Life Extension and the Domination of the Body

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Abstract

This paper investigates the prolongevitist debate; that is, the debate surrounding whether to extend human lifespans through medical technology (prolongevitism) or not (apologism). Apologists such as Daniel Callahan emphasize an approach to this debate which focuses on social self-criticism and ideology. I investigate the way the ideology of medicine Callahan describes enables modern medicine to dominate the body and discover that this ideology relies on a dualist conceptual structure. I describe the way in which mind/body dualism functions as an important component of this ideology of domination. By identifying this dualist structure as an essential component of the ideology of medicine, I make it possible to critique and find alternatives to potential solutions to this ideology of medicine. Through this strategy, I criticize standard apologist responses to the prolongevitist debate. While I share the apologist concern regarding the ideology of medicine, I believe their response to the problem of ideology is inadequate. I find alternative answers to the question of how to overcome the ideology of the body through theories of discourse and phenomenology. My new approach emphasizes cultivating a positive embodiment relationship through phenomenological practices and the criticism and creation of new discourses of the body.

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INTRODUCTION

 When I began this project, movies like *Transcendence* and *Lucy* were coming to the box office: films that had transhumanist themes, with heroes obtaining incredible power by overcoming the limits of their biological being and conquering mortality through technology. It was not just popular media playing with the transhumanist vision, though. I found myself meeting increasing numbers of academics, including a panel at Philopolis Montreal, who were inspired by the ideas of transhumanism.

 I myself was incredibly curious. Not at the idea of conquering biological limits through technology, though. I was inspired by the sudden ubiquity of these themes. Why was this idea, this fantasy that technology would enable us to escape biological limitation, especially in the case of mortality, so attractive to so many people? My hypothesis was that this transhumanist dream was not something completely new, that it had its roots in ideas about technology, medicine and the body that came before it, but that perhaps this was a concentrated, more extreme expression, a kind of ad absurdum, of the structure we had already internalized. This is why I set out to investigate the debate surrounding prolongevitism, the project of human life extension, and the interplay of medicine, power, and the body upon which the prolongevitist debate is based.

 The first section of this thesis focuses on the prolongevitist debate as it currently stands. I begin by outlining some of the recent technological developments that have made human life extension a viable possibility and giving some background on the diverse factions within the prolongevitist movement and their justifications. There are two reasons I begin by describing the current state of medical research in human life extension. Firstly I want to show that this project is more than a conjecture of science fiction. Much of my audience is part of a generation that may see dramatic life-extending technology develop and have to wrestle with the consequences of it. A second more subtle reason to begin by describing this research is to show medicine as a tool of human power over the body.

 Since I am focusing on power over the body, I want to make it clear that I am approaching the problem with a theory of power that focuses on 'power over' others rather than merely a 'power to do' something, in other words, on control of other beings, including nonhuman beings, rather than simply capacity to act (Allen). As will become evident later, I am also espousing a systemic and constitutive model of power rather than a model that is strictly action-theoretical (Allen). What I mean by this is that I am not examining solely individual actors in atomistic terms, but rather I am operating on an understanding of power that shapes the world, its actors, and its possibilities. Power shapes the way we think, act and exist. Even the concept of power itself is shaped by power relations (Allen). As such, I recognize that power is everywhere and cannot be avoided. Simply recognizing the influence of a power structure is not enough to say it is problematic. When I want to make it clear that the exertion of power is unjust or illegitimate (Perhaps, for example because it is inappropriate, excessive or harmful) I will refer to it as domination. The project of delineating when power becomes domination is an ambitious task outside the scope of my project, but I hope to show that the domination of the body is at least one case that is clearly problematic and needs to be resolved.

 After describing the current state of life-extending research, I trace the arguments for and against prolongevitism. Prolongevitism is the position that the human lifespan can and ought to be extended. Its opponents, whom I will call apologists, believe life cannot and/or should not be extended (Overall, 16). I use Christine Overall’s *Aging, Death, and Human Longevity* and Daniel Callahan’s *The Troubled Dream of Life* to illustrate the perspective of prolongevitism and apologism respectively. From Overall I gather that human life extension is justified on the basis that life is instrumentally valuable for the goods it brings, but it is unclear that there is no limit to how long life should be extended. From Callahan I gather that there are harms that arise from the cultural attitudes prolongevitism relies on (such as, for example, the cultural attitude that places autonomy and control at the centre of dignity). It is because of these harms that we can say the exercise of power that medicine exerts over the body is a domination. In the face of this domination, he espouses 'acceptance' of death, what other philosophers might describe as 'receptivity' (Jordan, 182). This value of receptivity is fairly ambiguous. For Callahan, it appears to mean merely 'not-dominating', that is receptivity is defined negatively, and the consequences of this for Callahan appear to be merely not extending human lifespans. I believe focusing in on these 'cultural attitudes' and understanding how they operate can give us a much clearer idea of how to proceed.

 Attitudes, or collections of ideas and beliefs which a culture internalizes that facilitate power structures (especially relations of domination) are ideologies. In the next section, I provide an anatomy of ideology and apply my description to the ideology of medicine. By ideology of medicine I mean the collections of ideas and beliefs underlying the practice of modern mainstream medicine in our culture. I discuss the internalization of ideology and the difficulties of exposing it. I use Val Plumwood's hypothesis that the conceptual content of ideologies has a dualized structure to explain the conceptual content of the ideology of medicine and the body. These dualized structures that are the hallmark of ideology take distinctions (that is, differences we can use to categorize subjects) and hierarchize these distinctions as dualisms so they can be used to facilitate domination. I demonstrate how backgrounding, instrumentalization, and hyperseparation (which she also calls radical exclusion) reinforce this dualist structure, and I show how medicine as an institution participates in a discourse that shapes this ideology.

 After the ideology of medicine has been uncovered, I return to the task of addressing it. I show how Callahan's idea of receptivity as 'acceptance' is not sufficient because it still plays into the dualistic structure he is trying to overcome. Then I discuss how other strategies of overcoming ideologies have failed in the same way in that they maintain the dualism they are trying to escape. Finally I try to offer up some potentially useful tools that might help undermine this dualistic thinking. The tools I propose, such as critical discourse and phenomenological approaches to cultivate positive embodiment form a more sophisticated concept of receptivity which recognizes and addresses the dualist structures underlying this problematic ideology of medicine. I emphasize cultivating a positive relationship with one’s body, an experience of the body that emphasizes recognition and mutuality, which I call positive embodiment by seeking out phenomenological experiences that bring the agency and significance of the body to the fore and bringing those experiences into critical discourse to build new understandings of the embodied self.

 Lastly, I return to the prolongevitist debate and apply what I have found. Essentially, my conclusion is that moderate human life extension can be done in a way that is receptive, and prolongevitists should not be so quick to criticise the idea that receptivity is an important part of a good death. Furthermore, apologists need not see the consequences of accepting receptivity as passively submitting to death when it comes. It is possible to make balanced and responsible decisions about death and life extension provided one has cultivated an appropriate attitude toward embodiment.

 I hope this project enables our society to make responsible technological and medical decisions in a time of rapid technological change. If a positive embodiment is prioritized as an influence in end-of-life decision making, we can cultivate better deaths and better lives.

I: ON PROLONGEVITISM

1.1) The Possibility of Life Extension

In this section, I discuss the technological conditions in which human life extension has become a viable possibility, followed by a discussion of the spectrum of prolongevitist positions, and the justification for these positions.

