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Should People Die a Natural Death?

Lars Sandman[1,2]

In the article the concept of natural death as used in end-of-life decision contexts is explored. Reviewing some recent empirical studies on end-of-life decision-making, it is argued that the concept of natural death should not be used as an action-guiding concept in end-of-life decisions both for being too imprecise and descriptively open in its current use but mainly since it appears to be superfluous to the kind of considerations that are really at stake in these situations. Considerations in terms of the quality of life cost of the intervention in relation to the quality and length of life benefits of the same intervention. In referring to the concept of natural death we risk to blur these considerations and end up in difficult distinctions between what is a natural and non- or un-natural death, a distinction which it is argued is of no real moral interest.

KEY WORDS: natural death; quality of life; length of life; artificial prolongation of life.

INTRODUCTION

Looking at the literature on death and dying, the concept of natural death has often played an important role in distinguishing a good death from a bad or less good death, even to the extent of having been given a large number of different and sometimes conflicting meanings drawing on this positive evaluative content (High, 1971; Illich, 1974; Momeyer, 1988; Weisman, 1973; Callahan, 1995; Seymour, 1999).[3] This should of course make us a bit suspicious about using the concept. At the same time a few recent empirical studies about people's views on end-of-life decisions show the concept of natural death to still play an essential role in these

[1]Senior Lecturer in Care-Ethics, University College of Borås, Sweden.
[2]Correspondence should be directed to Lars Sandman Ph. D., School of Health Sciences, University College of Borås, SE – 501 90 Borås, Sweden; e-mail: lars.sandman@hb.se.
[3]We also find the concept "natural" invoked in other normative contexts—for example in relation to giving birth, in relation to gene-technology, in relation to homosexuality etc. (see for example Takala, 2004).

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decisional contexts (Costello and Horne, 2003; Eliott and Olver, 2003; Seymour, 1999). Hence, we should take a closer look at these uses to see if they voice essential normative concerns, not reducible to other forms of normative concerns, and if so—what kind of normative concerns.

The aim of this article is hence to analyse these documented uses of a natural death to see what kind of normative concerns they voice, and moreover, to see whether they are suitable as action-guiding terms and necessary in the sense of not being reducible to other normative concerns. I will argue that the views on natural death found in these studies on the one hand either suffers from being ambiguous or from having non-accepted implications, and on the other hand are superfluous in expressing concerns better expressed in other terms. My positive claim in this article is that what primarily is guiding the considerations at end-of-life decisions in the reviewed studies is the future quality and length of the dying persons life, in relation to the cost of the intervention discussed, and considerations about whether death is natural or not, does not add anything substantial to these considerations. Moreover, I will claim that this is the focus end-of-life decisions should have.

Before turning to the empirical studies we will however take a quick look at some other uses of a natural death in the medical/care context to give a background to the uses in these studies. In epidemiology and forensic-science the predominant use of a natural death is in distinguishing natural deaths from the kind of non- or un-natural deaths that can be characterised as accidental deaths or deaths from injury, death by suicide or homicide, and death by euthanasia or physician-assisted suicide. Here the relevant distinguishing feature seems to be that a natural death is in some sense internally rather than externally caused (Oehmichen and Meissner, 2000). However, Oehmichen and Meissner (2000) has observed the problem of distinguishing a death which is internally caused from a death which is externally caused, since most internal causes of death in turn have partly external causes, even to the point of making people judicially liable for these external causes (cf. law-suits against tobacco-companies for causing lung-cancer etc.). Moreover, when it comes to end-of-life decisions this use of natural death would be of no guidance since we almost always (apart from few cases when we would be considering euthanasia or physician-assisted suicide) are facing a choice between an internally caused death now or an internally caused death later, in other words, between a natural death now or later.

