

Levinas and Responsibility for the Other:

A practical theological analysis of the cases of Nancy Crick and Terri Schiavo

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ABSTRACT

The cases discussed in this paper concern new situations in health care which demonstrate the inadequacy of traditional models of bioethics. I propose that an analysis informed by Levinasian conceptions of the Other will yield a richer critique and one which will do greater justice to a Christian vision of health care and of persons as the subjects and participants in health care. The contribution of Levinas in this analysis is three-fold: identifying features of the cases that would normally go un-noticed or unexamined; highlighting the importance relational perspectives in health care; and, prioritizing the Other in all ethical deliberations. These perspectives are vital in the construction of a practical theology of health care based on relationality.

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In this paper I first outline the cases to be examined that of Nancy Crick and Terri Schiavo both reasonably high profile end-of-life cases. The initial presentation of the cases is simply the factual outline – much as would occur in any study of a bioethical case. In fact, presented in this way the cases are relatively unremarkable. However, I argue that they herald a significant change in health care. Where traditional bioethics focuses on the licitness, the rightness and wrongness of actions and the role of health care professionals – usually a physician. A relational paradigm in health care leads to different kinds of analysis, different issues being highlighted and potentially different outcomes. It certainly informs a quite different theological contribution.

Following the presentation of the cases the next two sections of the paper, exploring the need for a new ethic in health care and the development of a relational analysis of the cases. In this way I draw out other features which are not included in the bare facts of the case but which demonstrate the significance of relational perspectives. Finally, I argue for a practical theology of health care drawing on the insights of Emmanuel Levinas.

The Cases:

Nancy Crick

Nancy Crick was a 70 year old Australian widow who lived with one of her sons, in close proximity to other members of her family. We know a good deal about her perceptions since she kept and published a web diary chronicling her experience. In 1999 she underwent surgery for bowel cancer. Following surgery she continued to experience discomfort, pain, nausea and vomiting. As a result of the surgery she had a colostomy, a bag that functions as a collection receptacle for faeces.¹ Nancy determined that she would end her own life when her efforts to seek medical assistance to die were deemed to be unlawful. Over a period of time she sought advice from health care professionals and determined her preferred option was to end her life. Her public campaign to have voluntary euthanasia/physician assisted suicide legalised included media interviews and an internet diary. Crick refused further investigative or alleviative surgery; found the palliative care regime that was trialled less than satisfactory; and continued in pain and discomfort. Crick ended her life on May 22, 2002 using barbiturates sent to her through the mail. Following Crick's death an autopsy confirmed what she had been previously told by physicians: she was free of cancer. It also revealed that her bowel was twisted, which had been suggested as a probable cause of her symptoms. It has also been suggested that her body weight was not 27 kilograms as claimed but nearly double that and that she was gaining weight, presumably following a more appropriate care regime instituted during her final hospital admission.²

Terri Schiavo

Terri Schiavo, a Florida woman collapsed in 1990 due to a suspected potassium imbalance which caused a heart attack and temporarily cut-off the supply of oxygen to her brain. She was subsequently diagnosed with hypoxic encephalopathy. Following initial treatment Schiavo was able to breathe unassisted but did require artificial means of nutrition and hydration. From 2000 her husband began attempts to cease nutrition and hydration; the various legal battles finally concluded in 2005 ruling that her husband could request the hospital to cease artificial nutrition and hydration. Terri Schiavo died on March 31, 2005.

Physicians argued that Schiavo exhibited eyes open permanent unconsciousness with physiological sleep/wake cycles. Her parents, in contrast, held that she was conscious, though with some form of brain damage which had obvious physical effects. The precise extent of her neurological damage was never completely ascertained while she was alive. It should be noted that while definitive diagnosis of the extent of brain damage was limited, there was medical consensus that given the severity of the damage and the length of time which had elapsed, Schiavo had little chance of recovery, in the sense of a return to her previous life or even substantial improvement. An autopsy confirmed this diagnosis and also that many of the claims of her parents about "eye-tracking" and some spontaneous eating when offered food, were highly unlikely to be accurate.

The Need for a New Health Care Ethic:

It can be argued that the discipline of bioethics has emerged as a means of guiding health care professionals in the wake of abuses and in reaction to new technologies and procedures. Yet, as health care in the Western world has evolved, these twin

approaches are increasingly inadequate. George Khushf, addressing the problem of evil, illness and the structures of healing, argues that illness is deeply revelatory. It discloses our radical dependency on the Other. He tellingly remarks:

Through illness individuals become aware of their insufficiency and they turn to others for help. However, most people do not appreciate the full revelatory function of illness – that it discloses a deep brokenness that is there already, and not brought about for the first time by the sickness. Instead, people think of the dis-integration of self and the alienation from community and God as a consequence of sickness, rather than as something unveiled in and by sickness.³

The cases examined here are acute examples of Khushf's point. Nancy Crick and Terri Schiavo reveal humanity's intrinsic vulnerability and the need for a relational perspective in health care practice. It is here that Levinas offers the possibility of new understandings.