The human self-preservation instinct is expressed in many ways. Not only do people try to preserve themselves in the physical sense of survival, but they also create works that will outlive them, or see their offspring as a means of continuing themselves. Self-preservation is also expressed beyond the level of the individual. We have come to value the survival of groups: from the family, to the community, to the nation as a whole, our entire species, and even recently whole ecosystems. Self-preservation is a fundamental element of our projects as human beings, and because it is so central to our existence it demands serious philosophical examination.

Science and technology have had an important role in this enterprise of self-preservation. In the most recent centuries, modern medical practice has helped us to greatly increase the average human lifespan (Callahan, 42-48). These adjustments to the average human lifespan, however, have been a product of reducing infant mortality and deaths from infectious diseases through improvements in nutrition and water purity, as well as developments in medicine and public health (Overall, 11). As fewer young people die, the average lifespan increases, but despite this increase the maximum lifespan has remained stable at 120 years (Overall, 10). On the horizon, the possibility of increasing our maximum lifespan is looming, however, and life extension of this nature will have an enormous impact. Advancements in technology have led us to ask new questions about the new possibilities of medical technology. It may soon become the case that we no longer need to be confined by the limits nature sets for us, and our expectations of the human lifespan will be for us to decide.

To illustrate, one example of recent research that could produce the technology that enables us to extend lifespans is a metabolic coenzyme, Nicotinamide Adenine Dinucleotide, abbreviated as NAD+, which when injected into mice was shown to reverse muscle senescence (Winter, 2013). This treatment is currently being tested on humans in small studies for potential side effects, although it is unclear if the anti-aging effects shown in mice can be replicated with humans (Winter, 2015). Such technologies will have a huge impact on how humans age, at least for those who can afford such treatment.

 But NAD+ is not the only way scientists are reversing cellular aging. By using modified RNA, researchers were able to extend the telomeres of human skin cells, allowing them to multiply much more rapidly as younger cells would, rather than stagnating and dying. The researchers hope this application can be used to treat diseases associated with aging (Blau, 2015)Reversing cellular aging is just one approach (although a seemingly promising example) modern medicine is considering for human life extension. Scientists are also considering other more ambitious methods involving nanotechnology (Kurzweil and Grossman, 4), body part cloning and replacement (Overall, 12), or genetic modification (Kurzweil and Grossman, 4, Overall, 12), to name a few.

 Given the current state of medical research, it seems likely that quite soon we will have to face some serious questions about human life extension. These questions are especially difficult and interesting because they take place in a field heavily influenced by our attitudes toward power: the human self-preservation instinct is expressed through medicine and technology. Medicine is the tool through which the human will to live is exerted on the body. Because medicine changes the body according to human will, it is a tool of power. On one hand stands death as our ultimate finitude, the end of any possibility of will or expressing one's will. On the other hand stands technology, the means through which we change the world according to our will. To better understand how to navigate this entanglement, we must begin by surveying the debate surrounding human life extension.

1.2) Prolongevitist Arguments

Those who support these life-extending proposals call themselves prolongevitists and claim that we ought to pursue these new possibilities. Avoiding death appeals to our self-preservatory instincts, but the prolongevitist position does not lean solely on such intuitions. There are many purported justifications for the extension of human lifespans. In her work, Christine Overall problematizes some of these justifications.

Some approaches to the justification of prolongevitism have claimed that extending the lifespans of the elderly has social, economic and technological benefits for society. (Overall, 117-121) For example, such an approach might be justified by the claim that children who have meaningful relationships with elders develop a stronger sense of empathy and that this benefits society. Overall rightly rejects such positions in that they instrumentalize aging people, asking them to justify their survival in terms of their usefulness to others.

Still others say that the reason human lives should be extended is because longevity has inherent value (Overall, 98). These prolongevitists might take an example such as an antique piece of furniture, or a centenarian tortoise, to show that things with longevity have greater value. Therefore, such arguments claim, longevity in humans should be valued and pursued as well (Overall, 97). The problem with these arguments is that the examples cited are not valued strictly for their longevity, but for the qualities they acquire by virtue of their longevity. For example, the antique furniture acquires its value not because of its age, but because of its value as a historical object that helps us to understand more about past times. In the case of the tortoise, the animal has value not by virtue of its age but by the possibilities it affords us in understanding the natural world. In the case of people, we value age because it can give us wisdom, experience, and knowledge, but also because reaching old age is viewed as a kind of achievement brought on by a well-lived life (Overall, 97). It is not the longevity in these cases that is valued, but rather properties these objects, animals, and people acquire as a result of their age.

Lastly, some prolongevitists have argued in favour of prolongevitism on the basis that life is valuable. Overall raises several problems with a value of life that is understood as intrinsic, but sees great potential in a prolongevitist argument that sees life as instrumentally valuable. One problem with the claim that life is intrinsically valuable is that if life is intrinsically valuable, then it calls into question practices such as euthanizing animals or allowing suffering people to die, which in many situations strike us as being very humane (Overall, 98). Another bizarre consequence of a commitment to the intrinsic value of life is that more life would be better, not just in terms of the length of individual lives but also in terms of the quantity of lives, so it would appear to leave us morally obligated to create as much life as possible, for example by having as many children as we could regardless of the quality of life they would be afforded (Overall, 99).

I believe Overall’s justification for prolongevitism, which is not based on the intrinsic value of life, is more easily defended and more intuitive. Overall claims life has instrumental value as a means to other valuable things:

It is the perceiving, planning, enjoying and acting features of human lives that have a high degree of moral significance. Capacities such as sensing, remembering, anticipating, feeling, thinking, valuing and choosing, enable human beings to live lives that are fully realized. Although we may not be able to go so far as to say that these features, or human lives possessing them, are intrinsically good, the prospect of ongoing opportunities for experiencing and doing, competence and creation, makes the possession and extension of human life valuable (102).

Inasmuch as anything in our lives has value then, life has value for us, and this means that life is a good, therefore it is reasonable for one to seek to preserve one’s life (Overall, 13, 17, 29, 104, 122). Overall emphasizes this point, explaining that in situations where others are tempted to end their lives we encourage them to continue not because life or experience itself is intrinsically valuable, but because the capacities listed above are still possible, can still be realised if that individual’s situation improves (103). It is because we have and value these capacities that we value our own lives, and because we have seen that modern medicine can preserve these capacities, that we may be inclined to agree with prolongevitism and see the extension of human lifespans as a worthwhile endeavour.

Despite the persuasive power of such an account, some problems still arise if we continue to trace the trajectory of this logic. Overall recognizes one such problem when she says, “One is led into difficult questions about just how much life is long enough. If prolonging life is, *ceteris paribus*, desirable, are there any reasonable limits to the length of a good life?” (122) A recent movement has emerged out of transhumanism, forming perhaps one of the most radical prolongevitist positions yet. Transhumanism is a movement that "promotes an interdisciplinary approach to understanding and evaluating the opportunities for enhancing the human condition and the human organism opened up by the advancement of technology." Transhumanists such as Ray Kurzweil say that medicine should aim to extend human life indefinitely (Kurzweil, 171, Kurzweil and Grossman, 4). Kurzweil’s position is that baby boomers who maintain their health now can (and ought to) potentially live long enough to see the life-extending technology of what he calls the biotechnology revolution, the life-extending benefits of which will enable them to survive long enough to take advantage of changes in nanotechnology and eventually AI, "Which has the potential to allow us to live indefinitely" (Kurzweil and Grossman, 4). Kurzweil believes people today have the capacity to live, in his words, “forever” (Kurzweil and Grossman, 3).