Another context where we find the concept a natural death used is in the so-called Natural Death Acts (see for example the Natural Death Act of Guam or of the Northern Territory of Australia) regulating people's right to have life-prolonging measures withdrawn or withheld when suffering from a terminal illness. However, this is not generally the label on these legal documents (see for example the Health Care Decision Law of California, which used to be called the Natural Death Act, and the Texas Health and Safety Code, having more or less the same content as the above acts), and we cannot therefore draw any far-reaching conclusions

from such a use. Moreover, since these documents only regulate people's right to choose a certain death (termed a natural death in some such codes or acts), without prescribing such a death, they do not make strong normative claims about natural death. We can hence find a number of different interpretations of how these documents relate to a natural death. First, these acts could be interpreted as allowing people an earlier natural death instead of a later un-natural death, i.e. implicitly claiming that it is better to choose to abstain from life-prolongation under certain circumstance since they would otherwise get an un-natural death. If so they would be in line with how a natural death is portrayed in the study about hospice carers (Costello and Horne, 2003). In some of these acts we find comments supporting such an interpretation (see for example the NDA of Guam), even if not really in line with the more liberal background to these acts. A second interpretation would be that they are allowing people to choose when to die as long as it can be considered to be a natural death, hence to choose an earlier natural death before a later natural death. That is, since these acts are supposed to safe-guard dying person's right not to have life artificially prolonged unless they want so, but not to enable these persons to have their lives shortened by euthanasia or physician-assisted suicide (see for example the NDA of Guam and of the Northern Territory), we could interpret the talk about a natural death in terms of a constraint on how the wanted death could be achieved. Third, in line with this interpretation, they can be drawing on natural death being positively value-laden and emphasise that withdrawing and withholding medical treatment or measures are in the right (=natural) category of death in distinction to euthanasia and physician-assisted suicide, which are in the wrong un-natural category. However, as noted above, the use of natural death in relation to these acts are far too open to allow us to draw any definite normative conclusions as to what a natural death might imply for end-of-life decisions. Hence, we turn to our empirical studies, providing us with a more 'fleshy' and normatively interesting use of natural death.

A NATURAL DEATH IN A HOSPICE SETTING

Traditionally the concept of natural death has had a strong hold in the context of palliative care, implying reluctance towards using extraordinary measures in order to prolong the lives of dying persons (Field, 1994; Walter, 1994; Seale, 1998; Timmermans, 1998; Seymour, 1999). However, the latest developments within palliative care has resulted in a less ideological stance towards the use of extraordinary or artificial measures in many palliative contexts, mainly in order to provide dying persons with adequate symptom-management (Clark and Seymour, 1999; Beck-Friis and Strang, 1999; Doyle et al., 1998) but also to some extent also to provide dying persons with longer life (see for example Thorns and Ellershaw, 1999).

On the other hand, the most recent WHO-definition of palliative care still claims (however, without using the wording "a natural death") that palliative care:

"Affirms life and regards dying as a normal process. Intends neither to hasten or postpone death" (Sepulveda et al., 2002, p. 94). Here it might be questioned whether this view on hastening and postponing death is actually in line with the above developments, and later in the definition it is also claimed that palliative care "may also positively influence the course of illness" (Sepulveda et al., 2002, p. 94), which is reasonable to interpret as if palliative care could also prolong life.

However, in a recent study about nurses' and health support workers' views on cardiopulmonary resuscitation (CPR) in a hospice context we find that the concept of natural death is still referred to when affirming that death should neither be hastened nor postponed. The study showed that 68% "felt that by carrying out CPR, many patients would die an un-natural death" (Costello and Horne, 2003, p. 160). Where an un-natural death was defined as "the involvement of inappropriate medical interventions with terminally ill patients that controlled and unnecessarily prolonged the patient's passage towards death" (Costello and Horne, 2003, p. 160) and "involved the use of intravenous infusion lines, parenteral feeding and cardiac stimulants" (Costello and Horne, 2003, p. 160). An un-natural death was considered problematic in that it interfered with the patient's possibilities to die a death with dignity, which was "perceived to involve the minimum use of medical intervention" (Costello and Horne, 2003, p. 160), and dying naturally was related to "passing away from this world quietly, with dignity and without pain" (Costello and Horne, 2003, p. 160).

