

## **NEW ETHICS AND PRACTICES FOR DEATH AND DYING FROM AN ANALYSIS OF THE SOCIOCULTURAL METACONTINGENCIES**

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**ABSTRACT:** *As long as mystical concepts of life, behavior, and humankind prevail, their implications will be respected in social practices. Such a divorce from reality has led to horrible suffering and vast confusion maintained through misguided cultural practices pertaining to slow dying. By confronting these events from the perspective of the natural sciences, new ethics and practices can emerge by which to cope with the problems of dying. These new practices assuage the often prolonged fear of dying, substantially reduce the actual suffering when the time comes, and integrate the business of dying into the cultural economy.*

According to traditional cultural mythology, the body of an organism "lives" in the sense that a body-driving spiritual entity inhabits it. At conception, or whatever equivalent moment characterizes the species under consideration, the spirit, which is the essence of life, arrives to take up residence in the body, although, in some versions, the spirit arrives somewhat later after the newly forming body has made some basic developmental progress. The spiritual body-directing entity remains in the body as long as the body can maintain itself as a suitable home for that spirit. When the body can no longer do that, the spirit departs leaving behind a "dead" body. In our contemporary culture the vast majority of people are committed to one of the many variations on this basic theme. Cultural practices pertaining to death and dying have evolved under the general requirement of respect for such mystical perspectives. People are then bewildered when the intense realities of death and dying are not well accommodated by those prescribed practices.

In contrast to the common mysticism, this work probes some important implications of beginning the analysis of death and dying from a natural science perspective. A good start can be made by delineating some basic concepts: A person and a live body represent two different classes of phenomena. A person is a behavioral repertoire, most all of which is conditioned during the lifetime of the individual. Hence, a person is by nature behavioral and, therefore, is a process rather than an entity. A person happens

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but is not possessed of ontological status. While an individual exhibits a broad range of behaviors of different kinds, behaviors in the verbal class (speaking, thinking, visualizing, knowing about, being aware, etc.) tend more assuredly to characterize a person.

A living body is an entity in the sense that it has ontological status. Its parts, independently or collectively, function both in relation to one another and in relation to elements of the external environment in which it exists. These functions are physiological and are called life.

A body mediates the behaviors that define a person, but those behaviors do not originate spontaneously within that body. Instead, the behaviors definitive of a person, including verbal behavior, are a function of behavior-controlling aspects of the environment in which that body exists. Both the bodily entities and the behavioral manifestations that they mediate are natural. We find that a "person" consists of the dependent behavioral variables in functional relations between body parts and environmental elements that function as the independent variables. "What you are is what you do" is an old kernel of wisdom, but the "...you do" phrase promotes the fallacy of the autonomous agent. A more accurate version is "What you are is the behavior that your body exhibits." And that behavior does not originate with a mystical construct called "you" that putatively inhabits the body and issues its own original directives for the movements of its host body's parts.

Nature consists of complex functional relations, most of which are resistant to our scientific inquiry. Nevertheless, people have made progress in improving the human condition only to the extent that those relations have been probed, discovered, described, and brought under control. Few people who have enjoyed the benefits of life in scientifically advanced cultures seem prepared to accept the intellectual alternative as equally helpful in improving the human condition (i.e., conjuring spirit-like agents that operate with presumably mystical and inscrutable methods to make events-behaviors, for instance-occur in magical ways).

### **The Principles That Inform New Ethics for Managing Death and Dying**

The intellectual foundations upon which this work is predicated have been developed in a somewhat comprehensive behavioral analysis of death and dying, including the necessary redefinition of various relevant terms. That article (Fraley, 1998) establishes the philosophical and scientific basis for this

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more applied extension. Following is a brief review of elements drawn from that earlier work, including some major principles that can serve as a basis for new ethical practices:

1. Traditional rights statements protective of persons, human beings, and human "life," must come exclusively under stimulus control of the verbal capacities of individuals and be divorced from stimulus control by their bodies. "Death of a person," insofar as the phrase retains significance, will henceforth describe the official status of the person upon irreversibly falling below certain arbitrarily defined minimums in the capacity to exhibit public and private verbal behavior. Thus, "human life" will no longer mean biological life, but will pertain to the "person" defined in terms of the capacity for verbal behavior.
2. Persons who are dead according to the criterion in item No. 1 thus no longer exist as persons. If the body of such a now-dead person continues to maintain biological life functions, that living body will no longer be construed as real property under the ownership of that person {since by then that person is no longer happening, and will never again be happening}. Such a personless body will be subject {a} to removal from all environmental support, {b} to salvage operations for useful parts, and {c} to disposal, all in accordance with prevailing laws and wills pertinent to previously used bodies.
3. Medical personnel, traditionally trained to preserve at all costs an often ill-defined status called "life," may now be trained to take into account the quality of life {Cautella, 1994}. They would be prepared to provide for the efficient and effective termination of both persons and live bodies {as appropriate} just as they are responsible for treatment aimed at recovery or restoration {when feasible}. A slowly dying person, reluctant to further endure, will no longer be maintained in prolonged agony, behavioral or physical, as a requirement of proper practice under the auspices of the medical establishment.
4. Pain and suffering, both nociceptive and emotional, by terminally ill patients will not be encouraged as a moral or ethical obligation, nor as a worthwhile natural experience. Terminally ill patients will not be encouraged to endure it, nor will other concerned parties be encouraged to accept it. Options beyond palliative medication

will include euthanasia and assisted suicide.

5. Patients' exercise of their own right to die will obtain according to the criteria of (a) irrecoverable loss, or impending loss, of capacity for significant positive reinforcement (Cautella, 1994), and (b) the cost to the patient of recovering degrees of that capacity, if that is possible.
6. Along with the behavioral death of the person and the physiological death of the body, a third kind of death is recognized, namely, a social death at which time certain classes of social contacts will undergo permanent termination ceremonially and ritualistically. This social death is correlated with imminent breakdowns in the capacity to be positively reinforced in certain long-established social relations.

### **Social Death as A New Cultural Practice**

It is proposed that every individual will be subject to three stages of dying, each featuring a different kind of death. Two kinds of dying will occur to *persons*, and one kind, to *bodies*. These three kinds of dying, concurrent in cases of "sudden" catastrophic death, occur sequentially in cases of slower dying. Of these three kinds of dying, two are somewhat familiar: one, the death of the person (in the sense of an irrecoverable loss of all or most of the verbal capacity), perhaps with continuation of some nonverbal operants and respondents; and the other, the final breakdown of the physiological relations that constitute the special life-supporting integrity of the body. This is biological death after which the body decomposes.

The new kind of dying precedes these other two kinds and can be called "social dying." It is not marked by any specific physiological correlates and is a contrivance of sociocultural origin, as are weddings and birthday celebrations. A person's social death occurs as a way of solving certain difficult social problems that have always accompanied dying and have often exacerbated the aversiveness for all parties. In the terminal stages of the illnesses of dying people, we see substantial changes in their behavior-controlling relations, plus progressive physical changes to their bodies that alter the capacities of those bodies to mediate behavior in accustomed ways. Together, those two kinds of effects so distort the normal behavioral repertoires of dying persons that their social relations suffer strange distortions and therefore pose unfamiliar and often substantial social problems. These special social problems arise at a

stressful time when the capacity of all involved parties either to tolerate those social changes or to initiate special countercontrolling self-management procedures is low. People struggle to maintain traditional social relations across an interval of extreme and unfamiliar behavior change for which they are generally unprepared and which they seldom understand.