The prolongevitist position seems to suggest that the body is so extremely malleable that given the right science and the right technology, we can bend the body to the human will. Take, for example, Kurzweil’s personal self-preservation regimen:

I have been very aggressive about reprogramming my biochemistry. I take 250 supplements (pills) a day and receive a half-dozen intravenous therapies each week (basically nutritional supplements delivered directly into my bloodstream, thereby bypassing my GI tract). As a result, the metabolic reactions in my body are completely different than they would otherwise be. Approaching this as an engineer, I measure dozens of levels of nutrients (such as vitamins, minerals, and fats), hormones, and metabolic by-products in my blood and other body samples (such as hair and saliva). (Kurzweil, 172)

Of course, Kurzweil’s practice is an extreme example of prolongevitism, but all prolongevitists rely on the assumption that the body can and ought to be modified and controlled by medicine. Such an approach to health suggests that human control of the body is something that is justified and does not need to be questioned. The prolongevitist position seems to take for granted that the human body is something that can and ought to be shaped to human ends, and that technology can facilitate this process in a way that is legitimate and reliable. This undercurrent should be cause for concern, as I intend to show. Nevertheless, Overall’s work suggests there is some legitimacy in the project of life extension when the instrumental value of life is recognized.

1.3) Some Less Satisfying Apologist Arguments

Certainly the prolongevitist spectrum is broad, but there are also those who completely reject the premise of prolongevitism: the apologists. Daniel Callahan is one such critic of prolongevitism. Before I address his more serious criticisms of prolongevitism (and the underlying problem that binds these criticisms together), I would like to set up and address his weakest arguments against lifespan extension. Callahan makes some (in my opinion, unsatisfactory) attempts at explaining why death should be accepted not for the negative effects of rejecting death, but for some benefits death might have to contribute. Firstly, he claims death can have a good side because it creates piquancy in life by limiting it (Callahan, 170). Secondly, Callahan claims death gives life a sense of completion (170). Callahan further claims that dying populations make space for more young people to be born (170).

The first argument, which claims that death brings piquancy to life, claims that once one reaches a certain age there can be nothing new to experience or to achieve, and so one would not want to continue living. Life has played itself out, and the excitement of discovery is gone, so one ought to simply accept death. However, one can always have new and exciting experiences that make life worth living, and enjoy old experiences anew, as Overall says in dismissing this argument (49). In the case of definite life extension, Overall’s rebuttal rings true. While Callahan suggests that a maximum lifespan of 80 years would be sufficient, I find it difficult to believe that another 20, 40, or even 100 years could not be used in a productive, rewarding way. Perhaps in the context of a radical, indefinite lifespan extension, as advocated by some transhumanists, this critique might carry some weight (after all, forever is a long time), but a moderate prolongevitist like Overall is certainly right not to take this criticism too seriously.

Callahan’s next argument, that death gives life a sense of completion and fulfillment, proves to be somewhat circular. Callahan seems to believe that any goal worth aiming for can be achieved within an 80-year lifespan, and therefore we should satisfied with the brackets of time we are allotted. With an unclear limit on lifespan, there would no obvious closure. Overall addresses this claim by explaining that how we define a full life is relative to the lifespan we expect (47). In a society where the maximum lifespan is 80 years, one would grade their expectations according to the maximum lifespan, and decide that a life in which one could fulfill the kind of goals appropriate for an 80 year lifespan would be a fulfilled, completed life. However, in a society where the maximum lifespan would be 150 years, the expectation of what made a complete and fulfilling life would be adjusted according to that norm. For example, in an 80 year lifespan, I might decide a reasonably full life would involve attaining a reasonable amount of education, building a relationship with a significant other, having a fulfilling career, having children, enjoying retirement, and spending time with my grandchildren. However, in a 150 year lifespan, I might expect to attain an education in several fields, enjoy higher levels of mastery in multiple crafts and careers, build a meaningful relationship with a significant other, or perhaps several fulfilling serial relationships, and get to know my great grandchildren. This argument does not need to be made strictly from conjecture. As the average lifespan has increased, we already see young people spending more time obtaining education and waiting to have children. Of course, this trend is encouraged by economic forces and academic inflation.

A moderate prolongevitist such as Overall is right to not take Callahan’s criticism that life gains a sense of completion from mortality seriously. Perhaps Callahan’s criticism would be stronger as a rebuttal to more extreme forms of prolongevitism, such as a form which advocates for indefinite life extension, as there would be no foreseen goalpost at which one could set one’s conception of a decent, fulfilled life; but to characterize this criticism as a serious problem for a moderate prolongevitist would be to misrepresent her position.

Callahan claims that the death of the elderly makes way for new populations. While this is true, it isn’t clear why current elderly people should be expected to accept death to make way for potential future populations. What seems implied here is the ageist and problematic assumption that somehow the lives of old people are less valuable than those of young people, a subject I will expand on later, as I explain Overall’s criticisms of what I call the stronger arguments of apologism. There are other more vehemently ageist arguments claiming that elderly people have a duty to die to alleviate the burden of their continued survival on younger populations. This argument suggests that the lives of old people are less valuable than even the *resources* of young people, and I take this position to be dehumanizing and instrumentalist. My discussion of ageism in the latter section on Overall’s objections to Callahan may further clarify why apologist arguments based in a duty to die are objectionable, however I will not be focusing on apologist arguments based on a duty to die.

While there are several apologist arguments that are weak, problematic or objectionable, I do believe Daniel Callahan manages to identify something contentious in prolongevitism that deserves further investigation. In the next section, I will narrow in on the objections he makes that have some value to the discussion.

1.4) Stronger Apologist Arguments

 In this section, I outline Daniel Callahan’s stronger apologist criticisms of the prolongevitist position. He recognizes two trends in the model of medicine which, when combined, produce several harmful effects, both to those who are dying and to medical practitioners. I believe these two trends need to be seen as components of an ideology of medicine to be fully appreciated and addressed.

Callahan’s strongest criticisms of prolongevitism rely on two related ideas about what prolongevitism is. Firstly, Callahan sees prolongevitism as the product of a model of medicine which pits itself against death, rather than trying to improve quality of life or facilitate an acceptable death. He reinforces his viewpoint by noting frequent militant imagery to describe the conflict between the ideology of modern medicine and death (Callahan, 51, 57, 73-74, 156). Noted transhumanist prolongevitist Ray Kurzweil certainly exemplifies this when he writes: “We consider the process of reversing and overcoming the dangerous progression of disease as a war. As in any war it is important to mobilize all the means of intelligence and weaponry that can be harnessed, throwing everything we have at the enemy.” (Kurzweil, 172) For Callahan, modern society has reduced ‘death as part of life’ to an empty cliché devoid of any real content (Callahan, 18). Rather, death is something constantly rejected and pushed away as alien.