Trying to pinpoint what a natural death is we seem to end up with a death which is internally caused by some illness or injury or degeneration of the person, which is not the result of artificial prolongation of life and which can be characterised as quiet or peaceful, dignified and painless. Now, artificial prolongation (CPR etc.) is not resisted under all circumstances and seems to be warranted in other situations:

> CPR for people who are clearly dying is morally wrong, no question but if they're having active treatment . . . and especially if they are young and having active treatment. (Costello and Horne, 2003, p. 160)

Here, it seems reasonable to interpret artificial prolongation in other situations as not resulting in an *un-natural* death, i.e. artificially prolonging life will only result in an un-natural death when the person is in a terminal condition where no cure is longer available and there is fairly little time left in life. If not, most people within palliative care, having earlier been subjected to artificial prolongation of different sorts, would already be robbed of a natural death. Hence, we only get an un-natural death if we artificially prolong life after we have entered a terminal condition. This would, however, seem a bit arbitrary on two different accounts: first, since it is difficult to pinpoint exactly when we enter a terminal condition; second, since it is difficult to see why artificial prolongation after we enter a terminal condition would result in an un-natural death but artificially prolongation of life before we enter into such a condition would not. In effect, it cannot be

the artificial prolongation *per se* that is problematic here, especially since other artificial measures, i.e. symptom-management (which might have life-prolonging effects (Materstvedt and Kaasa, 2002)) are warranted.

A few suggestions could perhaps account for this view on artificial prolongation when in a terminal condition. First, when people reaches a terminal condition chances of successful artificial prolongation of life are small, i.e. the cost of artificial prolongation has no corresponding benefits in terms of quality or length of life. Second, even if successful, the circumstances of death and dying are more important than further stretches of life when in a terminal condition. That is, it is more important that dying and death is quiet or peaceful and dignified than having an extra bit of life.

Now, it is true that chances of successful artificial prolongation of life are smaller when the person subjected to such measures is in a terminal condition (Thorns and Ellershaw, 1999), even if it would seem to depend on whether the person is in an early or late phase of this terminal condition. A terminal condition, if it relates to the impossibility of cure, might last for a considerable amount of time (i.e. up to a couple of years or even more). Applying this to the concept of natural death would imply that successful artificial prolongation of life does not hinder the achieving of a natural death (later on) but unsuccessful prolongation does result in an un-natural death. In effect, an un-natural death is a death where I actually die when attached to the artificial life-prolonging measures, which obviously affects the circumstances of death, and where the artificial prolongation has not resulted in any corresponding benefits in terms of a stretch of life with acceptable quality. However, this should only make the hospice personnel reluctant to those situations when artificial prolongation has little chance of being successful. Hence, this reluctance might not only be related to whether artificial prolongation is successful or not but rather to the fact that artificial prolongation affects the circumstances of dying and death, independently if it is successful or not. That is, any such intervention is likely to disturb the quietness of the care situation as well as the dignity (in the more aristocratic, serene and elevated sense, see Sandman, 2001, 2002, 2005) of this situation, and even if it results in a further stretch of life worth living to the dying person this extra stretch might require life-sustaining measures which will continue to disturb both the quietness and dignity. If so, the naturalness of death will have more to do with the artificial circumstances of death than with the artificial prolongation or causes of death.

Once again, it seems likely that the hospice-personnel will not avert all artificial measures surrounding the dying person, as long as they are quiet and do not disturb the dignity of the situation. At this point it seems however that the distinction between natural and un-natural death becomes too arbitrary and loose to be workable as an action-guiding distinction. That is, if "natural death" allows some artificial measure but not other artificial measures, and rather stands for quietness and dignity it seems we have lost most of what we in other context might associate with natural and un-natural. In other words, dignity in most senses

(see Sandman, 2001, 2002, 2005) except for the more purely evaluative sense (being more or less synonymous with good) is a highly culturally influenced phenomenon which might require a large number or artificial measures to realise. It is also difficult to see that quietness would in any way have an intimate link with the non-artificiality of naturalness here. For example, the artificial ventilator might be both quiet in itself and result in peace for the person being connected to the ventilator, in distinction to the fear and chaos of being suffocated to death. Hence, my interpretation is rather that the concept of natural death is used to label a certain version of a good death, containing some aspects of naturalness (in the sense of non-artificiality), but with the main focus on certain evaluations, i.e. of quietness and dignity before a longer life, evaluations not necessarily shared by the dying person.