A new kind of dying, instituted as a cultural practice, could eliminate or minimize these difficulties. Categorized as "social dying," like the death of a *person*, it involves the termination of certain classes of behavior. But, whereas the death of a person is essentially due to the loss of the body's capacity to further mediate the behaviors characteristic of a person and involves the cessation of all or most operant behavior plus much of the conditioned respondent repertoire as well, social death involves individual and group-arranged social practices of behavior management to terminate certain classes of social behavior on a specific occasion. On the occasion of social death, certain kinds of social interactions between the dying person and significant others will be brought to a close at what is deemed a socially appropriate time. This event will function to end the opportunities for the kinds of social behavior being terminated. The event will be scheduled to precede or coincide with incipient breakdowns in the capacity of the dying person for further positive reinforcement through the social relations being terminated and, in some cases, to free time for the dying person to deal with other increasingly important matters that the terminated social relations might have hindered.

Social dying is ceremonial. It occurs while the person still retains the unique and characteristic repertoire that establishes personal identity. It is normally scheduled after the terminal and irreversible status of the person has been medically established. The option may also be exercised by a person, who given odds on an unlikely but theoretically possible survival and the costs attached to the effort, does not accept the gamble.

Functionally, social death will ceremonially terminate the social relations of the dying person with certain previously close individuals. In particular, it will break those long-term, much strengthened relations with loved ones, friends, colleagues, and close associates that have formed the essential social matrix of one's life but which are simply not going to be helpful during its brief remainder. It is to be done while many of the contingencies that produce those relations are still in place-before those relations have been gutted of the contingencies that give them essence and meaning-and before the familiar social topographies can be maintained only under unpleasant contingencies of substituted contrivance easily recognized as pretense and sometimes seen as

Insincere. Social dying is a farewell ceremony occurring while the dying person can still participate *in character* and can still do so in familiar social contexts (i.e., under at least some of the natural social contingencies that have always prevailed). Whether it would end all or only some of the familiar social contacts would vary with the particulars of each case.

Certain ceremonial events of this nature are already common, although much more is implied here than what is now typical. At present, an individual who, for whatever reasons is not expected to survive much longer, may receive special visits, perhaps from old friends. Whether made explicit or not, the meetings are understood by both parties to be occurring for the last time. A person may be the guest of honor at a special program or ceremony to honor that individual for his or her accomplishments—an event occasioned by the imminent demise of the guest-of-honor. Family and close friends often gather with a terminal person and, individually or in small groups, have those special intimate conversations of review and summation about the relations that have bound them together. Under the new practices, all such events could continue independently, but some or all may also be incorporated in some way into the more ceremonial *formal ending of intimate social contacts* being described here.

Like other social ceremonies, this one would have its own name, as does "wedding," "bar mizva," or "birthday." Something would be coined, perhaps anagrammatical, like "foreniskon" from the italicized description in the preceding paragraph (formal ending of intimate social contacts), or the equally descriptive but more obvious name, "exsociation."

The particular forms that the event may take would have to evolve. The departing person may engage with intimate others in familiar activities of a reinforcing nature, for instance, the sharing of some sort of ritualized drink or meal. Gift-giving may be a part of the occasion, with the terminal person providing parting gifts to the survivors—a more ritualized version of the disbursements now done informally before death and more formally after death through wills. Passages may be read from texts or spoken, perhaps edited in response to particular characteristics of the involved parties. Testimonials could be offered, and shared experiences recalled. Music may contribute to the mood. Esthetically rich scenes may afford some moments of shared appreciation. At the end of the ceremony, or at some point, an essential feature would be the separation of the terminal person from the company of all or a predetermined subset of the others. That parting would be permanent, and the separated parties would not again have personal direct contact with

one another. That social departure would mark the time of social death of the individual in much the same way that the ceasing of circulation and respiration mark the physical death of the body, or that lapsing permanently into a coma marks the death of the person.

The choice of which, if any, companions would remain in social contact beyond the forensic ceremony would normally be left to the dying person and would depend largely on the nature of the subsequent assistance that such companions would be able to render. Obviously a graduated forensic would be a possibility, with different sets of former social intimates being separated from the terminal person at different times, perhaps with one or more particularly capable persons surviving all such differential departures and remaining in close association to the very end.

In most cases, all parties to an episode of dying prefer that the dying person be fondly remembered. But the horror of slow dying, with the unrelenting progressive degradation of the person before the eyes of helpless witnesses, is so much more awful and intense than any prior interactions forming the substance of more agreeable memories, that after the dying person is finally gone, it can remain nearly impossible for stimuli relevant to the departed to evoke those pleasant but weaker memories instead of a torrent of horrible visions and nightmarish reexperiences of the death agony. That, plus the elicitation of the aversive respondents of guilt and shame that the survivors often feel because of their failures to have intervened more effectively. Survivors often self-manage an avoidance of stimuli that would evoke remembrances of their departed friends and loved ones lest they be plunged at once back into that horror. Then they feel ashamed about that, because they know that their absent loved ones wanted to be remembered fondly, ...wanted memories of themselves to remain sources of reinforcement for their survivors. Because the aversive emotional respondents, strongly conditioned during episodes of slow dying, are so long lasting, years may pass and a survivor still not be capable of experiencing the kind of loving, warm, and fond memories of a deceased individual that are wanted and deserved.

The ritualized social termination of the forensic insures that the surviving intimates can retain appropriate memories of the departing person. Through that practice, the intimate others do not have to witness the protracted horror of slow dying, and the conditioning of intense aversive respondent reactions is thus avoided. The memory of the dying person is preserved in the more agreeable forms endowed by the mutually reinforcing



social interactions of a lifetime. That can be a kind of gift from the departing person in arranging the forenicon. Nor does the terminal person have to endure the added burden of seeing the awful effects on loved ones when forced to bear helpless witness to that person's slow dying. Thus a major social benefit of the ceremony is the reduction of social stress on all parties, especially that attendant to traditional slow dying. This is especially useful to the dying person who increasingly lacks the physical strength to cope with increasing stress.

Obviously, the person's departure from the company of the intimate others may be by way of suicide that could be a part of the ceremony in which the others participate. For example, the person may expire peacefully in the arms of preselected loved ones as a result of a lethal combination of drugs. But even this briefer episode of sharing in a peaceful death may be deemed excessively aversive and unnecessary, so a forenicon that would feature person-and-body death in the company of one's intimate others, may be relatively uncommon.