The second concept, closely related to the first, is that prolongevitism foolishly places human beings outside and above nature (52, 62-63, 125-126). We have pitted ourselves against the unstoppable natural force of death, assuming it is a deficiency that can be corrected, if only we have the appropriate technology (58). Callahan summarizes these concerns beautifully when he says, “where a lethal nature once held sway, roughly and unilaterally asserting its force, technological artefact has been brought in to take its place. Medicine has worked to bring nature to heel, to exploit nature itself cleverly to overcome the limits that it set on our biological lives” (58). Like Icarus and his wax wings, medical technology is supposed to carry us outside the limits nature has set for us, but Callahan suggests that there will be a cost for our hubris.

Callahan identifies these two trends (in which medicine pits itself against death and in which humans are seen as outside of nature) and shows how they result in a series of harmful effects on those who are faced with their own mortality as well as the medical practitioners who strive to support them. In a system where the model of modern medicine pits itself against death, Callahan claims, emphasis is placed on ‘solving’ death rather than acknowledging it and coming to terms with it. If death is seen as something that must be treated and prevented, then it is a human and professional failure when we cannot do so. This is why we tend to avoid the subject, shunning it rather than resolving our feelings about it (29-30). We focus on medical decision making and the process of managing death rather than focusing on our feelings, needs, and relationships through introspection, conversation, reflection, social connection, and ritual (13, 41, 128-129). Technology gives us options for managing death, but this freedom does nothing to enhance our ability to understand and come to terms with it, in fact, it appears to discourage such an approach (36, 58). In a culture where death is something that must be mastered, working through the inward, emotional side of the problem becomes devalued and mourning is not taken seriously as part of the process (129, 157). Callahan seems to be genuinely concerned for the well-being of the dying and their loved ones when he says “our goal should be to create a dying that is accepted without overpowering fear and a death that has lost its power to terrorize” (53).

Another way, according to Callahan, in which a model of death as something dominated and controlled by modern medicine is harmful is that it is the product of a matrix of values that are packaged in the liberal concept of the self that valorizes self-control, self-determination, and self-direction (121). Callahan believes these ideals are fundamentally out of touch with our human reality. We are weak, we are vulnerable, and we are subject to human nature (123, 125, 158). By holding independence, separation, and transcendence (both from others and from natural forces) up as the human ideal, we can do a great deal of harm to those being subjected to these forces because they experience the succumbing as a loss of dignity (130-144). Inasmuch as we are embodied beings, social beings, and beings with needs, in other words human, we are all vulnerable. (Mackenzie et. al., 4-5) To treat such vulnerability as a source of shame by valorizing such impossible conditions as independence, separation and transcendence is to set up an unattainable standard for dignity.

 Not only does this model of medicine as a master over the human body (and, therefore, human beings as masters over nature) harm patients, but it also impacts medical practitioners. Callahan explains the idea of the technological imperative, which insists that because one has the means to save someone’s life one ought to (84). Intuitively, this imperative seems very reasonable, but it leads to technological brinkmanship, in which doctors try for as long as they can to preserve human life, until they cross the threshold of causing more harm than good (40-41, 45, 46). This is because it is increasingly difficult to draw boundaries between when intervening medically can be fruitful and when patients will die whether we intervene or not (42, 44). This pattern leads to what Callahan calls ‘technological monism’, in which natural death and death as a result of medical failure are conflated. It is difficult to tell whether more could have been done to save a patient, and so a natural death is seen as a professional as well as a human failure (68). Callahan explains this reduction of natural and human causes to solely the realm of human agency, saying, “each death is understood as in principle a medical and thus a human causal and moral responsibility” (68). This can be a great cause of guilt among medical practitioners, as they internalize a sense of responsibility for what is ultimately out of their hands (69, 65, 59). While particular causes of death may be preventable, death itself is an inevitable fact for each individual.

 By pointing out how modern medicine's exertion of power over the body has harmful effects, Callahan shows this exercise of power has become a domination because it has become inappropriate, excessive and harmful. Recognizing the harmful effects of these ideas is certainly a serious criticism of prolongevitism. Callahan advocates for an 'acceptance of death', which, as I show later, equates to a choice not to extend human lifespans and rather to allow the elderly to die by not providing treatment. Other authors have expressed a similar idea of acceptance in the language of receptivity (Jordan, 182). M.C. Jordan describes receptivity as a component of dignity, an intrinsic good that consists of working within and accepting natural limits (including the limits of the body) rather than fighting against them. I am sympathetic with Callahan's concerns involving our cultural attitudes toward the body and nature and provoked by the idea of receptivity, but I believe receptivity is understood too simplistically. To take a closer look at these cultural attitudes and how they support the exercise of power (specifically medicine's power over the body), we must see them as a form of ideology. When these cultural attitudes are understood as components of an ideology of medicine, we can have a more robust understanding of how they operate and how to overcome them.

II: THE IDEOLOGY OF MEDICINE AND DOMINATION OF THE BODY

2.1) What is Ideology?

 Callahan makes an interesting and useful move by reframing the prolongevitist debate from purely 'practical' concerns to focus on culture. Human beings are social: we adhere to groups that shape our beliefs and practices. The beliefs, symbols, and images of a particular group are what we call culture and the process through which culture changes is called discourse. When we want to highlight the aspect of culture which pertains to power we use the word 'political'. Our experience of death is always mediated by our social and cultural environment, and the application of medicine, because it is a form of power over the body, is therefore political.

 Identifying and challenging cultural ideologies is a difficult task, as noted by many feminist philosophers. Bioethics, for example, has until recently focused primarily on specific issues such as provider-patient interaction “rather than raising questions about the political role of medicine or cultural self-criticism” (Sherwin, 86-87). Overall distances herself from this tendency in bioethics, saying, “This is not a book about the standard end-of-life issues, such as suicide and the so-called right to die, assisted suicide, and active and passive euthanasia, topics that are the usual focus of biomedical ethicists.” (14-15) She emphasizes the importance of the question of prolongevitism, explaining, “Exploration of this issue raises central questions about the nature, value, and meaning of human life itself, and its social and cultural context.” (Overall, 13)

 Callahan also shows concern about the superficiality of common bioethics questions, without realizing the connection between that superficiality and ideology. Callahan places emphasis on an approach to death that focuses on self-examination and reflection rather than merely making decisions, and says, “The debate has mainly been about law, regulation, moral rules, and medical practice, and about making legal, or ethical, or medical choices about dying. It has not been about death itself, about how we should think about it in our lives.” (Callahan, 13) When he claims the question he wants an answer to is “What kind of stance should be taken toward death by our culture?” (Callahan, 14) essentially he is asking what kind of ideological attitude toward our mortality we should take.

 Clearly both Overall and Callahan are concerned with a cultural criticism of the way we conceptualize death. It shouldn’t be surprising that our approach to death is a politically salient topic, because after all death is our 'ultimate finitude' (Callahan, 85). Death is the end of any possibility of exerting power, therefore exerting power over death is the means through which we preserve our power.

 It is with the cultural context of prolongevitism in mind that I propose that the 'values of medicine' Callahan critiques are in fact part of a broader ideology of the body that is deeply problematic. In this section, I want to provide a picture of what ideology is and how it operates. After this, I will discuss the conceptual content of this ideology and the discourse within medicine as an institution that reinforces this ideology.