A starting point for relational perspectives in health care is simply to take account of patients' life-orientation and the mythic conception of life's meaning and purpose. Joel Shuman argues that where no account of this is taken the medical outcomes are routinely adversely affected.⁴ His reference to his own grandfather's experience is instructive. The old man, after being diagnosed with a terminal condition, was removed from the isolated rural community where he had spent his entire life. He was taken several hundred miles away to a major medical institution for palliative treatment, with unfortunate results. Shuman argues that the moral harm done to his grandfather resulted, *not* from any deliberate intent or medical incompetence, but from a generalised failure of the health care system—what he describes as a “fundamental inability to know and to care for its patients.”⁵ At its heart, it is an inability to allow the patient as other to remain Other. The patient in this case had been encouraged to believe that the “world of the physicians”, that is, the clinical setting, was worthy of trust in terms of his care and treatment; this trust was then betrayed:

That trust had no real basis in a commonly held, deliberately arrived at vision of what it might have meant for my grandfather to live well for the remainder of his life...⁶

Those caring for Shuman's grandfather focused on what they could do for their patient, instead of what their patient needed:

...for though my grandfather's physicians knew as much as there was to know about his disease, they seem to have been totally oblivious—and in their minds, perhaps not unjustifiably—to the things that really made him the person he was – a simple man of remarkable character, with deep attachments to work and land and family, who had lived an exceptional life and who deserved a death consistent with that life.⁷

Levinas would support Shuman's concerns. In rejecting traditional metaphysics and epistemology to focus on the one-to-one human relationships he argues are archetypal for all relations—that is, the face-to-face encounters between persons. Commenting on the face of the Other, he writes,

The first thing which is evident in the face of the other is this rectitude of exposure and defencelessness. In his face, the human being is most naked, destitution itself. And at the same time, he faces. It is a manner in which he is completely alone in his facing us that we measure the violence perpetrated in death. Third moment of the epiphany of the face: it makes a demand on me. The face looks at me and calls me. It lays claim to me.⁸

The physicians treating Shuman's grandfather clearly have not encountered the old man's face. In the face, the Other is stripped bare in a vulnerability that cannot be hidden. It calls forth immediately an ethical response, as "the face looks at me and calls me". Ultimately, this claim is, "do not kill me".⁹ An essential asymmetry is involved in this kind of relationship. There is a kind of primordial fear present as the self faces the possibility of being negated by the Other. In the field of health care this asymmetry has particular resonance and rejection does involve facing death. But the apprehension in the presence of the Other, when it does not turn back on itself, becomes the basis for responsibility to and for the Other.

As our capacity for some improved health outcomes increases the dilemmas facing us also grow. These dilemmas demonstrate the inadequacy of the previous bioethical formulae in the same way that Levinas found traditional metaphysics and epistemology wanting. In its place and utilizing Levinas' thought I propose a relational analysis of such situations in health care.

A Relational Analysis

Nancy Crick's web diary is an eloquent testimony to her loneliness, isolation and suffering. Those who assisted her in coming to the decision to end her life and supported her in that decision reinforced, or reflected back, those feelings. Despite the "community" which gathered around her to witness her death, she saw herself as an isolated individual who could no longer sustain a sense of self sufficient to continue in life. Understanding herself to be a person-in-relation may have altered the outcome. Those who promoted her cause failed to express her vulnerability in this regard. For purposes of their own, they championed the cause of the individual fundamentally separated from all other persons, and for whom any decision has no impact on the lives and being of others. The argument offered by those supporting Crick's choice to end her life moved from the narrow case of voluntary euthanasia to the acceptability of a personal choice to end one's life at anytime, for any reason. This makes a certain degree of sense if persons are simply individuals who happen to exist within a social context; it is not meaningful, however, if the relational aspect of personhood is included. Nancy Crick's web-diary,¹⁰ the video tape she made in order to present her own views,¹¹ and some of the commentaries on her choices,¹² all reinforce the view that she understood her life and her personhood in purely functional terms.

Crick wrote in the web-diary that when she postponed her death from 10 April, 2002 she received a number of hostile messages from some who previously supported her, indicating that she was failing the Voluntary Euthanasia cause. She notes that her supporters have become critics precisely because she was not doing exactly what they wanted her to do. Her justification for postponing her euthanasia was that she needed to explore palliative options in order to meet the objections of those who oppose euthanasia.¹³ Throughout the process the diary increasingly reflects her view that her death serves the cause:

I am honoured to be called a torch-bearer for Voluntary Euthanasia¹⁴

I appeal to visitors to my site if you have personal experience or have knowledge of a relative, a friend, or acquaintance in a similar situation to mine please provide details in either my guest book or send me an e-mail. I want to collect as much evidence as I can to put under the noses of our politicians, and ask them

this question...”HOW MUCH LONGER WILL YOUR CONSCIENCES ALLOW YOU TO IGNORE THE PAIN AND SUFFERING OF A GROWING NUMBER OF THE CITIZENS YOU CLAIM TO REPRESENT.”¹⁵ (Emphasis in text)