We must remember that scenes of one's death in the comforting arms of loved ones, imagined in advance, tend to depend on assumptions that the intense reality of the moment is not likely to sustain. Few loved ones, in the midst of being subjected to one's dying and untrained for the occasion, will be prepared to assume their imagined roles in the dramatized style prescribed for them, and their botched performances on an occasion of such seeming importance can subject them to years of private shame. And when the time comes, the expiring person may not be in a physical, emotional, or operant condition to appreciate a prescribed play nor take the lead in acting out a carefully imagined heroic demise.

Probes for these kinds of problems, with subsequent corrective conditioning, could occur through dress rehearsals of the kind that commonly precede similar events such as stage presentations and weddings. Perhaps in the ritualistic and ceremonial spirit of the forenicon, similar rehearsals could be made to seem acceptable and appropriate. But, as in many overstaged weddings, all parties can be forcing themselves to play an expected role, and unless care is taken to prevent it, no one may be left to experience a comfortable appreciation of the event.

Approximations of the forenicon are occasionally reported. A former police chief, diagnosed with inoperable cancer held his own "Irish Wake" attended by 300 of his friends and associates (Mio, 1998). The idea was sufficiently intriguing that the Associated Press reported the story nationally.



The person's social relations with many of those in attendance probably ended with that occasion, although that was not a formally specified aspect of the event. However, unlike the forenicon proposed in this article, an unstated implication was that the central figure would then retire to face his own long agonizing ordeal of slow death in the usual way. Visions of that impending phase tend to envelop such contemporary approximations under a pall of foreboding doom and can render insincere much of the forced levity.

### **Death Assistance as a Social Service**

If the person has opted to survive the forenicon, what happens next can vary. The ceremony can quickly remove the dying party from a social community that would increasingly become unhelpful and burdensome. However, dying persons do need and want help. The deteriorating condition of dying people leaves them weak and unable to adapt effectively, without special help, to often unanticipated and certainly unfamiliar circumstances. In that situation, former loved ones and intimate associates can, in many cases, seem like bungling amateurs who do not know what to do, impose their own ethics, and, increasingly, function as little more than troublesome distractions.

Departing persons, instead of trying to share their person and body deaths with loved ones, may deliver themselves into the hands of professionals skilled at helping people die. When the time comes, dying people need the competent skilled attention of trained professionals who are quite prepared to deal effectively with serious and difficult matters often unanticipated by the dying individuals. Those people would be experienced in showing respect for the dignity of dying people. They would be efficient and effective facilitators, given to easy working relationships with their clients. Those professional facilitators would be prepared to follow prearranged plans with care, but could also delineate new options, provide technical information and briefings on what to expect, and respond knowledgeably and appropriately to changes in the client that, in many cases, the client would not have anticipated.

Clients may enter into contractual agreements with facilitators long in advance of the need for their principal services and engage in a long series of preliminary interactions aimed at building trust and clarifying the details of the services that may later be provided. But interactions with the facilitators would be more in the nature of business and professional relations-albeit as pleasant and relaxed as possible under the circumstances. When people finally become weak, sick, vulnerable, confused, and distressed they need around

them competent, effective people of pleasant disposition whom they can trust completely-people who are under professional, social, and economic contingencies to provide, in a protective and sensitive manner, precisely the kind of services that the circumstances require.

The contemporary literature of medical ethics is preoccupied with debates about the roles of physicians and other *existing* health care professionals in helping people die. A trend is now developing toward training them more broadly and thoroughly to deal with those special problems. The publicly visible exploits of Dr. Jack Kevorkian have provided one model (Gibbs, 1993; Kevorkian, 1991). But, as noted by Wanzer, Federman, Adelstein, Cassel, Cassem, Cranford, Hook, Lo, Moertel, Safar, Stone, and Eys (1989), many physicians oppose that movement because, moral issues aside, they simply believe that helping people to die, whether through direct or indirect action, is beyond the physician's role. The doors of medicine have always been open to recruits to whom an often spiritually defined life is a sacred status and who see their formal involvement with the medical establishment primarily as a means to get more technical in support of that personal commitment to a metaphysical view of life.

The facilitators described here would represent a new kind of professional. They could represent a new medical specialty evolved by way of expansions within existing medical school curricula. Alternatively, these facilitators may be trained apart from traditional organized medicine, as are funeral directors, and occupy a professional niche between medical personnel who focus on healing and morticians who concern themselves with the disposition of dead bodies. Obviously, these facilitators would take over a portion of what both doctors and morticians now do. One contemporary grass roots alternative called the Natural Death Care Project, based in California, advocates care of the dying by loved ones and emphasizes circumvention of the commercial funeral establishment through the at-home preparation and disposal of dead bodies, which is legal across much of the United States (Carlson, 1997; Newman, 1997).

If conventional ethics changed to accept and favor professional death assistance, neither the massive medical nor funeral establishments, if freed from traditional legal and ethical restraints, could be expected to stand aside during the competition for shares in such a potentially lucrative business. Because the transition from curative care to palliative care is often so gradual, a stark discontinuity in professional responsibility can be ill-defined along a patient's course of treatment-which could exacerbate professional territorial

disputes that could adversely affect patients. But whether organized medicine can redefine and expand its mission as necessary to fill this new kind of role is problematic. Certainly the skills to provide the services described here would require a very high level of professional training, especially in basic and applied behavior science plus a wide variety of medical, technical, business, and legal skills, only a subset of which are currently produced in medical schools. Alternatively, such training, which does not now exist anywhere as an integral curriculum, may be developed more easily in settings other than medical schools where opposing traditions would have to be overcome. The newly trained practitioners may then obtain degrees and credentials other than medical.

In their work environment the facilitators would remain steadfast and keep the procedures on schedule. They would be skilled social interactors capable of helping each client focus conclusively on the positive aspects of that client's past, thus eliciting, to the greatest possible extent, a final sense of pride in the accomplishments of that life. They would be capable of discriminating, professionally, between a well-founded reconsideration by the patient and bouts of aimlessness resulting from the patient's waning capacity to think effectively. The facilitators would be prepared to compensate for the possibly increasing weakness, indecisiveness, and confusion of the client—which would be exactly the kind of service that many clients would require at that time. These more business-like arrangements would contrast with the close personal social relations with intimates that, under these circumstances, would only tend to muddle a rather complex and typically difficult situation.

The criteria under which one could exercise a right of access to the services of these facilitators would have to evolve within the culture. The most liberal approach would leave the matter to the discretion of the client and the client's eligibility as defined in professional policies established by the organizations that represent the profession. Perhaps access would require medical records showing a terminal prognosis. Persons not medically eligible, but who have other reasons to die, could be permitted a potential avenue of access through the courts by way of petitions that they would initiate on the basis of law yet to be drafted and adopted.

These proposals share some characteristics with the growing hospice movement (Health Care Financing Administration, 1994), but hospice care has arisen within the traditional ethical and cultural framework, primarily in response to the inadequacy of the medical establishment to deal with persons whose condition it cannot improve. The palliative care phase of a dying

patient's treatment is not ideally accommodated in facilities that are operated primarily for corrections and repairs followed by intensely pursued regimens for healing and recovery. Hospice care has been established to remove dying people from the often disruptively frenetic activity of the hospital setting, where terminal patients are troubling reminders of the limits to medical effectiveness. In the hospice, terminal patients continue their palliative care under more restful circumstances-with emphases on both physical comfort through pain control and emotional tranquillity through contact with more attentive and sensitive helpers than standard hospitals can provide.