In effect, the concept of natural death has no clear and independent role to play in these end-of-life decision contexts and what is essential here could better be expressed in terms of the quality of life cost of the intervention in distinction to the chances of benefits and costs of continued life (from the perspective of the dying person). To the extent there are important values lost in artificially prolonging life, they are values to the dying person's quality of life or to his or her close-ones' quality of life and are better expressed in terms of such values, i.e. in terms of well-being or desire-fulfilment or autonomy or relationships or whatever values we find important to a good life. Or, in other words, to the extent people are not benefited by a natural death, a natural death should not play a role in end-of-life decision-making and hence we should not avoid artificial prolongation of life because it robs people of a natural death, but because it on balance is of no or negative value to people.

A NATURAL DEATH FROM THE PERSPECTIVE OF DYING PEOPLE AND COMPANIONS OF DYING PEOPLE

Looking at cancer-patient's views about CPR and DNR-orders (do-not-resuscitate orders) we find similar references to natural death and the view that artificial prolongation or maintenance of life results in un-natural death (Eliott and Olver, 2003). However, here the emphasis is even more on the futility of artificial prolongation in terms of resulting in a further stretch of life of negative or marginal value to the dying person or, alternatively, of negative value to the close-ones. Consider the following quotations:

> If I ever get to the stage where there is no hope, I would like someone to put me to sleep. (Eliott and Olver, 2003, p. 102)
>
> . . . why stretch it out, why try and preserve a life with agony and pain (Eliott and Olver, 2003, p. 103); . . . we could save their life, you know, bring them back, but only for more suffering, so do not resuscitate. (Eliott and Olver, 2003, p. 103)
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> If you have cancer . . . you get to a stage of acceptance anyway that you're going to die. Just to prolong it . . . [for] a few days or a few weeks, I don't believe it is necessary. (Eliott and Olver, 2003, p. 104)

> When you suffer and your family's suffering as well, I can't see the quality of life in continuing with it. (Eliott and Olver, 2003, p. 104)
>
> I wouldn't think there'd be any point whatsoever in resuscitating to bring me back to the quality of life that I have got, . . . a burden having doctors and nurses just virtually keeping me alive, for no reason . . . . (Eliott and Olver, 2003, p. 104)

Hence in the material presented in this study, the considerations are in terms of the cost of the intervention in relation to the corresponding benefits or further costs of continued life, and once again the naturalness or not of death does not seem to be essential in the end-of-life considerations. That is, people do not resist artificial prolongation of life just or even mainly on account of them resulting in an un-natural death, but rather on the account of the cost of artificial prolongation not having any corresponding benefits. And as noted in this study, the cancer-patients probably do not resist artificial interference or prolongation at other times and under other circumstances: "Any medical attempts to treat cancer. . . can be viewed as artificially interfering with the progression of the illness (and delaying death). Yet these were, presumably, favourably viewed by participants, many of whom were actively undergoing such treatment" (Eliott and Olver 2003, p. 102).

The impression that the talk about natural death in end-of-life decisions in effect amount to considerations about quality of life assessments is also supported in Seymour's (1999) study about companions to dying people and their views on natural death and the use of technology (which is part of a larger set of studies around these issues, see also Seymour, 2000, 2002). In her study, there is no necessary connection between a natural death and a non-artificial death and a natural death does not imply a death free of the use of technology or medicine but rather a death in which medical technology is used to achieve a natural death which is defined as a death which was "expected, appeared to be amenable to human manipulation and intention, was accessible to lay-understanding and seemed to 'fit' the wider context of the dying person's life" (Seymour, 1999, p. 701). Hence Seymour's study seems to show the concept of natural death to be even more descriptively open, and hence even more problematic as a guiding concept. However, before we definitely draw that conclusion, let us take a closer look at how the concept of natural death is portrayed in her study.