I made a promise to myself not to suffer another winter & shortly I will keep that promise. It is my life – my choice.¹⁶

The dominant message of the web-diary is that it is her function to be an advocate for medically assisted suicide and legal sanction of euthanasia. It is ironic that Crick proposed a change in Queensland law to permit medically assisted suicide or voluntary euthanasia based on independent diagnosis of terminal illness, when the person concerned was mentally stable and rational.¹⁷ Sources close to Crick acknowledged after her death that she was not suffering from a terminal illness in the usual sense of the term and claimed that she knew this about her health status.¹⁸ Van Gend cites Nancy’s physician and confidant, Philip Nitschke, maintaining that Crick’s medical condition was irrelevant to the decision to end her life.¹⁹ Syme presents evidence that Crick’s decision was made with no interference from her family or friends in support of his view that her decision was autonomous.²⁰ Recently, Graham Downie has reflected that:

In dying with dignity, as her supporters put it, she demonstrated the need for very sound medical and personal counsel for anyone concerned about a terminal illness.²¹

While Crick agreed to delay her suicide until after her son’s birthday and granddaughter’s wedding,²² there is little evidence from her comments on these events that she was relationally engaged with the people or events. This stands in stark contrast to her eager anticipation of the euthanasia rally held on March 25, 2002 – the day after her granddaughter’s wedding.²³

A nuanced relational approach to Crick’s situation would appreciate the limitations to relationality already sedimented in her life. Previous choices and relationships, ingrained patterns in physical, psychological and sociological development, all have their effect. But these need not close off the opportunity for further development. Some relationships are inherently asymmetrical, as between parent and child, doctor and patient, teacher and student, employer and employee. Levinas recognised that such asymmetry was a feature of all human dialogical encounters. Problems arise not from

this inherent asymmetry but when the weaker partner is so objectified as to not be a subject of communication. To be, in fact, rejected.

I would suggest, then, that those who became significant to Nancy Crick in her last year were not genuine dialogue partners, but rather echoed back to her the judgment of the worthlessness of her life. The point of contention in her decision was not ultimately euthanasia or medically assisted suicide, but her medical condition of not being terminally ill and probably able to be cured; hence, not a candidate for either option as presently proposed, at least in Australia. Crick's plea was for someone to provide her with a relatively certain means to end her life (sodium pentobarbital-Nembutal-being her preference), and to have people with her when she died.²⁴ Those publicly supporting her decision made it clear that what they supported was the autonomous decision to end life whenever a person chose to do so, regardless of their state of health and possibilities of cure.²⁵ Crick herself recorded in her diary that postponing her announced date of death led to a number of pro-euthanasia advocates criticising her personally, while the euthanasia advocate handling the media for her was more concerned with protecting euthanasia organisations than with Crick.²⁶ By her own account, she felt that she was the object of a monological communication in her last year. Her relations with physicians trying to introduce a range of options for her were rejected—in favour of those who endorsed the position that she had arrived at: her major contribution to the world would be to challenge existing laws by ending her life.

Concerning euthanasia, the traditional moral-theological approach argues that such an act is morally wrong due to the deliberate intention of terminating the life of an innocent person (even if carried out at their own request). Such an approach is helpful when it is possible to clearly delineate between life and death, ordinary means of health care and extraordinary means, terminal conditions and temporary lapses in health. In an era of advanced medical technology, it is no longer always clear how this moral norm operates. Are all acts deriving from an intention to end life to be considered euthanasia? Opinion on this varies, with some thinkers arguing that all acts which result in death where the activity undertaken directly causes death are equivalent to euthanasia. This perspective would hold that discontinuation of life-support equipment, the cessation of nutrition and hydration, or even some forms of pain relief are all morally

equivalent to euthanasia. Others argue that the distinction between intending to kill and taking a course of action which results in death is of moral significance.

Peter Singer, for example, has argued that appeals to the principle of “double effect”,²⁷ and distinguishing between ordinary and extraordinary means²⁸ obfuscate the genuine moral issues. The principle of double effect was the central defining principle of Catholic medical ethics prior to the Second Vatican Council.²⁹ It is specifically designed to deal with a range of health care procedures where there are both good and bad effects flowing from a proposed action, for example, where physicians administer high doses of analgesia where the intention is pain relief, even when it is known that the dosage will hasten the patient’s death.