Under hospice care, efforts to ease emotional distress are seldom informed by a natural science of behavior and, instead, often follow the vicissitudes of humanistic psychology driven by religious and mystical philosophies (Webb, 1997). Because the hospice movement has evolved within the ethical milieu of the ambient culture, it represents a specialized extension of traditional medical care conducted according to existing cultural values and ethical prescriptions, including the prevailing constraints on treatment options for patients. The practical aspects often reflected in hospice operations stem largely from prevailing natural contingencies that may go unanalyzed but which nevertheless insure some degree of compassionate rationality. The hospice movement does not feature the more radical departures in organization and practice that can follow from an entirely new kind of analysis of cultural fundamentals as set forth in this article.

The extensive cultural experiment with euthanasia in the Netherlands has been predicated exclusively on decisions by the highest courts holding that the individual right to self-determination is sufficiently strong to resist any controverting argument (Gomez, 1991). Support for the entire movement is thus based largely on that single kind of foundation. A terminally ill person who is deemed competent to decide, has the legal right to die with the assistance of the medical personnel who are providing care. Terminally ill but incompetent persons, whose decisions are being made by competent others, are entitled to a similar right if exercised by those decision-makers in the person's behalf.

While those court decisions have substantially settled the question of legal rights, they could not change the prevailing definitions, concepts, nor epistemologies that influence peoples' thinking about death and dying beyond the edges of the legal umbrella. No corresponding revolutions occurred in the prevailing behavior science nor in aspects of the sociocultural milieu informed by behavior science. Although a terminally ill person has legally bolstered

rights to die on demand, there has been no cultural infusion of a more effective philosophy and science with which to consider such questions. The consideration of every case has remained subject to the same troubling intrusion of mystical variables, ideologically inspired illogic, and ill-conditioned emotional disruptions that attend death and dying in other places. Aside from the legally settled matter of one's right to die under certain conditions of terminal illness, people are still left to resolve conflicts between (a) traditional implications of the putative sanctity of mystically construed life in general and (b) legal rights to infringe on that sanctity in certain cases where doing so seems rational. Intractable dilemmas usually feature invalid assumptions, and without a more effective philosophy and science that can penetrate analytically to a challenge of fundamental assumptions, people cannot transcend their faulty premises-and more importantly, new people will not be conditioned to function without those premises.

### **Issues in Schedule Management**

The arranged deaths of the person and of the body might occur at the time of the forenicon, or they may be delayed. A person may have some matters of personal business to conclude that, for whatever reasons, are better undertaken after separation from one's intimate friends and family members. If that were anticipated, the timing of the forenicon could be advanced to allow for the necessary interval between social separation from the intimate others and the inevitable bodily system failures that would begin to preclude the completion of such activities. In contrast, if the terminal person, having said good-bye, would prefer an immediate end to life, the individual, with or without the assistance of the facilitators, could engage at once in a terminal option.

If a postponement of death were necessary to conclude unfinished business or to get one's affairs in order, one may attend independently to such matters before entering into a final business relation with the facilitators who were going to help one die. However, the end-of-life services provided by the facilitators may be expanded to include assistance in various ways with such matters. One might receive professional quality help with legal, business, and financial matters; the disposition of remaining property; and special assistance pertaining to the legacy that one is establishing for those who come later. Such potential expansions in services imply teams of specialists whose combined skills exceed the capabilities of even the most comprehensively trained individuals.

### Issues in Self-Management

Since, for most people, the idea of one's own dying is both a strongly conditioned aversive stimulus and an elicitor of aversive emotional respondents, the situation calls for effective and perhaps creative self-management. A culture that would engage in the practice of forenicon and death facilitation through an established cultural agency would undoubtedly condition people to find contemplation of one's dying less aversive than in our culture, which would be helpful. However, since biological evolution has produced organisms that are predisposed in most every way to survive, behavior known to have lethal implications and unsupported by strong contingencies of positive reinforcement, must normally be pursued under contingencies of negative reinforcement: That is, it is escape behavior. But circumstances must be aversive enough to make escape into death seem preferable. It follows that *negatively* reinforced death-promoting behavior (social, person, or body) normally depends on the strength of the aversive stimuli available to function as the negative reinforcers.

These facts can pose a dilemma for the terminal person. On the one hand, the strength of the negative reinforcers (aversive stimuli) can be increased in a natural way simply by delaying action while a disease or lethal condition matures. A person with cancer, for example, who does not yet feel much pain or other distress of the body, and who therefore may be disinclined to pursue the escape behaviors of social dying by scheduling a forenicon, need only wait awhile, and the body will provide *any* necessary level of aversive stimulation. But such delays also yield losses in the capacity to behave in the manner of the person whom the individual has become during his or her lifetime. If the person were to wait too long to engage in the practices of social death (because "things weren't yet bad enough"), the readiness to initiate it may be gained, but the capacity to behave one's way through it effectively may be lost.

One way out of that dilemma is to attach some positive reinforcers to the arrangements for a combined person/body death so that one would be inclined to arrange a more timely forenicon, partly as an enabling operation for accessing those positive reinforcers and partly to avoid the indignity of death under purely negative ones. That way, some reinforcing contingencies supplement some aversive contingencies. Something along those lines has always occurred among the self-management practices leading to some suicides. The arrangements for abrupt person/body death could be cast in the

form of some exciting or exhilarating adventure that actually holds only a remote promise of success, and thus survival, and that carries a concomitant implication of quick and painless body/person death attached to the more probable failure. The person confronts some activity featuring the excitement and thrill of a clearly dangerous adventure--one carefully chosen to afford contact both with strongly conditioned positive reinforcers and an acceptable form of lethal consequence for the likely failure. In each person's fantasies are the elements from which possible arrangements may be developed.

The odds on surviving or dying could be adjusted in accordance with a variety of factors: the person's physical capability to engage in such activity, the pain or distress being felt by the person, the amount of time left to the person before such activity would no longer be possible, the economic capacity of the person to fund such activities, and possibly others as well.

If the certainty of dying is so aversive that it is interfering with arrangements to terminate, that aversiveness may be mitigated by the easy self-deception of courting the less obvious realities of high frequency plays against long odds of dying: That is, the individual engages in any easily accomplished activity having a lethal consequence in the improbable event of failure, *but does so repeatedly*. No matter how skilled an individual may be at walking confidently on a rail across a deep crevasse, by simply accepting the self-challenge to see how many times in succession one can do it, the terminal consequence is assured, while the person's confidence that it is not going to happen immediately remains unshattered right up to the instant of the critical falter. Each occasion of survival could be celebrated with a measured indulgence in some strong reinforcer-until the failure occurs.

The need for professional facilitators who could provide many kinds of death-related assistance would give rise to a new kind of commercial enterprise within the culture at large. Helping terminal people prepare to die-and subsequently to experience more efficient, more useful, more dignified, more productive, more tolerable, or simply more enjoyable deaths could become big business.

