin which Hamlet has committed on the basis of demonic information, and for which he will be damned. But if he fails to avenge his father, he could not live with himself and the regretful dreams that might come in the sleep of death. In this quandary (intensified, according to some commentators, by an Oedipal conflict) he is paralyzed by the prospect of eternity dead, therefore, impotent, but wracked with the moral torments fuelling his suicidal thoughts, an unacceptably bad prospect; ‘Aye, there’s the RUB.’

The RUB is morally challenging and doctors confront it often when they work in rescue medicine considering resuscitation in a seriously compromised patient, a severe brain injury, or a devastating stroke. Facing the dual prospects life and death, we often hear ‘Well, doc, go for it; after all, any chance is better than none.’ But is that so? The person may be left in an unacceptably bad state, hence the RUB!

This is a stark and taxing choice but one hopes that the person making it on one’s behalf has a very clear idea of the proper sense of life and the role of relatives or other surrogate decision makers. In most jurisdictions, those making the decision ought to try and do what the person at risk would have wanted to happen to him or her and not what the relatives or anybody else think should happen, or, worse, what is demanded by an

²¹ Ibid 17.

inflexible value. We should try and do what would be of *substantial benefit* to the person concerned where that is best defined as:²²

An outcome which now or in the future the patient would consider worthwhile.

Thus the ethical responsibility of the health care team is to make the best decision they can in the face of medical uncertainty about the unfolding clinical reality (and the relatives may be an invaluable source of information on what, for the patient concerned, would constitute *substantial benefit*).

Our ethical worries reflect, in part, the widespread and rationally unsustainable belief that life is to be saved at all costs, coupled, for some, with the view that beginning treatment and then stopping it is worse than not beginning at all. But the need for the best information – for instance, about the severity of the initial insult and about its response to treatment – favours what we might call a trial of treatment rather than absolute withholding. It is important that everybody understands that treatment is being trialed and that the patient's response is an important indicator of how long the treatment should continue. If the uncertainties are acknowledged, the idea of a trial of treatment clarified, and the need to act in a way consistent with a sense of life as coloured by the patient's values (as a human subject) is kept in mind, then people tend to cope well with withdrawing treatment (and do not see it as an inexplicable change in clinical management). Most people understand that the withdrawal of potentially life-saving treatment is an issue to be revisited once its likely effect has been gauged and that any decision (in which the RUB is a factor) should be made in the light of some all-in sense of what makes for a good human life (in terms appropriate to the individual concerned).

The RUB cuts out the simplistic 'two options' approach to life and death situations and makes it clear that the chance of survival might only be bought at the cost of a very high risk of an unacceptably bad outcome. A sense of life guides us to take stock and face our responsibility to do what is in the best interests of the patient (as a subject) or what s/he would want if he were able to choose. By engaging others in the process of decision, the team can get a sense of the values and interests that the patient had before the catastrophe and respect the more or less integrated story that is their patient's life, as a lived experience. Even if there is not an explicit advanced directive one can, as a result usually make a judgment about the fittingness of certain possible endings to the patient's story.

In an entirely analogous way we can, in a discussion of CPR with the patient him or herself, convey the reality captured by the RUB so that, the 'any chance is better than none' approach becomes much less attractive than it otherwise seems. Life (valued positively) and death (valued negatively) can then be compared in the light of a sense of life and a third alternative - *life to be valued negatively* - can be put into the moral balance along with the other two.

The RUB does not make life and death decision-making easier and may make it harder but it does make it more responsive to the hopes and fears of any person faced with the mortal perils that wait behind a hospital door. As a result, it becomes more likely that what we decide on that person's behalf at the threshold of life is in keeping with what

²² A Campbell, G Gillett and G Jones, *Medical Ethics* (Oxford University Press, 4th ed, 2005) 12.

that person would have written into the story him or herself as apprehended by an ethical participant equipped with a sense of life.

VI EUTHANASIA

In relation to the thorny issue of active voluntary euthanasia I feel deeply hesitant in a way that I think of as being informed by a sense of life so that:

my own practice rests on the solid foundation of a commitment ... to saving life, and this sustains me when I would be tempted to settle for an easier solution. ...I cannot, as things stand, envisage myself needing to be the means of active euthanasia for any patient, but I have a great deal of respect for those whose humanity and care for their patient leaves them, they feel, no alternative. I do not envy them.²³

We are now able to return to the idea of a sense of life and its use in clinical practice as a path toward a more philosophical reflection on human life and its value.

VII A SENSE OF LIFE IN THE MIDST OF THE CLINIC

One can think of a number of ways in which the sense of life as it pertains to human subjects might inform our clinical lives. We might, in the light of Nussbaum's writing, cultivate and not allow to slip away a sense of life as a sense of the freshness of what life brings and the way in which life can refresh us and renew us when we are flagging or losing a sense of 'what it is all about' or 'whether it is all worthwhile'. The sharing of our stories of inspiration, worth, serendipity, and courage in the face of adversity that find their expression in each of us provide some indications as to how those things might illuminate clinical decisions.