Seymour first distinguishes between three different cases or patterns in relation to a natural death. According to the first pattern, death is expected but life is the outcome, something which is seen as a subversion of natural death. According to the second pattern, death is probable or expected and death is also the outcome, something which is seen as an ideal or natural death. According to the third pattern, life is probable or expected but death is the outcome, something which is seen as betrayal of faith in medical technology or an un-natural death (Seymour, 1999).

In Seymour's account the companions' expectations will play an important role for how death is viewed. When death or life is in line with the companions

expectations, it is positively evaluated as natural or ideal, and when it is not thus in line, it is negatively evaluated as something un-natural or problematic.

At this point it is essential to distinguish between death being just expected and death being expected and also accepted or even desired. It is obvious that death might be expected without being accepted or desired and in the discussion it seems the expectation that the close-one is about to die is accompanied by an acceptance of or even desire for the close-one to die and the expectation that the close-one will live is also accompanied by a desire that the close-one will live. Hence, we need to qualify a natural death (in this context) to be at least an accepted expected death, and in the following "expected" will mean "expected and accepted" or "expected and desired," depending on the context (and often indicated in the text, for clarity). In pattern one, we find an example of when a patient is expected to die, and the next-of-kin have accepted and even desire this, but the patient's life is prolonged:

> . . . [the medico-technological] intervention meant that she and her children had not only to endure a further period of extreme practical difficulty as they struggled to care for Mr Cook, but also . . . [that] all the distressing feelings associated with his imminent death would be re-experienced. (Seymour, 1999, p. 697)

In pattern two we find an example of when the expectation (in terms of acceptance) fits the death of the patient and in pattern three an example of when the patient is expected (and it is so desired) to survive, but dies. It is obvious from Seymour's accounts and reasonably so, that *ceteris paribus* if what we expect and accept or desire happens this is better for us, than if what we do not expect and do not accept or even avert happens. Is it also reasonable to claim that people's expectations should guide whether we also view death as natural or not, or what would such a view imply?

First, there is a problem here relating to whose expectation we should take into account. Seymour's account of Mrs Cook in the record above, clearly shows that the expectation (acceptance/desire) is not only related to what is best for the dying person (Mr Cook), but also to what is best for Mrs Cook and her daughter, something, which obviously might conflict in some situations. Hence, letting people's expectations around death decide whether it is natural or not might end up with situations where death is natural to some people but un-natural to other people, which is not very conducive if we want the concept of natural death to be action-guiding. Of course, we could argue that it should be the dying person's expectations (acceptance/desire) that should decide whether death is natural or not, but at this point it is obvious that the concept of natural death is redundant. Why not let the dying person's expectations or rather desires decide whether to prolong life or not, and ignore whether it can be characterised as resulting in a natural death or not?

Moreover, even if we disregard this, it is problematic regarding the expectations in themselves around when death should occur as a criterion for whether

death is natural or not, and resulting from this for when death should occur. When we expect (and accept and/or desire) something to happen we do so due to some feature of the situation, or at least due to what we believe to be a feature of the situation. In Seymour's account people expect (accept) death to occur because they interpret the condition of the dying person as irrevocable, or they expect (desire) life to continue because they interpret the condition of the dying person as manageable, or they expect (desire) death to occur because they interpret the condition of the dying person as irrevocable and death as good for (at least the remaining close-ones and perhaps also for the dying person). Now, a criterion for when death should occur should then rather be formulated in terms of what people's expectations (acceptances/desires) are based upon, than in these expectations themselves. To be sure, if someone expected (in terms of accepting or desiring) death to happen, but could not provide any reason for such an expectation, we would not accept it as in any way guiding what to do or not to do, as we would do when someone expect (desire) to get coffee. Hence, even if there are expectations or desires which we accept without asking for reasons (often for being trivial) we should not do so when it comes to more substantial values as matters of life and death. Someone might object to this and claim that to the extent we respect the self-determination of persons we should accept what people desire, just due to the fact that they desire them and choose to act and decide on these desires, disregarding what they actually ground these desires in. However, even if it is important to respect the self-determination of persons since we believe self-determination to be good for persons and beneficial to their good lives, in matters of life and death we should not accept people deciding when death should occur on whim or without being able to provide relevant reasons for such a desire, and claiming that they just desire death to occur without having any reasons to support this desire is not a relevant reason. Hence, even if we give weight to self-determination, the desires which form the base of such determination should be grounded in something beyond themselves, and what lies beyond is in essence the reason for death to occur.