## Discussion

The changes that occur to a person across that person's interval of slow dying are typically unprecedented both in that person's life and in the experiences of other involved parties, especially those who have had only limited contact with dying people. Almost everybody contemplates death,



their own and that of others, and most people anticipate what it will be like. Often plans are made about how one will behave during one's own dying, or when others die. Certain activities may be designed, perhaps to bring closure to unfinished business of various kinds. Speeches may be rehearsed. One may recall death scenes from literature and imagine oneself playing out an admired role. A courageous confrontation with death, or perhaps a well-planned suicide to diminish the agony for self and others, may be contemplated. Without knowing just what is implied, one resolves to maintain one's dignity, to be as helpful to others as possible, and to behave in ways called brave. But all of this verbal foreplay occurs before one contacts the awful changes that define episodes of slow dying.

The ethical and procedural prescriptions that prevail in our culture to govern behavior during the terminal events of life are in some cases products of theorists who have had more contact with their own assumptions about dying than with dying people. Even when potentially sufficient contact with dying people has occurred, such theorists have usually lacked a natural science of behavior adequate for accurate analyses and interpretations. Instead, they have merely culled the topography of death-related events for apparent confirmations of their often ideologically based assumptions. So, like unprepared people down through history, like the American soldiers who found themselves in the forests of Viet Nam with a mission prescribed by political theorists who themselves had never faced such an enemy and with combat skills taught by trainers who had fought in other kinds of wars, people tend to arrive at dying with ethics, rules, and various other skills that too often do not fit the situation, and we hear once again that old lament, "It wasn't supposed to be like this!"

Two fundamental reasons can be cited for the unpreparedness. The first is the general lack of sophistication in what currently passes for behavior science throughout this culture, which leaves people unable to analyze effectively the relevant events and develop a more appropriate approach. The second is that the large and significant changes that define dying occur mainly in a part of the environment that remains relatively constant and stable throughout the lifetime of an organism, namely, that part of the controlling environment found inside the skin. We are simply not accustomed to dealing with drastic changes to our bodies, especially to those parts that normally do not present us with stimulating variation. We are quite accustomed to the kinds of smaller bodily changes that occur within familiar ranges: the chemically induced arousals and depressions of normal emotional variation, small fluctuations in

body temperature with occasional fever and chill, the variety of temporary changes that accompany familiar mild deprivations and satiations on primary reinforcers. Even the temporary breakdowns in physiological function and organismic integrity experienced during the typical injuries and illnesses of a lifetime provide experiences that are well below the severity and aversiveness that victims often report in the late stage of slow dying. For many who must face slow dying, nothing like it could ever previously have happened to them.

In many cases, during dying, two contemporaneous and directionally opposed differentials are functionally effective: (a) With degradation of bodily integrity the aversive stimuli increase to unprecedented proportions, which demands increasing coping skills, and (b) during the same interval, the behavioral repertoire that defines the person is diminishing, due to a combination of decreasing contacts with the evocative antecedents and loss of bodily capacity to continue mediating those behaviors, leaving the person progressively less able to cope. In short, worse and worse things are happening to a person who is less and less capable of dealing with them. An increasingly incomplete person confronts an increasingly aversive challenge, and both trends are largely irreversible. Given that neither the magnitude of the aversiveness nor the extinguishing of the person are ordinarily taken into proper account in the traditional planning for death, it is no wonder that traditional ethics, rules, and practices tend to fail people so badly on those occasions. This aspect of our culture is in need of redesign, and it is to that end that this paper is addressed.

For 25 years the courts, progressively, have been withholding punishment from medical personnel for behaviors that ever more closely approximate those prescribed in this paper. It has been a convoluted acquiescence. The courts have been constrained by constitutional and other fixed barriers representing the state's formally codified interest in the preservation and sanctity of human life, which originally meant that quality of life, no matter how awful, should never justify ending one's existence. That state interest has existed as a rigid and abstract concept. Since that code-hardened interest could not be breached directly, the courts have had to resort to a variety of indirect and curious definitions and interpretations. For example (Collins, 1987; Rymer, 1988), providing food and water have been deemed to be medical treatments; withholding treatment (including food and water) in order to afford a patient an easier or sooner death has been justified, while intervening directly to accomplish the same outcome even more easily and sooner is still punishable as murder. Not only are the proeuthanasia desires of unconscious

patients occasionally divined by the courts, but the courts have interpreted "intentions" that never existed in the first place by declaring that, should the person have considered the matter, the person *would have* supported the bias of the court; and, finally, death itself has been redefined away from the old concept of the cessation of circulation and respiration toward the irrevocable loss of verbal behavior. All of those legal devices have enabled doctors to end the lives of terminal patients while allowing all parties to maintain the pretense that the state's interest in the preservation and sanctity of human life *per se* was not being violated.

But, like some doctors, some judges are calling for the removal of the ideologically based obstruction to more rational responses to the realities of dying. Collins (1987) quoted Associate Justice Compton of the California court system. In Compton's opinion in the case of Elizabeth Bouvia (a bed-ridden quadriplegic afflicted with cerebral palsy and crippling arthritis who had petitioned the court to allow actions that would result in her death), he pursued the court's declaration that "a desire to terminate one's life is probably the ultimate exercise of one's right of privacy" (Collins, p. 275). Addressing the fine legal line between (a) allowing "natural" death to occur by "stepping aside," and (b) acting directly to hasten or aid death, Justice Compton declared that the state, instead of frustrating Bouvia, should attempt to relieve her suffering by "permitting and in fact aiding her to die with ease and dignity." And he added, "the fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane" (p. 275). Compton concluded that Bouvia should have been able to "enlist assistance from others, including the medical profession, in making death as painless and quick as possible" (p. 282).

When ethical restrictions are removed and the state stands mute, humane and painless death is quickly arranged. For example, when executing a convicted felon by lethal injection, one injection quickly puts the person to sleep; a second injection while the person is asleep results in a quiet unconscious death within a few minutes or less. A comparison of that death with the best that doctors can do by, "letting nature take its course" makes doctors seem sadistic and cruel—especially when they possess the means to end the life of a suffering patient in the same humane and painless way that the felon enjoys. Dr. Jack Kevorkian's crusade to facilitate the quick and painless dying of suffering medical patients in the state of Michigan has made him the repeated target of attempted prosecution by the state even though his efforts shortened the agony of slow dying for numerous people (Gibbs, 1993; Kevorkian, 1991).