The distinction between ordinary and extraordinary means of health care refers to situations in which patients, their families and carers can make a decision to forego treatments which will prolong life but where the treatment is no longer beneficial to the patient in any meaningful sense.³⁰ In contemporary health care practice, this distinction has led to the cessation of nutrition and hydration of terminally ill patients. Singer argues that the choices made in such situations are tacitly, if not openly, choices designed to bring about the death of the patient; and that most people believe that the death of the patient in such circumstances is the correct outcome.³¹ He suggests that it would be more honest and practical to simply acknowledge that the root intention is to ease suffering by bringing about death.³²

In defence of these principles—double effect and the distinction between ordinary and extraordinary means—Luke Gormally points to an important distinction between “intention” and “foreseen causation of death”.³³ Intentionally causing the death of a person, that is, choosing a course of action designed to bring about death, is always wrong; it is incompatible with human dignity. But this does not rule out all medical decisions which could lead to death. The foreseen causation of death can be compatible with human dignity; nor does it shape the fundamental moral disposition of the agent as the intention to kill must. Acting intentionally to cause the death of another is, as Levinas would argue, an instance of the ultimate negation of the other.

The case of Terri Schiavo demonstrates how strict legal interpretations of relationships are inadequate and may even enshrine rejection of the Other. A major feature of the Schiavo case is that the primary relationships of which Terri Schiavo was part, her marital relationship with husband Michael and her relationships with her biological family, parents and siblings, were not in agreement about the decision. That is, her biological family wanted nutrition and hydration to continue, it was her husband who conducted the legal battle and made the decision to withdraw treatment, with court orders to enforce his determination. It should be noted that while definitive diagnosis of the extent of brain damage was limited, there was medical consensus that given the severity of the damage and the length of time which had elapsed, Schiavo had little chance of recovery, in the sense of a return to her previous life or even substantial improvement. An autopsy confirmed this diagnosis and also that many of the claims of her parents about “eye-tracking” (following movement) and some spontaneous eating when offered food, were highly unlikely to be accurate.³⁴

The scenario then is this: a severely compromised and damaged patient who requires artificial means of nutrition and hydration to maintain biological life, but who is not terminally ill, nor likely to die from anything other than dehydration or starvation. Her husband believes that her quality of life is insufficient to warrant ongoing care; her parents and siblings dispute this claim. The courts consistently determine that her husband has the legal power to make decisions about her ongoing care. There are many controversies in this case concerning alleged physical abuse by the husband, money from a malpractice suit and the validity of conflicting medical opinions. Two aspects of this case are instructive for our purposes. Firstly, the legal determination that adult relationships which are chosen and have legal standing—marriage, for instance—should take priority over biological relationships. Secondly, that the law is not a particularly sound arbiter of the reality of relationships.

In relation to the first matter, the courts recognised that being in relationship to the patient brings a responsibility, even duty, to make decisions on behalf of the vulnerable incapacitated patient. Clearly this is a stance which, drawing on Levinas, I argue should be supported in a *prima facie* sense. Interpersonal relationships do bring such responsibility and when the relationship is chosen and serious, and of long-standing, as

in marriage, it should take a certain priority over other relationships, even familial relations. This is should not be an unlimited priority, however. I believe that the courts made a formal determination in this case based on a legal reality which was predicated on a fictional relationship.

At the time of her original collapse and injury, Schiavo and her husband were married and there is no serious evidence to suggest that it was not a genuine relationship in that Terri Schiavo was, at the time, undergoing treatment to achieve pregnancy. However, by the time of the final court decisions in this case, the husband Michael was in a *de facto* relationship of long standing—about eight years—with two children from that relationship.³⁵ Whether, as has been alleged, he wanted to cease treatment in order to preserve the monetary award for malpractice given for Terri's ongoing care for his own use is irrelevant to my argument. The point is that he had made decisions which repudiated the level and kind of relationship which the courts were maintaining still existed due to the fact the couple had never divorced. There might be a number of reasons why Michael Schiavo decided not to divorce Terri Schiavo. It is reasonable, however, to assume that had she returned to consciousness, Terri may have viewed her husband's adultery and two children from this relationship as grounds for her to divorce him!

The distinctions in this case are not only due to the medical circumstances but also due to the relational circumstances. In the Schiavo case the people in the two major relationships of her life, her parents and her husband, fundamentally disagreed over the value of the medical prognosis, what it meant for Terri to be maintained in her current health state and over who should make such decisions. While the marriage continued legally, no reasonable observer would believe that Michael Schiavo's primary relationship was with his legal wife and not with his *de facto* wife and children.

A relational perspective would have taken this real set of relationships into account, and pointed out that the husband's claims of duty and responsibility for his wife were, at least, compromised. The overriding value of the sanctity of life cannot absolutely depend on whether or not a supposedly legal marriage must take precedence over

other relationships. Instead of looking to who had the patient's best interests in mind, the legal decision turned on very narrow legal definitions.