 An ideology is a collection of related ideas and beliefs that reproduce power relations and are mainly unconscious, that is they must be uncovered through a process of analysis (Code, 196-197). Patriarchy, racism, classism, ableism, ageism and anthropocentrism are all examples of hierarchical systems that have their accompanying ideology. For a long time, philosophers believed that it was possible to form observations that are unaffected by one's beliefs and assumptions. (Goldenberg, 2623) Such an approach assumes the possibility of an unconditioned observer who is a "neutral spectator… separate from the objects of knowledge". (ibid, 2624) But recent philosophers of science (ibid 2623), as well as feminist epistemologists, Marxists and ecofeminists have come to recognize that "facts are theory-laden, theories are value-laden, and values are moulded by historical and philosophical ideologies, social norms, and individual processes of categorization." (Gruen, 124) Because there can be no value-neutral observers, there can be no value-neutral observations, and the way we make sense of these observations (i.e. the theories we compose) will be in accordance with the values we hold. The values in which theories are grounded tend to be those of a narrow, privileged group, but are presented as allegedly 'objective' 'value-free' and 'neutral'. (Sherwin, 93, Jagger, 188) This is because ideology is internalized (and therefore obtains the appearance of some kind of objective truth) but also because discourse, the process through which cultural ideas and beliefs develop and change, amplifies the voices of those with more power.

 Because ideology is internalized, the way ideology presents the world is to us is naturalized. (Code, 196-197) Because ideology is mainly unconscious it requires analysis to correct. Marxists have frequently reflected on the way in which ideology allows us to accept even explicit contradictions without a question because of the depth at which we internalize these worldviews. Anthropologists will refer to metaphors such as 'fish examining water' and 'pushing the bus one is riding' to convey the difficulty of overcoming the ideology to which one subscribes (Martin, 11)

 When we use the term ideology, we tend to refer to ideas and beliefs that have a fairly broad scope. We can have, for example, Western ideology, North American ideology, or Canadian Ideology. Institutions can subscribe to an reinforce ideologies. Subcultures can have ideologies as well. We do not speak of ideology at the level of the individual, but in the process of discourse ideas and beliefs can move from individuals to larger groups and institutions and back again. Larger groups and institutions affect the belief systems of the individual, and the individual (often with the help of subcultures) can influence the ideology of larger groups and institutions. As will become clear in my latter explication, however, the process of discourse has a tendency to amplify the voice of those who already have more power in discourse, making their needs and desires a greater priority.

 Exposing ideology is a process in which one must constantly engage. Because ideology is so deeply engrained, even those who become aware of it have to struggle constantly against internalized ideological inclinations to check themselves against systems of thought they have internalized. During her work interviewing women on their experiences of pregnancy and childbirth, anthropologist Emily Martin came face to face with this problem. Her subjects often talked about childbirth as something they went through rather than did, as their contractions were involuntary. Martin realized she had always accepted this account of pregnancy as a brute fact, rather than a cultural organization of experience. She reflects, "The length of time it took me to make this shift stands as a vivid testimony to how solidly entrenched our own cultural presuppositions are and how difficult it is to dig them up for inspection." (Martin, 10-11)

 The ideology of the body will prove an especially difficult concept to address, because "as embodied humans investigating embodiment, we are in the thick of things: we can't remove ourselves to some detached point from which we can reflect on what being bodied means." (Scully, 7) Examining ideology must entail a stepping back from the way we understand our experiences, and this distancing is especially difficult in the case of something as intimate as one's own embodiment.

 Surely there are many obstacles to a critical examination of the ideology of the body. I believe philosophy can be a useful tool in uncovering the beliefs we have internalized. However, rather than understanding philosophy as an "attempt to overcome social and historical structures to reach into an ahistorical platonic world of pure being" (Lloyd, 108) I think we must recognize whatever new structure we implement as also constructed, also responding within a social and historical context, and furthermore as a structure that can and ought to be altered or destroyed when needed (although perhaps with some difficulty). We cannot raise our inquiry to some other realm: there is no space 'outside' ideology. This inability to escape ideological space raises some problems I intend to address later, but with an understanding of what ideology is and how it works I would like to move on to the conceptual content of the ideology of the body.

2.2) Dualism and the Body

 Val Plumwood's *Feminism and the Mastery of Nature* investigates the thesis that "forms of oppression from both the present and the past [including oppression on the basis of race, gender, and class, as well as the oppression of nature] have left their traces on western culture as a network of dualisms, and the logical structure of dualism forms a major basis for the connection between forms of oppression" (2). In other words, Plumwood's central thesis is that the hallmark of oppression is a dualist conceptual structure. A distinction is any difference that can be used to separate one's experiences into categories (43), but these distinctions become dualisms when they are placed in value-based oppositional hierarchies, so they can be used as the basis for denied dependency on a subordinated other (41). Some examples of distinctions that have become dualisms through a relation of domination and subordination reason/nature, male/female and mind/body. So, for example, in the case of the male/ female dualism, men's dependency on women has been denied and women have been subordinated under men. Thus, a dualist conceptual structure serves as the marker of gender-based oppression. Through the denial of dependence and relation of domination and subordination, each side of the dualism shapes the others' identity of dominator and dominated. What we mean by 'female' is shaped by its relation of subordination to its dualist opposite, 'male'. To be clear, this is not because 'male' and 'female' are actually opposites, but because they have been conceptually categorized this way. Because Plumwood sees this dualist relation as the underpinning of many forms of oppression rather than strictly or mainly gender-based oppression, she focuses on the problem of 'dominator identity' rather than merely 'masculine identity' as feminists before her have (72).

 Many feminists have claimed this dualistic pattern of thought has its origins in Cartesian mind/body dualism, but Plumwood recognizes the Platonic dividing line as the point at which the conceptual ground for the hierarchy was lain. It was with Platonic philosophy that nature became associated with the bodily, emotional, sensory, animal, wilderness, nonhuman, barbarian, feminine and temporal (80), and logos (which in the enlightenment took the form of rational subjecthood) became defined relationally as the exclusion of nature and its correlates (88).

 If this dualist conceptual structure is a hallmark of ideologies of dominance, and there is an ideology of dominance of the body (which Callahan describes as the ideology of medicine) then we should see it in the way our culture conceptualizes the body. Plumwood claims these conceptual dualisms are re-enforced in five ways: backgrounding, hyperseparation, incorporation, instrumentalization, and homogenization. I believe the dualism of mind/reason and body is especially clear in the way it is reinforced through backgrounding, hyperseparation and instrumentalization. Callahan implicitly refers to some of these patterns of domination in his investigation of prolongevitism, especially science and humanity`s domination of nature. He claims medicine, as a science, “assumes the possibility of dominating, manipulating, and redefining nature and its potencies.” (Callahan, 126)

I take 'nature' and 'natural' as a kind of shorthand for that which is outside the realm of human manipulation at present. Nature stands in contrast to 'humanity' and that which is 'man-made'. This distinction is rooted in an alienated account of the relationship between humans and nature, in which humans are apart and outside of nature as external controllers rather than at home in it (Plumwood, 71). Sometimes nature is that which cannot or should not be taken into the realm of human control, such as 'human nature' or sometimes nature is presented as that which ought or will soon come into the realm of human control, for example, 'natural resources'. Technology and science are means by which human beings take nature into control. In the case of prolongevitism, the nature that Callahan is concerned about is the nature of the body, and the science by which that control is taken is medicine. Callahan means to say that the body, which is 'natural' in the sense of being outside human control, is the type of nature which ought not to be taken control of, rather than the type that ought to be. In Plumwood's language we see an alignment of dualistic systems: on one side is the human, technology, science and medicine, which control the underside, that is, nature and the body. This acceptance of a hierarchized dualism, in which medicine controls the body, is the content of the ideology of the body I will investigate. I intend to show how this dualism is re-enforced in terms of backgrounding, hyperseparation, and instrumentalization.