Over the years, a number of organizations have emerged that in various ways support a person's right to die (Burleigh, 1988)-for example, the Catholic Health Association, the Council on Ethical and Judicial Affairs of the American Medical Association, the National Commissioners for Uniform State Laws, and the New York-based Society for the Right to Die. The Hemlock Society (P. O. Box 66218, Los Angeles, CA 90066), which publishes the *Hemlock Quarterly*, has a political lobbying arm called Americans Against Human Suffering (Risley, 1988/89), that works to change state laws that constrain doctors who would help terminal patients die, including the promotion of ballot initiatives (Ubell, 1989). The Hemlock Society has also issued publications advocating the option of active voluntary euthanasia for the terminally ill, including *Common Sense Suicide: The Final Right* (Portwood, 1978), *Let Me Die Before I Wake* (Humphry, 1982), and *Who Believes in Voluntary Euthanasia? A Survey of Hemlock Society Members* (Surber, Quinn, & Wilner, 1983). Founders of The Hemlock Society, Derek Humphry and Ann Wickett, authored a larger and more comprehensive work, *The Right To Die: Understanding Euthanasia* (1986). (The Winter 1988/89 issue of *Free Inquiry* featured articles supporting euthanasia by six leading advocates: Admiraal, Fletcher, Humphry, Kuhse, Larue, and Risley.)

The Society for the Right to Die (250 W 57th St., New York, NY 10107) has actively supported the state-by-state adoption of *Living Will* statutes that permit living persons, while still "competent," to specify their preferences about medical treatment should they later become unable to make medical decisions for themselves. Most states now have such a statute. (See "When a client asks," 1989, for a state-by-state listing of provisions of such statutes; Ubell, 1989.) The rights granted under living will statutes, however, pertain only to refusal of treatment and do not explicitly entertain an option of euthanasia. In some states the person can appoint a proxy who will interpret any ambiguities that arise in the subsequent execution of the terms of the living will. Most living will statutes allow for the inclusion of personalized instructions in addition to standard clauses and grant immunity from liability for health professionals who comply with the provisions of a living will. Among the states *requiring* physicians either to honor the provisions of a living will or transfer the patient, about half also specify penalties for noncompliance.

Several years ago, the Society for the Right to Die convened a national committee to develop ethical recommendations for physicians who deal with dying patients. The committee, chaired by Dr. Daniel Federman of Harvard

Medical School and former president of the American College of Physicians, issued a report (Wanzer et al., 1989), endorsed by 10 of its 12 members, which stated that it is ethical for doctors, indirectly and with certain specified safeguards, to assist terminally ill patients in committing suicide by prescribing sleeping pills or other drugs and telling those patients what dose will end their lives and how death will occur. Further, "if such a patient acts on the wish for death and actually commits suicide, it is ethical for a physician who knows the patients well to refrain from an attempt at resuscitation" (p. 848).

However, the authors explicitly withheld including this practice of assisted suicide as a final step in their recommendations and instead urged a "flexible" approach of "continually adjusted care" for the terminally ill. The committee report stated that assisted suicide should be "considered as a separate alternative." That report asserted that a physician should ease pain and actively support a peaceful death. A prolonged, agonizing, yet inevitable death should *not* be allowed through physician inaction if the patient wishes to die quickly and peacefully. Yet the report stopped short of an explicit endorsement of euthanasia within the United States and presented a detailed description of the practice in the Netherlands where it has been estimated to occur between 5,000 and 10,000 times per year (see also Gomez, 1991).

In cases of direct physician intervention, the usual method is to inject "a short-acting barbiturate, followed by a paralyzing agent" (Wanzer et al., 1989, p. 848). The authors cited a 1988 poll by the Roper Organization, taken for the National Hemlock Society, which surveyed 1,982 adult Americans. Asked whether a physician should lawfully be able to end the life of a terminally ill patient at the patient's request, 58% said yes, 27% said no, and 10% were undecided. Though a frontier ethical position in the medical literature, that committee's formal ethical prescriptions reflected existing practices that the committee said were "certainly not rare," although doctors tend not to talk about them. In 1997 the United States Supreme Court cleared the remaining legal obstacles to an assisted suicide law passed three years earlier by voters in the state of Oregon, the first state to follow the lead taken by the Netherlands (Cain, 1997). State funded, doctor assisted suicide is legal within six months of the estimated time of death, but doctors have been conservative, and most instances occur within hours or days of what would be the more natural time of body death—often after person death has occurred.

Critics continue to argue against relaxing the rigid codified prohibitions to make suicide and euthanasia more acceptable and perhaps routine. One of

their more sophisticated objections suggests that such attenuations of fixed restraints will leave practitioners and decision makers more susceptible to the pervasive influences of economic contingencies. For example, a letter to the editor in a local newspaper (Mullins, 1988) contained the following passage:

With ever increasing life expectancy and mushrooming health care costs, many people-even some Hemlock members, are fearful of what may happen if dignified death acts are passed nationwide. As soon as assisted suicide is legitimized by law, it is not beyond possibility that increased pressure from health insurance providers, including Medicare, to keep costs down may lead us to involuntary euthanasia. First, the facts of the "crisis" would be told. Then there would be statistics revealing the large percentage of health care dollars going to care for those who are irreversibly disabled, either physically or mentally, and are kept alive at institutions. And since death is now considered just as legitimate an option as life, giving lethal injections to these people will not only be good for the individual, but good for society as well. Assisted suicide for nonproductive members of society could become the "patriotic" thing to do. (p. B8)

Such objections rely on a fundamental fallacy. Economic contingencies are always part of any such decision making. They never stop, and they are never absent. If person death has already occurred, then recourse to economic criteria is entirely appropriate. The cost of maintaining a person-dead live body is an immediately relevant issue.

For persons still alive as such and contemplating their own imminent demise, planned death is always fundamentally an economic issue of some kind. Individuals contemplating suicide often take into account the savings of various kinds implicit in their earlier deaths. At the group level, anthropologists, economists, and behaviorologists have long been aware of a basic reality, namely, that nonproductive members have always been tolerated in any group *only* to the extent that they can be afforded. Under contingencies of survival made stringent by scarce resources, the unproductive are always sacrificed first. Doing so is always regarded as rational given the alternatives of first sacrificing the most productive individuals, or merely choosing at random who is to be sacrificed. *How* the unproductive are sacrificed, and which cultural agencies become involved, depends on the sociocultural topography of the group. That culling is not prevented in the long run by imposing legal sanctions to block a currently employed approach. Beyond abundant resources, no reliable protections exist for the unproductive. It is no accident that sentiments favoring the preservation of personless life at all costs are strongest and most widespread in the richest nations on earth. What would



people like the author of the quoted letter say if they, personally, were to be taxed into destitution to pay for the life-prolonging medical services of terminal patients? Are we to believe, on the basis of their arguments, that they do not have their price?

Natural contingencies of survival are insensitive to pain and suffering. Those natural evolutionary mechanisms feature a complete neglect of individuals who play no further role in species survival. The world is the product of natural events that remain unaffected by the intense and prolonged suffering that can be visited upon such individuals. Natural "solutions" to basic problems of ecological economy visit extreme horror on individuals whose continued existence is of no further biological advantage to their species. But with the emergence of (a) human beings, (b) the biological evolution of intellectual capacity, and (c) the maturation of human culture, a new and different, but equally natural mechanism is evolving for the remedy of that "defect." New cultural practices can enable economical, humane, and painless dying, which renders the experience more tolerable.