A Practical Theology of Health Care

A practical theology of health care based on relationality contests decisions about life based on rigid and abstract determinations of either a legal or biological character. The moral discernment it envisages presupposes an unfolding search for meaning within an ultimate and theological conviction of human destiny as sharing in the very life of God. While such a conviction does not offer a ready solution to all moral dilemmas, it does highlight the value of the relationality in which all persons exist. This relational context is preferable to an exclusive focus on the morality of a particular isolated act. It also provides a basis for refuting Peter Singer's claim that people have given up on the sanctity of life in all but name. Only a relational context can provide a sufficient basis to uphold moral ideals and make sense of concrete decision-making in such cases. In these end-of-life cases a relation-based analysis highlights a much stronger and clearer sense of who should be responsible for decision-making. In situations where a number of different relational perspectives can achieve consensus in support of a particular well-founded medical position, a more ethical outcome is likely. In situations of significant dispute between the parties it is unlikely that the outcome will be ethical, even if warranted legally and medically.

In the Schiavo case, however, the different reasoning process would have highlighted a number of flaws in using the legal system to arrive at moral decisions. In this case the courts upheld a decision based on the legal marriage of Terri and Michael Schiavo even though the relationship, as marriage, had been effectively repudiated and for a number of years. While Terri Schiavo was in care for fifteen years, it is clear that her legal husband was, in fact, in another marriage for at least half that time. An analysis of the case based on relational personhood would have taken into account other relationships as well as the marital relationship equally, coming to a conclusion that weighed their competing claims more validly based on actual relationship rather than just a legal definition of relationship. For Nancy Crick, a relational analysis would have suggested

that her sense of isolation and refusal to accept most medical advice might have more in common than has been highlighted in public discussion of the case.

Such a physical description of relationships savours of a clinical detachment foreign to the language of relationship. Yet this objectification and sterilization of the language of relation makes possible the rejection of the other in a radical manner.³⁶ Here, there are two levels to be considered. On the objective level, the relationship can be considered in a purely physical fashion, with its various biological and clinical components. On the subjective level, the relationship implies recognition of the other in a more personal manner, as this other is given, inviting in its otherness to enter unreservedly into the relationship which already exists, through further choices and continuing commitment. A moral space is opened up in which new identities are formed and flourish within an inter-subjective community. This kind of space, identity and interdisciplinary approaches to community are properly the focus of practical theology.

Applied in the context of health care, relational anthropology demands recognition of the fact that patients are not pathologies or disabilities or conditions, they are persons-in-relation. This recognition, in turn, demands a paradigm shift in health care away from a pathological focus to one focused on human health as a means to achieve the optimal flourishing of persons. Within such an altered paradigm someone like Nancy Crick would be supported in her health condition and challenged to accept that a return to health or at least an optimal level of health for her age and medical history was possible. Those who joined with Crick to advocate her death would be challenged about their own anthropologies and agendas.

A theology of relational personhood generates a very different model of health care and a very different health care ethic. Conceptualising persons relationally shifts the primary task of health care from pathology to the care of persons. This transformation involves risks for health care professionals because relationality demands that the person who is a health care professional invite relationship with patients and be open to relational encounters. Embracing the Other involves opening the self to risk; it necessarily, this will cause professionals to be more open to the pain and the suffering of the Other. This is the consequence of moving beyond the comfortable boundaries of a functional repair

model of medicine to a model of health care which is genuinely able to effect transformation in the lives of those involved in health care. The need for such openness to transformative possibilities is demanded both by the nature of persons and by the nature of health care. The latter has a focus on human flourishing not just cure of illness; this cannot happen unless the transformation of persons is encouraged. Such transformation is invited and demanded by the face of the Other in the clinical encounter. These cases demonstrate the importance of relational anthropologies in offering models for thinking and a means of discernment of how to proceed.

Relational personhood provides a quite different grounding for analysis of concrete cases in health care ethics. Instead of attempting to start from an objective calculus or ethical principles approach, whereby a set of pre-determined standards are applied to a given case, regardless of context, utilizing a relational perspective requires that the analysis occurs from the viewpoint of the subject. In this context the subject is not primarily an individual but a *person-in-relation* and, therefore, their relationships are a vital part of the analysis. Such a focus means that physicians and ethicists involved in a case such as Nancy Crick's for example, do not have to endorse and/or carry out her request to die simply on the basis of an emphasis on autonomy constructed as the rational request of an individual. Rather, a relational health care ethic adopts a broader set of criteria.

The relationships which became significant to Nancy Crick in the last year of her life were those that endorsed her desire to end her life. They championed the idea that an individual should be able to request medical intervention to end their life in the case of terminal illness and an unwillingness to continue treatment. No relationship which argued a contrary position was accepted as meaningful. This seems decidedly odd. A group of people who are virtual strangers or who have only been known for a brief period of time are taken on as "dialogue" partners but close members of her family are not. From the description of her life in the diary, a reasonable person might conclude that Crick's family neglected her, perhaps prompting a turn to strangers and an articulation of a desire to die. Her acquaintances who supported a bid to end life on the basis of a single choice are embraced; but those who argue for life, choices and options are rejected. The value of empirical evidence was denied, while erroneous

assumptions about Crick's health status were uncritically accepted. These circumstances would suggest that the claim of rationality in the case of Nancy Crick is misplaced. The conception of the autonomous rational person relies on an understanding of reason as meeting objective criteria and being subject to public scrutiny. While it might be plausible that Crick's desire to forego burdensome and futile treatment is understood and endorsed widely as a rational desire, it is unlikely that the same endorsement can be made in the light of the medical evidence: Crick was not terminally ill, she was presented with a range of treatment options which were all standard for her situation – she rejected all views which did not coincide with her own.