Backgrounding is the process in which, for any pair in the dualistic hierarchy, power is re-enforced for the dominant through the denial of dependence on, and recognition of the needs of, the subordinate group. So, for example, in the case of class exploitation, backgrounding both establishes the identity of the dominating class and denies its material dependence on the subordinated class, which it exploits. The dominating class’s attributes and contributions are always taken as the defining focus. In the exploitation of labour, the subordinate group provides the labour society needs while the economic elites describe themselves as ‘job creators’. This language reframes the consumers of labour, treating their demand for labour as what is valuable while the labour contributed by the exploited party is treated as unimportant. The dominant class places their contributions in the spotlight while devaluing the contributions and de-emphasizing the needs of the working class. By focusing on the contributions and needs of the dominant party, it is implied that the contributions of the dominant party are more important, and that the work of the subjugated party is not actually useful or needed, as admitting the usefulness of the subjugated group would be a confession of vulnerability on the part of the dominant party. (Plumwood, 48-49)

Taking the mind/body, mind/nature dualisms, in what ways have we backgrounded the body in the context of prolongevitist medicine? In what ways has medicine become a ‘master’ of the body which backgrounds the body’s contributions to the medical process? Callahan’s concerns surrounding technological monism and the guilt of medical practitioners surrounding death (Callahan, 67-69) suggest that we reduce the body to an organism that is not actively contributing to the process of health and that we see ourselves as the sole source of causality in the context of death and dying. (Note here that the ‘self’ which is the source of causality is understood as consciousness alienated from the body. As we shall see, hyperseperation facilitates this process of backgrounding. The symptoms of dualism support one another in a network that continually reinforces dualized thinking.) Feminist philosophers have mirrored this concern when they say that science treats the body as a machine that can be 'fixed' by mechanical manipulations (Martin, 19-20). When reflecting on Phillipe Aries’ work, which analyses historical perceptions of death in the medieval era, Callahan points out that death was once seen as an inevitable force to which humanity was subject. Now, death has been swallowed into the realm of human power, and thus, human moral responsibility (Callahan, 30-34). This ideology of medicine refuses to recognize the contribution of the body or nature outside its merely being a tool for human ends. This ideology does not see the work of the body as important in the eyes of modern medicine; the body is seen as a chaotic organism that can only be saved through human action.

Behind this emphasis on human medical practices and the control of the body (rather than its active contribution), it is also implied that humanity is somehow beyond the body, that we do not rely on the body for every aspect of our lives. Philosophy has traditionally conceived of the self as “a disembodied locus of consciousness” (Scully, 8) and even as recently as the 20th century “psychology, philosophy of mind, and cognitive science has rested on a picture in which the body lumbers about the world receiving sensory stimuli, leaving the mind to make sense of it all through some translational process and doing its best to control the body’s acts.” (Scully, 85) However, there is a growing amount of evidence suggesting that human cognition is deeply embodied, (Scully, 90) including cognition of language (ibid., 91) and metaphor (ibid., 91-93) as well as moral cognition (ibid., 93). Rather than being beyond the body or above the body, we must recognize how deeply embodied we are.

We see this denial of the significance of embodiment most strongly in the extremely radical transhumanist rhetoric of brain emulation. The idea that we could upload ourselves to some digital platform and still have something we could recognize as ourselves, as human, with the body merely pared away, shows how deeply engrained this backgrounding is. Of course, the rhetoric of brain emulation has as its predecessor thought experiments used in philosophy of identity. Experiments involving brain transplants dismissed embodiment as unimportant to psychological continuity (James 39), reduced the body to a mere container for the personality (James, 33) and assumed personality traits that were more obviously contingent on embodiment (such as dexterity) were unimportant (James, 33). These attempts to sever the mind from the body conceptually show not just how the body is tossed aside as unimportant but are also very important to the notion of hyperseparation.

 Hyperseparation (which Plumwood sometimes refers to as radical exclusion) is the emphasizing of differences between the two sides of a dualism and the elimination and downplaying of similarities. One of the ways hyperseparation helps re-enforce hierarchical structures is that it can be used to create two ‘natures’ that should be treated differently (Plumwood, 49- 52). For example, the emphasis on differences between white men and black men has enabled us to stereotype black men as violent criminals with no self-control, and white men as their radically separated opposite, with no common ground. This establishment of two different ‘natures’ has enabled the state to justify differential and sometimes brutal treatment, such as racial profiling, police brutality, and inordinate rates of incarceration. Another example can be found in the role biological sex plays in gender:

In a sexist society a person’s biological sex is always relevant to how that person is treated; sex identification...is made an obsession. Because dominance structures demand dichotomies, natural differences are exaggerated and embellished; this allows the more powerful group to distinguish itself from the other, claiming not only difference but superiority and hence a legitimate right to dominate. To justify the hierarchy, differences must be established and emphasized. (Sherwin, 30)

Without the clear separation of the two genders through biological sex, it would not be possible to classify genders, and thus to assert the superiority of maleness, nor to speak of female characteristics as inferior and complementary (Lloyd, 103-104). Thus hyperseparation is an essential component in a dualist logic that justifies the inferiorization of one side.

 The ideology of medicine insists that mind and the body, human and nature are excluded from one another and hyperseparated. This ideology equates human beings with the mind, and with it rationality, science, and technology and relegates the body to the realm of nature as the irrational scientific object. The ideology of medicine insists that the mind is something separate from the body when in fact the two are intimately connected. Many feminist authors have shown how the body is tacitly marginalized in philosophy and have emphasized how important embodiment is to thought. (James, 30) Bodily processes and emotions affect our rationality, and the way we think about our world is deeply impacted by our embodied experience. Meanwhile, the body has its own rationality and technology though we may not be as consciously aware of the complexity of its processes. We think of the body as merely flesh when in fact it is an amazingly elaborate and efficient organism. The wilder fantasies of prolongevitism imagine the mind being able to overcome the limits of the body, to transform the body through scientific ability, but the body is part of who we are as human beings.

Plumwood describes instrumentalization as failing to recognize the needs of others, and only seeing others as a means of fulfilling one’s own needs (53). As Kant pointed out in the second formulation of the Categorical Imperative, treating others as strictly means only denies their autonomous status and renders them vulnerable to violations of dignity (Kant, 45-47). Certainly this is a common feature of exploitation. For example, sweatshop workers’ needs are ignored while they are used as a means to producing cheap goods. This is one of the characteristics of exploitative relationships that first come to our minds, and it is the material dependence of the dominant party (and with it, the instrumentalization of the subordinated party) that lays the ground work for backgrounding.

Instrumentalization is very clear when it comes to marginalized groups of people, but recognizing instrumentalization in nature is a little more difficult. Do bodies have needs? Does nature? Ecosystems certainly do, as their continued existence relies on many factors that we can influence, and have influenced, while exploiting them. What about the human body? One might suppose that the body is, by definition, the tool of the mind. We use our bodies to fulfill our own needs. Certainly the body has needs: exercise, diet, medical care, but they are also the needs of the ‘owner’ of the body, who wishes to use the body for her own purposes. This view only shows how deeply engrained our instrumentalization of the body is.