A philosopher who has much to say to us here is Emmanuel Levinas, himself indelibly inscribed by the events of the holocaust. Levinas notes that human faces reveal others who are not things, in fact they are subjects each of whom lives in a world that is, in an important sense, not my world but who share my world with me. I encounter these other subjects who mean something to me in a different way by calling to me or reaching out to me. They cannot therefore be definitively categorised or described because they always present themselves in ways that may surprise me and challenge me and therefore they do not fit neatly into my conception of the world. The being-present or 'proximity' of another person with which I become acquainted more and more deeply as we enter into discourse, signals to me that my story of the world is not the only one and that there are different worlds into which I might be introduced if the people who live those worlds are gracious enough to accept me. They tell me things about differently inspir[it]ed worlds which can never be mine but which can by my contact with them enrich me in a way that nothing else ever could. That is why Levinas is moved to say: 'You shall not kill is ... the principle of discourse itself and of spiritual life'. After the enormity of the Holocaust, the power of this remark is unmistakable. Diamantides remarks, generalising the point he finds in Levinas: 'Ethics, of course, is not simply law, either in theory or practice. But justice and law surely proceed from the ethical relation found in proximity.'²⁴

²³ Gillett, above n 11, 230-1.

²⁴ M Diamantides, *The ethics of suffering* (Ashgate, 2000) 13.

We might be moved, at this juncture to speak in terms of the world of spirit - the human spirit or the spirit of medicine - as something transcendent of any given human individual, drawing on the fact that for each one of us the face of the other opens a 'pore'/'door' from a personal world to a differently inspir(it)ed world. The world of spirit would then, speaking ontologically, be the set of all inspir(it)ed worlds replete with the diverse stories each human being brings to that shared world just by living and finding meaning in their lives. It would then follow that the world of spirit is diminished when any of its stories are lost or, to put it differently, when the life of any human being is cut off while their story is being written even though, because we are finite or mortal individuals, our stories do have endings which can be more or less fitting (and are tragically unfitting in cases such as the suicide of a young person).

So we can now speak of a sense of life and the spirit informing the doctrine of sanctity of life complementing each other. A sense of life gives us a sense of life's value and what it is that makes a life valuable which is only appreciated as one lives and encounters other living human beings whose lives are not only distinct from my own but also full of things that make them worth living. Clint Eastwood's character in *Unforgiven* observes: 'It's a helluva thing you do when you kill a man, you take away everything he has and everything he's gonna have.' Expressing a sense of the value of life as incalculable (despite the fact that the Talmud is prepared to fix the price of the life of a person taken by bandits at the equivalent of two year's crops) and deserving of deep respect because irreplaceable in a way that is neatly encapsulate by his pithy remark.

Levinas' invocation of 'Thou shalt not kill' as the principle of discourse and spiritual life now takes on further substance such that the very idea of ending a human life should always give us pause²⁵ even where we are sure that a sufficiency of the powerful considerations in favour of ending a life ought to guide our decision. A sense of life would seem an essential qualification for ethicists involved in such decisions and in the formation of policies and procedures relating to them.

VIII INSPIR(IT)ED PERSONS WITH A SENSE OF LIFE.

I have argued that to judge well as ethicists we need 'a sense of life', a characteristic that has several dimensions which cannot easily be defined but can be indicated as preparatory work for further definition.

First, we ought to be finely attuned to others in that it is in discourse and inter-subjectivity that we find the grounding for a sense of what is at stake in matters of life and death. This is the ground on which human subjects are encountered, subjects who, as Thielicke and Pope John Paul both note, are the beings we are concerned about in ethical life. Human beings as biological entities have a status derivative from the subjective beings who, in life, they are. Notice I have not said that our bodies are inhabited by subjects as if there were a thing – the 'soul' or 'spirit' – in principle separable from the body even though certain discourses indicate a 'metaphysical' distinction (cf Aristotle's distinction between form and matter). I regard human beings as subjective bodies or embodied subjectivities who are born of women, live entangled

²⁵ I have explored 'the pause' in several pieces of work (see eg above n 11, Ch 12).

with our environment, and exhibit a being-towards-death with more or less resolve. Our sense of life attunes us to whole beings of that sort.

As subjects attuned to our own (and others) being-in-the-world we should be deeply open to discourse, not merely in order to catch on to what others are saying out there, nor merely as expectant listeners for the echoes of our own 'take' on life but as *mortal-beings-in-the-world-with-others* caring (even concerned) about the life-worlds of others and what stories and inspir(it)ations they bring to our shared world.

Attentive or attuned awareness of and responsiveness to others as others makes us recognise and respond to mortality, perhaps as instanced in 'the widow, the cripple, and the orphan' (not as mere exemplars of types but) as embodied particular subjectivities each one of whom is a unique (and perhaps unquiet) piece of the spirit world of which we all partake (or, to use Diamantides' phrase, are in proximity).

As these thoughts and attitudes inform our souls in ethics and medical law, we can become individuals in possession of a developed 'sense of life' in Nussbaum's sense. That should make us alert to freshness, the unrepeatability of the moment, the fragility of goodness as lived by mortals, the need for desire to be properly informed, and to the care of the self so as to attend to the health of the soul through argument and engagement with others in the light of spirit and truth.

If these dimensions enter into the nature of our being, then our being becomes ethical because they are intrinsically transformative. The result of that transformation is a being suffused with a sense of life in such a way that our understanding of life, death and human nature is likely to be more rather than less adequate to the encounters with mortality that abound in the clinic.