Hence looking at the different patterns in Seymour's account, what are the substantial features of the situation that allows the companions to expect (accept/desire) death to occur or life to continue? Starting with pattern one.

As touched upon before the first pattern concerns Mr Cook. In Seymours's description: "a fifty-four year old man . . . [with] a long history of chronic physical and mental illness. His companion was his estranged wife, who, although living apart from him, had continued to assume responsibility for his day-to-day care" (Seymour, 1999, p. 696).

When Mr Cook is unexpectedly recovered as a result of the medico-technical interventions and finally discharged to the home, Mrs Cook sees this as a failure and an intervention in the natural course of events. My meta-interpretation of Seymour's account is that Mrs Cook expects death to occur, since Mr Cook is suffering from severe illness. However, her expectations would also seem to be in

line with her desires, i.e. that Mr Cook should die or be allowed to die. Following Seymour again:

> For her, this intervention meant that she and her children had not only to endure a further period of extreme difficulty as they struggled to care for Mr Cook, but also . . . that, eventually, all the distressing feelings associated with his imminent death would be re-experienced.
>
> [The interventions was] disconnected both from the wider context of her husband's life and from the prolonged anxiety experienced during the years in which she had struggled to care for him and in which she has witnessed the gradual decline in his mental and physical health. (Seymour, 1999, p. 696)

The reason Mrs Cook desires that Mr Cook is allowed to die amount to considerations about her and her children's future suffering if his life is prolonged but also his own future suffering if his life is prolonged. Hence, in essence, the reason Mrs Cook regards the prolongation of Mr Cook's life as un-natural would not be the technological or artificial prolongation *per se*, but rather quality of life considerations and considerations about how long the prolongation will be. Mrs Cook says: "I mean it *was* wonderful that he got better and responded: people do get better . . ." (Seymour, 1999, p. 697)—indicating that she does not view prolongation as negative in itself, but only given the circumstances and especially when the circumstances does not allow prolongation to result in good quality of life for the dying person and/or his close-ones.

Taking a look at the second pattern which concerns Mrs Richards, Seymour describes her as a ". . . seventy-three year-old woman admitted to intensive care with a diagnosis of pneumonia and septicaemia [who] died after a withdrawal of cardiovascular drug support, three days after her admission to intensive care." (Seymour, 1999, p. 697) In the case of Mrs Richards, her death is both expected and accepted, and given the circumstances and when it occurs, the companions find death ideal or natural. In Seymour's account of Mrs Richard's daughter's views:

> . . . it was possible for her [Susan] to preserve some sense of the rightful place and natural sequence of events: death occurred only after it had become clear that such an outcome was inevitable and after all treatment options were exhausted. (Seymour, 1999, p. 699)
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> [The daughters] witness[ed] a quiet, dignified and gradual event . . . [and] the actual moment of death is recollected as timely, and its management portrayed as essentially compassionate and humanised . . . (Seymour, 1999, p. 699)

And in one of the daughter's own words:

> . . . she wasn't going to get better, then you know, fine, let's get on with it." (Seymour, 1999, p. 699)

Here the considerations amount to both considerations about whether it is at all possible to prolong Mrs Richards's life, and it is concluded that it is not possible or only marginally so. Furthermore, the discussion revolves around the quality of life of the companions viewing the death of Mrs Richards, possible future quality of life of Mrs Richards and the quality of the moment of death or very last moments in life.