Attention to her relational circumstances would have yielded a different analysis: it would have highlighted that meaningful primary relationships were lacking in her life, leaving her vulnerable to expedient relationships – ones where her personhood was neither affirmed nor promoted. Crick was vulnerable and instead of her needs being met by those with whom she was in relationship, her vulnerability was being exploited by people who viewed her as a means to an end.

This analysis demonstrates why the notion of relational personhood represents a necessary ingredient in health care: not only is the analysis of particular cases different, but in order for the health outcomes to change it is necessary to alter the structures within health care delivery to enable relational analyses to be acted on. Nancy Crick's distorted perspective about her health condition could not ultimately be challenged by health professionals due to the dominance of the concept of patient autonomy and wariness about the dangers of medical paternalism. The focus on patient autonomy in cases concerning euthanasia and assisted suicide is counter-productive since any analysis is too tightly constrained by pre-determined criteria and unable to take sufficient account of subject-specific issues.³⁷

While it is difficult, even in well publicised cases such as this, for one to propose a precise course of action, one feature of the case does offer scope to suggest a more relational approach. Based on Crick's web diary, the writings of health care professionals and commentators at the time of her death, it appears that no medical consultations were held with a wider group of people than Crick herself. As noted

above, she appears to have had a distant or tenuous relationship with her children. Had her children, and even grandchildren, been included in discussions about her health status and prognosis Crick may have received a different range of support and/or advice. Had Crick's treating physicians been able to take into account the nature of women's relationships with their families and associated features of depression, poverty, vulnerability and poor social support,³⁸ then they may have had a wider range of options open to them and Crick may well have found other solutions to her situation.

Had her supporters in the voluntary euthanasia movement been aware that her health condition did not meet the criteria for terminal illness, it may be that they would have proposed a different course of action, since it was reasonably predictable that the public sympathy which is often aroused in cases where the terminally ill want to die would not be forthcoming in a situation where a person refused all advice, treatment and assistance. In reaction to the announcement that Nancy Crick had not been terminally ill the Australian community significantly reduced support for voluntary euthanasia, even if only on a temporary basis.³⁹ At the very least, as David van Gend argues, any discussion of euthanasia and/or assisted suicide needs to take account of "the grim nature of some family relationships." He goes on to cite a House of Lords decision to reject assisted suicide/euthanasia on the grounds that "[W]e are concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to seek early death."⁴⁰

Conclusion

A relational theology recognises the patient as one who suffers and who is "other" in a manner that transcends the projections or field of competence of the professional carer. This is to say that the patient is a person—with the totality of relationships and values involved in such a status; therefore, not just a pathological object.

At one level, it is impossible not to recognise that another person is *other*. Yet this commanding alterity is muted by the effort to classify people into manageable groupings—such as nationality, ethnic origin, complexion, financial resources, or by type of illness, health status, disability and trauma. Such classifications are clearly a

pragmatic necessity. But these kinds of categorisations are not designed to appreciate the individuality of each case and uniqueness of each person. Taken to an extreme classifications based on pathology or ethnic origin have resulted in horrendous atrocities: to be negatively “classified” has meant being dehumanised or even demonised, with all semblance of personhood excluded. Levinas’ approach to the other as calling the ego into moral responsibility, expressed in the biblical command, “Thou shalt not kill”, is especially poignant in the health care context.

While theology is rightly focused on the reciprocity of relationships between the divine and the human, it just as rightly maintains that there is no simple symmetry between the human way of relating to God, and the God’s way of relating to the human. God is always the infinitely Other, never a projection of human need nor an object of human manipulation. Person(s) in the divine sense are never reducible to the human concept of self. This transcendent sense of otherness or alterity is analogically applicable to the love and care existing between human subjects: the ultimate otherness of the human person is found in its origin and destiny in God. If such personal alterity is not respected—in health care and in social relationships and services—a distortion enters into relationships concerned: the “other”—in its inexpressible uniqueness and transcendent destiny—is reduced to the “same”, as, say, a projection of “my” needs or concern or as even as an object of “my” care: the unique “you” becomes merely an extension of “me”. The cases of Nancy Crick and Terri Schiavo demonstrate the dangers when health care allows such distortion to be commonplace. On the other hand, by recognising the otherness of an individual, particularly in a situation of suffering, we are faced with the appealing vulnerability of the other, and the inescapable fact of our own vulnerability as well. A relational perspective may not have altered the outcomes for either Nancy Crick or Terri Schiavo – but it would have altered the way the cases were understood and, perhaps, the perspectives which were brought to bear on the people whose lives were at stake. Certainly they would have called attention to the radical nature of their Otherness.