The logic of instrumentalization allows us to treat our bodies the way we would a pack-animal that is fed only so labour can be extracted: as a resource to be exploited and nothing more. As scientific management tries to extract as much production from labour as possible, the model of modern medicine extracts as much life as it can from the body. The body is reduced to an exploitable resource from which life-time can be extracted, and this taints our experience of the body.

It is unclear what it would take to think of and experience our bodies in some other way than as a means of getting what we want. Perhaps it would involve some aesthetic appreciation of our own bodies, or practices of love and respect toward our bodies (exercise, massage) that are not thought of instrumentally. The objectification of the body is perhaps one of the greatest obstacles to undoing the damage of this mind/body hierarchy.

Through the application of Plumwood’s framework, we can see that what Callahan is describing in his critique of modern medicine is an ideology. Modern medicine operates on a body of unexposed, related beliefs about humanity, nature, mind and the body that reproduce a power relation of domination, specifically, the capacity of medicine to manage the body as a resource. Now the conceptual content of the ideology of the body has been exposed, I will examine how the institutional structures of medicine and science re-enforce this ideology.

2.3) Medicine and Discourse

 Where does this ideology come from? Who is responsible for it? Certainly there are no specific individuals, such as doctors for example, who are responsible, as ideology is internalized and unconscious. After all, not every doctor subscribes to this ideology, and the ones who do are socialized to think in this way (Martin, 13).

 To answer this question, I would like to introduce the concept of discourse. Discourse is a collaborative meaning-making game in which individuals, groups and institutions participate to build socially constructed understandings using language and representation (Scully, 7). Not all players are equal in the game of discourse: institutions and groups have more power than individuals, and some individuals have more power than others. Power is essentially the capacity for people and institutions to shape their social/cultural environment and its structures. This is what Val Plumwood gestures towards when she says that ruling elites use their social resources to exert "control over culture disproportionate to their numbers" (190). The individuals with more power have greater control, not only in terms of shaping our concepts, institutions and practices, but also in terms of shaping our understanding of (and therefore the power of) other players. Individuals can shape concepts in such a way as to increase their power in the discourse game.

For example, the ideology that facilitates the backgrounding, hyperseparation, and instrumentalization of the body is the product of the universalization of a narrow, privileged perspective (This process in which the perspective of a privileged few is taken as default and universal is what Code called ‘the culture of no culture’(Goldenberg 2625)). The perspective that is being universalized here is that of people who have the resources and opportunities to take their embodiment for granted and dismiss it as unimportant: those who are healthy, not only in terms of having access to food and other resources to sustain their physical well-being but also who are able-bodied and cisgender. Furthermore, the privileged perspective that is being universalized and taken as default is that of those who do ‘mental’ rather than 'manual' labour (although even this distinction is an artificial separation). It is only from such a perspective that the body could be taken for granted in such a way. Facing a disability, an illness, gender dysphoria, or the physicality of demanding labour brings the significance and power of the body to the fore, but these experiences, though quite common, are taken as unimportant.

 Discourse means not only do institutions and the norms they impose influence individuals, but also that individuals can shape the way institutions understand concepts like the body, especially in communities of radical discourse, a topic I will discuss later. The discourse of the body has been going on for a long time and has involved many groups and institutions. Two institutions that participate greatly in the meaning-making discourse of the body and are intimately connected to the prolongevitist debate are medicine and science. The language and representations they employ in their search to understand the body deeply influence the way we understand and think about the body. Medicine, as a form of science, represents the body as a knowable object to be observed. The purpose of this knowledge is to dominate the body: to figure out ways of extracting the intended effects we want from the body, of instrumentalizing the body. Francis Bacon, the icon of the scientific ideology which arose during the Enlightenment, was the first to express “the mind’s task in knowledge not as mere contemplation, but in control of nature” (Lloyd, 10). Bacon constantly speaks of nature as a woman who must be courted for the purposes of extracting (carnal!) knowledge. For Bacon “knowable nature is presented as female, and the task of science is the exercise of the right kind of male domination over her” (Lloyd, 11). If nature is a woman who must be seduced to give up knowledge of her, then Bacon’s romantic playbook was not abstract contemplation as Descartes held, but rather observation. He believed “Knowledge must be painstakingly pursued by attending to nature; and this attending cannot be construed in terms of contemplation” (Lloyd, 11) and that like a woman, “Nature is mysterious, aloof--but, for all that, eminently knowable and controllable” (Lloyd, 17).

 This concept of science, in which knowledge is brought forward through observation of nature for the purpose of control of nature, is still very present, in all branches including medicine. The practitioners of this patriarchal ideology of science “presume license to probe for [nature’s, and therefore the body’s] secrets, as well as to define its norms and deviations” (Sherwin, 92). We see this today in the empiricist discourse of evidence-based medicine. The body here is portrayed as an object that can only be knowable through evidence (Goldenberg, 2621). The evidence collected here, however, is only a specific type that is hierarchized as better and more reliable than other types. Quantitative data procured from homogenous subject populations in controlled studies (ibid, 2627) is valued above qualitative data (ibid, 2628) such as data which might be procured through interviews rooted in ethnographic, anthropological, sociological, narrative, historical, phenomenological and/or subjective approaches. (ibid, 2629) This hierarchy devalues other ways of knowing and understanding one’s body and enforces the idea that one can only understand one’s body properly through the mediation of medicine and science. Simultaneously, the political consequences of this hierarchy are masked because the evidence is presented in the language of 'facts' (2622) rather than explicitly acknowledging (and therefore opening up to evaluation and negotiation) the value system that underlies this inquiry. (2623) Evidence based medicine denies its own subjectivity by ignoring that empirical evidence must always undergo subjective interpretation. (2624) By misleadingly claiming the 'factual' basis of an evidence-based approach, medicine is able to avoid openly acknowledging any type of bias, while still amplifying the inequalities of society. One such example is the abundance of research in reproductive-related issues and a neglect of gendered dimensions of other health problems which seem to impact women differently in terms of cause, incidences, responses to treatment and prognoses because of biological conditions, social factors, and social conditions (2627)

The conceptual content of the ideology of the body has been uncovered, and the discourse that makes such an ideology possible and reinforces it discussed, but what motive do we have to resolve this ideology? If there is no space outside discourse, outside social construction, outside ideology, that we can flee to, why bother to even address it? If it is true that we can never stand in a neutral position, that ideology is inevitable, that we must always operate on the basis of some system of thought, how do we know when and why a given ideological system must be confronted?

Throughout the work I have referred to respected liberatory movements such as feminism, Marxism, and anti-racism, and their work in combating ideology. I see these paradigms as examples to be emulated, but their justification in combating ideology is an important difference between their work and mine. Sexism, racism, ageism, and homophobia are problematic because they deal with the oppression of people. In the past, our motivation for participating in liberation movements has been grounded in a very Kantian conception of the unjust nature of oppression: because the oppressed group in question has rationality, autonomy, and human dignity, or some kind of consciousness, the domination of that group is seen as unethical. However, in this case, it is the body that is seen as literally a tool for our use. Does this mean that the body has moral standing of its own? What is the basis for critiquing the ideological construction of bodies? It could be said, in response, that the normalization of the instrumentalization of the body is a symptom of a broader internalized ideology. After all, there have been many people who do not see slavery or animal abuse as problematic because this exploitation has been naturalized. The birth of any liberatory movement is the moment this naturalization becomes dislodged. Since ideology is naturalized, it makes the oppression it facilitates seem unproblematic. Liberatory movements begin when they reveal the tensions and inconsistencies in our cultural discourse. Chipping away this naturalization is a necessary condition of recognizing oppression and striving to end it.