#### REFERENCES

- Burleigh, N. (1988, July). The right to die. *ABA journal*, pp. 72-75.
- Cain, B. (1997, November 10). Doctors prepare for assisted suicide. *The Daily Athenaeum*, p. 2.
- Carlson, L. (1997). *Caring for your own dead: The final act of love*. Hinesburg, VT: Upper Access.
- Cautella, J. R. (1994). General level of reinforcement II: Further elaborations. *Behaviorology*, 2, 1-16.
- Collins, P. (1987). The foundations of the right to die. *West Virginia Law Review*, 90, 235-282.
- Fraley, L. E. (1998). A behaviorological thanatology: Foundations and implications. *The Behavior Analyst*, 21, 13-26.
- Gibbs, N. (1993, May 31). Rx for death. *Time*, 141, 22, 34-39.
- Gomez, C. F. (1991). *Regulating death: Euthanasia and the case of the Netherlands*. New York: The Free Press.
- Health Care Financing Administration. (1984). High-cost hospice care (HCFA Publication No. 03360). Washington, DC: U.S. Government Printing Office.
- Humphry, D. (1982). *Let me die before I wake*. Los Angeles: The Hemlock Society.
- Humphry, D., & Wickett, A. (1986). *The right to die: Understanding euthanasia*. New York: Harper & Row.
- Kevorkian, J. (1991). *Prescription-medicide: The goodness of planned death*. Buffalo, NY: Prometheus Books.
- Mio, L. (1998, February 10). A no-tears farewell. *Cleveland Plain Dealer*, pp. A1, A9.
- Mullins, H. (1988, June 18). Euthanasia not limited [Letter to the editor]. Morgantown, WV: *The Dominion Post*, p. B8.



## ETHICS & PRACTICES FOR DEATH/DYING

- Newman, J. B. (1997, November). At your disposal. *Harper's*, 295, 61-71.
- Portwood, D. (1978). *Common sense suicide: the final right*. Los Angeles: The Hemlock Society (also distributed by Grove Press).
- Risley, R. (1988/89). In defense of the Humane and Dignified Death Act. *Free Inquiry*, 11-15.
- Rymer, R. (1988, May/June). The judge. *Hippocrates*, pp. 58-59.
- Surber, M., Quinn, V., & Wilner, D. (1983). *Who believes in voluntary euthanasia? A survey of Hemlock Society Members*. Los Angeles: The Hemlock Society.
- Ubell, E. (1989, March 5). When a life is in your hands. *Parade Magazine*, pp. 16-17.
- Wanzer, S., Federman, D., Adelstein, S., Cassel, C., Cassem, E., Cranford, R., Hook, E., Lo, B., Moertel, C., Safar, P., Stone, A., & Eys, J. (1989). The physician's responsibility toward hopelessly ill patients. *The New England Journal of Medicine*, 320, 844-849.
- Webb, M. (1997). *The good death: The new American search to reshape the end of life*. New York: Bantam Books.
- When a client asks for a "living will." (1989, March 6). *Lawyers Alert*, pp. 15-17.



## **Addendum to the Preceding Article:**

### **PURSUING AND INTERPRETING THE IMPLICATIONS OF A NATURAL PHILOSOPHY AND SCIENCE WITH THE VALUES ASSOCIATED WITH OTHER EPISTEMOLOGIES**

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#### **The Importance of Seemingly Relevant Questions**

The preceding article ("New Ethics and Practices for Death and Dying from an Analysis of the Sociocultural Metaphysics") has troubled some readers by not dwelling in more detail on the issues of how, and by whom, arbitrarily defined limits are to be set. The phrase "slippery slope" has often been evoked to characterize that thematic family of issues. Concerned readers have asked how, and by whom, it shall be decided that a failing person has lost the capacity (perhaps permanently) to be a person as I have defined that capacity. Similarly, they want to know how, and from whom, we are to get the determination of limits on "significant positive reinforcement," below which a person's life is, to that person, not worth living, and to others, not worth supporting. And they have again asked those same kinds of questions about the criteria for deciding when social death would be timely and appropriate. Such questions are relentlessly pressed: Who can decide such things? How can they be decided? How *should* they be decided? -as if to imply that the answers lie beyond the safe reach of our behavioral technology.

In a sense, the nature of such decision making is not central to the theme of the preceding article. That work is about how our behaviorological philosophy and science implies and supports new approaches and practices-practices that happen to require, as part of their operations, our confronting and making those kinds of decisions. I did not dwell on that decision making, because it is not much of a real issue. Declaring those kinds of decisions to be impossibly difficult may be an almost universal bromide, in part, because people often think that more is at stake than is actually there to be lost. Common assumptions about the intrinsic gravity of such moments are

generally exaggerated. Such decisions seem difficult only because the nature of those decisions, and the relations to which they pertain, are traditionally misinterpreted. The issues to which those kinds of decisions pertain need not be cast in the traditional ways that have always made them seem so perilous. That class of problems, properly framed in contexts that our philosophy and science can weave, may be emotionally troublesome to contemplate, but it does not present, for operant solution, problems of extreme difficulty.

To better appreciate this point, focus on a relevant distinction. Let us suppose, on the one hand, that people have souls representing small individual allotments of the special essence of an all-creating, attentively concerned, and potentially vengeful God-and that the definitive aspect of a person resides with that soul, including its more secular facet, which is known as the autonomous or semiautonomous body-directing self. And let us further suppose that these critical features are lodged mainly in a metaphysical mind that is construed to superimpose on a brain and to represent a channel between the physical and metaphysical worlds. Now, in contrast, let us suppose, on the other hand, that human beings are entirely natural and evolved biological entities, the essence of which is entirely behavioral, and that all behavior occurs in functional relations between naturally occurring bodies and naturally occurring environmental variables. Given the challenge to define death and dying, to distinguish among its types and phases, and to act decisively on the basis of those determinations, which of those two perspectives makes that challenge seem more difficult and attaches more importance to the implications of even small errors?

The real difficulty lies in bringing our behavior into alignment with the implications of our own natural philosophy and natural science foundations with which to interpretively relate to behavioral phenomena. The relevant implications of natural science carry us away from the ideas, and especially away from the values, that traditionally have made impossible dilemmas of such decisions in the first place.

For example, making the arbitrary call on when, exactly, a minuscule remnant of fading capacity for verbal behavior reaches the zero level (the exact moment of person death) is of relatively little importance in the same sense that the exact moment at which doctors in an emergency room arbitrarily declare body death is of relatively little importance. The important issues pertain to earlier medical moments during which the progressive systemic disorganization may still have been reversible.

If a person has lived for 87 years, and, in the final episode of dying, makes

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management decisions (or, of necessity, relies on the management decision of others) to the effect that that person forfeits a short additional interval of low quality life (person or body), that outcome is not nearly as important as traditional ideologists tend to insist. The elderly person who preemptively commits suicide to avoid four or five months of agonizing torture while slowly dying of cancer could perhaps have lived another few days, or even another few weeks, before the onset of intense physical discomfort that would then overwhelm that person. Medications can often reduce pain, but they may leave a person drugged into a stupor that for many would rob living of its worth, and for those who could still think clearly in spite of their pain medications, any remaining capacity to contemplate one's irreversible deterioration toward inevitable death would usually elicit emotional anguish. For many people, the contemplation of their certain and impending death dampens the pleasure of otherwise enjoyable occasions. Given an interval of life of that quality, the decision to end it is not necessarily difficult for the person in question. After long years of good life, the loss of those days, especially days lived under those conditions, may be of little worth to that person, and others who recite cliches about every moment of life being precious have been led by some unfortunate ideology to a potentially tragic misinterpretation of some harsh realities.