¹ Nancy Crick, *The Diary of Nancy Crick* [website] (2002, accessed 26 August 2003); available from [Http://pandora.nla.gov.au/pan/24513/20020424www.protection.net.au/nancycrick/htm](http://pandora.nla.gov.au/pan/24513/20020424www.protection.net.au/nancycrick/htm)

² David van Gend, "Nancy Crick's Death Not in Vain," *Human Life Review* 28, no. 3 (2002).

³ George Khushf, "Illness, the Problem of Evil, and the Analogical Structure of Healing," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: William B. Eerdmans, 1998), 34.

⁴ J. J. Shuman, *The Body of Compassion* (Boulder, Colorado.: Westview Press, 1999).

⁵ Shuman, *The Body of Compassion*.

⁶ Shuman, *The Body of Compassion*.

⁷ Shuman, *The Body of Compassion*.

⁸ Emmanuel Levinas, *Is It Righteous to Be? Interviews with Emmanuel Levinas*, ed. Jill Robbins (Stanford, California: Stanford University Press, 2001).

⁹ Silvia Benso, "Of Things Face-to-Face with Levinas Face-to-Face with Heidegger: Prolegomena to a Metaphysical Ethics of Things," *Philosophy Today* 40, no. 1 (1996).

¹⁰ Crick, *The Diary of Nancy Crick*(accessed)

¹¹ Nancy Crick, "Transcript of the Nancy Crick Video," *The Sydney Morning Herald*, 24th May, 2002 2002.

¹² Rodney Syme, *Nancy Crick* [website] (Voluntary Euthanasia Society of Victoria Inc., 2002, accessed 26 August 2003); available from <http://www.vesv.org.au/docs/crick050602.htm>, Rodney Syme, "Response to the Nancy Crick Case," *Monash Bioethics Review* 21, no. 4 (2002). and, Eric Gargett, "Beyond Nancy Crick," *Monash Bioethics Review* 21, no. 4 (2002).

¹³ Crick, *The Diary of Nancy Crick*(accessed) 27 April, 2002.

¹⁴ Crick, *The Diary of Nancy Crick*(accessed) 28 February, 2002.

¹⁵ Crick, *The Diary of Nancy Crick*(accessed) 10 March, 2002.

¹⁶ Crick, *The Diary of Nancy Crick*(accessed) 25 March, 2002.

¹⁷ Crick, *The Diary of Nancy Crick*(accessed) See entry for March 3, 2002.

¹⁸ Syme, *Nancy Crick*(accessed), van Gend, "Nancy Crick's Death Not in Vain."

¹⁹ van Gend, "Nancy Crick's Death Not in Vain."

²⁰ Syme, *Nancy Crick*(accessed)

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- ²¹ Graham Downie, "No Need to Legislate for Euthanasia," *Canberra Sunday Times*, 9 July 2006, 16.
- ²² Crick, *The Diary of Nancy Crick*(accessed).
- ²³ Crick, *The Diary of Nancy Crick*(accessed) See entry for March 17, 2002.
- ²⁴ Crick, *The Diary of Nancy Crick*(accessed).
- ²⁵ Philip Nitschke, *Voluntary Euthanasia - a New Radicalism* [web site] (Online Opinion, 2002, accessed 17 December 2003); available from <http://www.onlineopinion.com.au/2002/May02/Nitschke.htm>, Miranda Devine, "The Death Knell for Euthanasia," *The Sydney Morning Herald*, 30 May 2002.
- ²⁶ Crick, *The Diary of Nancy Crick*(accessed).
- ²⁷ Peter Singer and Helga Kuhse, "Allocating Health Care Resources and the Problem of the Value of Life," in *Unsanctifying Human Life*, ed. Helga Kuhse, (Oxford: Blackwell Publishers, 2002), 269
- ²⁸ Peter Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics* (Melbourne: Text Publishing, 1994).
- ²⁹ David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington, DC: Georgetown University Press, 2005).
- ³⁰ Kelly, *Contemporary Catholic Health Care Ethics*.
- ³¹ Peter Singer, "Is the Sanctity of Life Ethic Terminally Ill?," in *Unsanctifying Human Life*, ed. Helga Kuhse, (Oxford: Blackwell Publishers, 2002).
- ³² Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.
- ³³ L. Gormally, "Against Voluntary Euthanasia," in *Principles of Health Care Ethics*, ed. Raanan Gillon and Anne Lloyd, (Chichester, England: John Wiley and Sons, 1994).
- ³⁴ J. R. Thogmartin, *Report of Autopsy: Schiavo, Theresa* (Largo, Florida: Medical Examiner, Sixth District, 2005), Autopsy Report.
- ³⁵ Ron Word, "Appeals Court to Consider Schiavo Request," *ABCNews*, March 30 2005.
- ³⁶ Alistair I. McFadyen, *Bound to Sin: Abuse, Holocaust and the Christian Doctrine of Sin*, Cambridge Studies in Christian Doctrine 6 (Cambridge, U.K.: Cambridge University Press, 2000).
- ³⁷ Jennifer A. Parks, "Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of the Woman's Death Request," *Hastings Center Report* 30, no. 1 (2000).
- ³⁸ Susan M. Wolf, "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia," in *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf, (New York: Oxford University Press, 1996), 284f .
- ³⁹ M. Otlowski, "Discussion: The Nancy Crick Case," *Monash Bioethics Review* 21, no. 3 (2002).
- ⁴⁰ van Gend, "Nancy Crick's Death Not in Vain."