Once again, it can be concluded that natural death has nothing much, *per se*, to do with the artificial prolongation of life since Seymour's account shows that the companions of Mrs Richards are given the option to have her life prolonged in order not to rob the daughter's of their mother's event of death, something they seem to view positively. Rather, why they consider the death of Mrs Richards to be natural or ideal or good (which seem synonymous here) has to do with considerations about possible future quality of life in relation to the quality of the event of death (both for Mrs Richards and her daughters).

Moving over to the third pattern, we find similar results. Here we meet Mrs Stafford, which in Seymour's account is portrayed as "a seventy-one year-old woman, who was admitted to intensive care fifteen days after undergoing elective surgery for resection of carcinoma of the bowel" (Seymour, 1999, p. 699). After having partly recovered from the operation, some complications developed and she ended up with respiratory failure and depressed consciousness. She recovered enough to be discharged from the intensive care unit, but six days later she suffered an acute deterioration ending up with a cardio-respiratory arrest. She died after an unsuccessful resuscitation attempt was made. In this case, Mrs Stafford's companions—a husband and daughter—found death un-natural since they expected and desired Mrs Stafford to survive.

Here it is interesting to note that they find it un-natural that it is not possible to artificially prolong the life of Mrs Stafford. In the words of Seymour, it was considered: "a betrayal of their faith in medical expertise and technology." (Seymour, 1999, p. 700) From the account it seems obvious she was not considered to be dying, primary to her undergoing elective surgery. She was rather expected to continue a good-enough life, after having undergone surgery her recovery is described in the following words:

> . . . Mum was starting to do perfectly well and for doing that to and then to die; its absolutely heartbreaking. (Seymour, 1999, p. 701)
>
> It was just, my mum was amazed herself, she just kept pointing to her stomach, she just couldn't believe where her stomach had gone, and you know, she was dozing off, but she looked really 100%, she looked the best she'd looked for years and years, she looked really fit. (Seymour, 1999, p. 700)

In effect, it would seem that the un-naturalness of death has more to do with the fact that death robs Mrs Stafford of a possibly good future life and not with whether life is artificially prolonged or not. In other words, if her life would have been successfully prolonged—artificially or not—this would seem to be considered natural. Once again, the concept of natural is used more or less synonymously with the concept of good, i.e. as a more or less purely evaluative concept with an open descriptive content. To the extent there is a common descriptive aspect to the concept, it is less about artificial prolongation or not and more about death happening as a logical or consistent consequence of what has happened before, as Seymour notes. However, logic or consistency in a strict sense does not come into this. It is not illogical or inconsistent in a strict sense that Mrs Stafford dies or that

Mr Cook continue to live—it is only illogical or inconsistent in the more loose sense which we give these terms when we say that if we view the circumstances as A we expect B to follow, but we might not have good reasons for either believing the circumstances to be A or even that B generally follows from A. Rather, in these cases A and B has more to do with hopes and values than with relations between facts.

In conclusion I will argue that we might again view the talk about natural death as of no real substantial action-guiding content but more as a value-laden concept expressing a positive evaluation of the situation based on other considerations about the facts of the situation, facts that boils down to considerations in terms of quality and length of life.

CONCLUSIONS

In this article I have looked at some current uses of the concept of a natural death within end-of-life decision-making and found that the concept both suffers from having a number of ambiguous and/or non-acceptable connotations, but also from being of no real substantial use within the context of end-of-life decisions, since the considerations behind the use of natural death has more to do with quality and length of life and not with whether death is natural or not.

Hence, if we are interested in being succinct and precise when talking about what is at stake in end-of-life decisions we should avoid confusing talk about a natural or un-natural death and instead focus on the kind of quality and length of life considerations which are really at stake. In the end my answer to the question in the heading is that it is of little interest whether people die natural or un-natural deaths and we should instead ask whether people are given the opportunity to die deaths which are the result of their own considerations about length and quality of life.

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