#### **Culturally Imposed Martyrdom**

With a certain kind of conditioning history, the skillful arrangement of which seems to be a prevalent specialty within our culture, anyone can be conditioned to behave as a martyr in behalf of life per se. Nevertheless, are we to suppose that while being slowly roasted to death over a bed of hot coals, one's agony would be rendered worthwhile by a series of comforting observations that one had not died yet? Contrary to the common lore that promotes such conditioning throughout our culture, it is not necessary for the preservation of life that is worth living (we can accomplish that without such flagrantly irrelevant ideology), and it often results in unnecessary and extreme human suffering, not only by those on whom the implications of such views are imposed, but, pathetically, by those who are proud to bear that suffering as an expression of their personal kind of humanity.

## **Practical Decision Making**

Questions of who can decide and who should decide are simply much easier to answer when the issues are reduced, through appropriate analyses, to more technical matters. We are culturally prepared to endow individuals with rights to determine their own affairs. We are quick to intervene given evidence that the person's irrevocable decisions may be affected by temporary emotional effects (e.g., depression). In general, however, we tend to agree that the person in question is in the best position to say when positive reinforcement has diminished to the point that living is no longer worth its response costs. We typically let the person assess the cost/benefit ratio of potential treatment plans and decide on acceptance or rejection.

In cases where the person is incapable of making that decision, many people are prepared to accept the decision of a trained medical expert. Others object, arguing that medical experts are frequently wrong. Actually, while doctors' opinions do show the variation typical of the members within any professional community, they are seldom wrong in answering the general questions of the kind raised in the preceding paper—for example, specifying that a given patient's illness is terminal and estimating the duration of the person's life. That is demonstrated by their occasional mistakes being deemed newsworthy. Doctors commonly shy away from absolute declarations and rely on actuarial data: "X-percent of persons who remain in this kind of coma for longer than five days will never again regain consciousness." When we feel uncomfortable about relying on a medical expert for such decisions, we often rely instead on the consensus of a group of medical experts. In the absence of the patient's own earlier-drafted directives, another common approach, which most people are prepared to accept, features a determination rendered by a group of persons similar to the patient but verbally competent to produce a group decision based primarily on how they respectively would make the call for themselves. These approaches to decision making are not to treat lightly matters of vast import. They simply deal practically with matters that are often of much less import than cultural wisdom has typically implied.

## **The Respective Worth of Relevant Criteria**

On the matter of the worth and place of self-determination in these matters, we must remember that evolution has selected and refined powerful behavioral tendencies toward individual survival. That renders person-life

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automatically and intrinsically important to each individual to a degree that extrinsic criteria may not support. For example, in a given case, it may not make economic sense that an individual be kept alive. It may also be clear to others that the person's quality of life, gauged by the frequency of positive reinforcement, is near zero. It may be equally obvious that the person is experiencing a high frequency of contact with aversive stimuli. And, finally, it may be clear that these conditions of living will not improve. Yet, as a consequence of the natural selection processes that have produced all things, that person may helplessly function as a self-torturer by acting to prolong his or her own exposure to those prevailing and irreversible aversive contingencies. Pathetically victimized by one's own nature, one is left to wriggle on the cross of one's own biological imperatives. It is an ironic manifestation of something that I described as follows in a thematically related article (Fraley, 1998):

Many traditional practices implicitly accept the horror and agony that nature carelessly visits on terminally ill people. Such people play no further role in contingencies of survival impinging on their species. Therefore, in the grand scheme of nature they are unimportant, so biological evolution has afforded them no special relief. Thus, alleviation of their suffering is left entirely to behavioral interventions. (p. 13)

The intervention issue in this context pertains to the evaluative weight that we allocate to a person's own behaviors, not to die, but to live. This challenging and intellectually interesting issue, unlike some other ideologically exaggerated trivialities, is more worthy of serious consideration.

### **The Timely Forenicon**

Critics ask who should decide when a forenicon should occur and by what criteria. The previous article dwelt extensively on the particular question of who should decide. The problem of *when* to schedule a forenicon is, by the nature of the task, a more difficult determination. It seems easy to say that the dying person should have as much responsibility for that as possible. Like the scheduling of some other kinds of important events in one's life, that decision may be facilitated by counseling, which one's intimate associates may provide informally. However, part of what I have proposed would make such counseling formally available as a social service, perhaps provided by government, or perhaps commercially. Many people are conditioned to avoid



going to the dentist in a timely way, and that avoidance can be mild compared with most peoples' avoidance of their own death-related matters. Most will need some help. The potential premature scheduling of foreniscos that seems to worry some critics would not be a frequent problem, and it could be further reduced with a little practical training at the cultural level in how to avoid jumping the gun.

Scheduling the forenisco too late would be much more likely, and that is where the more troublesome problems would probably arise. While no one wants to make a mistake in scheduling an important event-and although the inevitable occasional mistake in the timing of a forenisco would probably be described as tragic by the involved parties-the importance of that error would pale in relation to the importance of having failed to get the regular medical examinations that could have prevented whatever lethal condition made the forenisco necessary in the first place.

### **Discussion and Conclusion**

Americans are relatively practical people and are highly skilled in the democratic establishment of criteria for complex, difficult, but necessary decision making. Every day, groups meet to decide which of several candidates will receive a life-saving donor organ-a decision that usually means death for at least some of those who do not receive it. Criteria are debated in advance of specific cases, decisions are reached as to which variables will be taken into account and which will not, and the specific cases that subsequently arise are resolved accordingly. On the basis of any such decision, a person lives, others die. The debate about the criteria continues in the background, and the list of acceptable criteria, as well as their respective weights, are continually adjusted.

Voices can always be heard arguing that such decision making intrudes into matters too complex, and too sacred, for human intervention. They may argue that humans must not play God. But since an implication of that view is that some people who could be saved would be allowed to die, apostles of that creed tend not to be taken seriously in our culture. It is time to stop taking seriously the similar arguments that prolonged terminal suffering, physical and emotional, is some kind of noble obligation that lends meaning and worth to a human life. I think it a far grander demonstration of humanness when employment of the intellect gets one past the sort of nonsense that makes a virtue of torture, whether imposed by nature or culture-by others or by self. To carry the general lesson in all of this to our

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own behavioral business, it would seem to be time for the members of our own natural science community to stop interpreting the logical implications of our natural philosophy and science on the basis of criteria derived from traditional and entirely antithetical epistemologies.

#### REFERENCE

Fraley, L. E. (1998). A behaviorological thanatology: Foundations and implications. *The Behavior Analyst*, 21, 13-26.