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REFERENCES

- Benso, Silvia. "Of Things Face-to-Face with Levinas Face-to-Face with Heidegger: Prolegomena to a Metaphysical Ethics of Things." *Philosophy Today* 40, no. 1 (1996): 132.
- Crick, Nancy. *The Diary of Nancy Crick* [website]. 2002, accessed 26 August 2003; Available from [Http://pandora.nla.gov.au/pan/24513/20020424www.protection.net.au/nancycrick/htm](http://pandora.nla.gov.au/pan/24513/20020424www.protection.net.au/nancycrick/htm).
- _____. "Transcript of the Nancy Crick Video." *The Sydney Morning Herald*, 24th May, 2002 2002.
- Devine, Miranda. "The Death Knell for Euthanasia." *The Sydney Morning Herald*, 30 May 2002.
- Downie, Graham. "No Need to Legislate for Euthanasia." *Canberra Sunday Times*, 9 July 2006, 16.
- Gargett, Eric. "Beyond Nancy Crick." *Monash Bioethics Review* 21, no. 4 (2002): 34 - 35.
- Gormally, L. "Against Voluntary Euthanasia." In *Principles of Health Care Ethics*, ed. Raanan Gillon and Anne Lloyd, 763 - 774. Chichester, England: John Wiley and Sons, 1994.
- Kelly, David F. *Contemporary Catholic Health Care Ethics*. Washington, DC: Georgetown University Press, 2005.
- Khushf, George. "Illness, the Problem of Evil, and the Analogical Structure of Healing." In *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, 30 - 41. Grand Rapids, Michigan: William B. Eerdmans, 1998.
- Levinas, Emmanuel. *Is It Righteous to Be? Interviews with Emmanuel Levinas*, ed. Jill Robbins. Stanford, California: Stanford University Press, 2001.
- McFadyen, Alistair I. *Bound to Sin: Abuse, Holocaust and the Christian Doctrine of Sin* Cambridge Studies in Christian Doctrine 6. Cambridge, U.K.: Cambridge University Press, 2000.
- Nitschke, Philip. *Voluntary Euthanasia - a New Radicalism* [web site]. Online Opinion, 2002, accessed 17 December 2003; Available from <http://www.onlineopinion.com.au/2002/May02/Nitschke.htm>.
- Otlowski, M. "Discussion: The Nancy Crick Case." *Monash Bioethics Review* 21, no. 3 (2002): 10 - 12.
- Parks, Jennifer A. "Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of the Woman's Death Request." *Hastings Center Report* 30, no. 1 (2000): 30 - 36.
- Shuman, J. J. *The Body of Compassion*. Boulder, Colorado.: Westview Press, 1999.
- Singer, Peter. *Rethinking Life & Death: The Collapse of Our Traditional Ethics*. Melbourne: Text Publishing, 1994.

_____. "Is the Sanctity of Life Ethic Terminally Ill?" In *Unsanctifying Human Life*, ed. Helga Kuhse, 246 - 261. Oxford: Blackwell Publishers, 2002.

Singer, Peter, and Helga Kuhse. "Allocating Health Care Resources and the Problem of the Value of Life." In *Unsanctifying Human Life*, ed. Helga Kuhse, 265 - 280. Oxford: Blackwell Publishers, 2002.

Syme, Rodney. *Nancy Crick* [website]. Voluntary Euthanasia Society of Victoria Inc., 2002, accessed 26 August 2003; Available from <http://www.vesv.org.au/docs/crick050602.htm>.

_____. "Response to the Nancy Crick Case." *Monash Bioethics Review* 21, no. 4 (2002): 32 - 34.

Thogmartin, J. R. *Report of Autopsy: Schiavo, Theresa*. Largo, Florida: Medical Examiner, Sixth District, 2005. Autopsy Report.

van Gend, David. "Nancy Crick's Death Not in Vain." *Human Life Review* 28, no. 3 (2002): 87 - 88.

Wolf, Susan M. "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia." In *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf, 282 - 317. New York: Oxford University Press, 1996.

Word, Ron. "Appeals Court to Consider Schiavo Request." *ABCNews*, March 30 2005.

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