A theorist like Callahan makes his argument for confronting medical culture on the basis of the negative effects on the parties who those dualistic structures allegedly benefit. Much as men can be harmed by the effects of patriarchy, Callahan identifies several ways in which patients and medical practitioners are harmed by an ideology that emphasizes control over the body. For example, one unfortunate effect of the domination of the body is that it forces us to deny our dependence and vulnerability, resulting in not only pushing the quest for control into self-destructive behaviour (as Callahan described in the case of technological brinkmanship) but also a sense of shame and humiliation when we are inevitably confronted with our finitude and limitation. As Callahan says, our obsession with control has resulted in undue fear. (197) Our ability to manage the technological side of dying has given us an unrealistic expectation of control over all aspects of dying, but as yet, there has been no machine or pill that can help us control the existential suffering of death.

There is one more reason, however, that confronting this ideology may be helpful: the domination of the body is deeply intersectional with other forms of oppression. The body is the site of racism, sexism, ageism, cis-sexism, ableism, even homophobia. Women have been equated with the natural and bodily while men are associated with mind and culture. (Martin, 17) And this association with the body has been spread to other marginalized groups over time. Sometimes the association has been explicitly stated, but other times it is implied in metaphor, digression and example. (James, 19) A major tenet of radical feminism is that “male dominance is grounded on men’s universal control over women’s bodies” (Jagger, 147), and the equation of the body with the feminine has facilitated the disdain of both (Jagger, 186). The dichotomy of the mental and the physical in terms of labour has been used to rationalize a hierarchical division of labour, not only in terms of gender but also class (Jagger, 189). This social stratification is always grounded in 'natural facts' about women's biology. While women’s work surrounding healing, child rearing, food preparation, counselling and birthing, has been devalued, men have appropriated the ‘theoretical’ and ‘cognitive’ labour of theorizing about these projects (Jagger, 187). Rather than merely trying to break the association of the subordinate side of the hierarchy with the body, this artificial division of mind and body has to be addressed (Jagger, 188-189). The body and bodily labour is an enormous part of our identities. In other words, the history of oppression, not just of women but other groups as well, has been based on a discourse that is closely tied to the discourse of the body. If we can change the discourse surrounding the body, it is likely to be very fruitful in confronting other forms of oppression.

Daniel Callahan does something very useful and important by identifying a concern with the domination of the body. This gesture opens the door to an acknowledgement of a deep-seated ideology that has caused wide-ranging damage in our society. He brings to our attention an undertone of prolongevitism that demands attention. To confront this ideology and seek out alternatives is essential to finding an appropriate response to the question of prolongevitism and will likely yield many other benefits along the way.

III: OVERCOMING THE IDEOLOGY OF THE BODY

3.1) Callahan’s Solution and Overall’s Critique

In this section, I will focus on Christine Overall’s criticism of apologism. Callahan recognizes some of the problems behind the system of thought that prolongevitism relies on, and his criticism becomes more persuasive when the system of thought is recognized as an ideology. His response to the problem of the ideology of medicine is to claim that death is something that should be accepted. As a “clear and unambiguous example of apologism” (Overall, 16) Callahan believes death is a truth of human reality that must be accepted, and that human lifespans should not be extended. Overall questions Callahan’s concept of acceptance, the basis of this acceptance on a natural limit, and the ageist assumptions underlying the concept of acceptance of death based on a natural limit. As I mentionned earlier, this acceptance is what other philosophers might describe as ‘receptivity’, a willingness to acknowledge natural limits. I take Overall’s criticisms of Callahan’s conception of acceptance as an affirmation that receptivity needs to be understood in a way that takes into account a deeper understanding of the domination of the body.

Callahan’s vision, a response to the ideological flaws of the current medical system, is an approach to medicine that recognizes the pacification of death, rather than the resistance of death, as a central goal (189). In other words, Callahan believes in “a renewed emphasis on the ancient and original aim [of medicine] of care and comfort” (209). This project would require the blending of the personal, medical and social approaches to death (196), focusing on a more holistic approach to death and grieving, including offering nonmedical social support.

A large part of this emphasis on the pacification of death would be the re-examination of the presumption to treat (201). If withholding treatment for urinary tract disease or pneumonia can lead to a better death than the long, difficult process of dying in a medical system where the default assumption is to treat disease, then Callahan advocates withholding treatment (202). Callahan believes there should be much less resistance to withholding treatment, and with each disease a patient encounters medical staff should keep in mind whether treating an ailment will benefit the patient or make the patient`s inevitable and eventual death more difficult (190). As part of this, Callahan believes medical futility should not be determined by individual medical practitioners on a case-by-case basis but rather established in institutional policies by joint medical lay panels in hospitals (215-216).

 In investigating Callahan’s arguments for the ‘acceptance’ of death, which he sees as the alternative to extending human lifespans, Overall notes several problems. The first is with the notion of ‘acceptance’ itself. Overall points out that acceptance of death and delaying death aren’t opposites. Callahan appears to equate resistance with denial, and acceptance with passivity and complacency in the face of death (34). As Overall explains, “to resist death does not require that one believe that it will not eventually occur” (33-34). However, while the desire to extend human lifespans itself does not entail a rejection of death, I think it is important to acknowledge that wanting to extend life indefinitely, in the way such radical prolongevitists as Kurzweil have discussed, is certainly a failure to accept death.

As I explained earlier, part of the reason Callahan raises his concerns about the denial of death is because this denial harms those who are confronted with their own death and those who are mourning; but as Overall points out, prescribing death acceptance does not actually make accepting death (and choosing against life extension) any easier (33). In *The Troubled Dream of Life*, Callahan has a section called *When a Death is Acceptable (180-186)*. It seems as though he is responding to a concern about how and when one ought to mourn a loss of life, but the point that he misses is that “the greater length of some people’s existence does not make death any less senseless or disrespectful of their life projects” (Overall, 5). A death-denying culture is toxic to those who are mourning, but the denial of the tragedy of death, a mourning-denying culture is equally toxic.

 Furthermore, Overall points out certain problems she has with the idea that this acceptance should be based on the idea of a natural limit. In other words, she finds the argument that lifespans should be respected because they are biologically imposed to be highly suspect (30). Feminist philosophers have previously criticised the use of a concept of ‘human nature’ as a basis for universal values, saying:

Implicit in such a plea [that is, the plea to use human nature as the basis of a common value system] is the assumption that the notion of ‘human nature’ makes sense, that there is in fact a coherent sense of self and world to maintain, and that there is a singular worldview that will grant meaning and sanity to everyone’s lives. Ecofeminists have explicitly argued that the sense of self and the relation of self to the world commonly invoked is not coherent and the privileging of a single worldview as providing purpose, direction, and sanity to all people ignores the diversity, complexity and richness of people’s lives. (Gruen, 123-124)

Not only is the naturalist way of speaking about human biology oversimplified and monolithic, but there are many situations in which appealing to such a concept as a guideline for health policy would be outright immoral, for example, in the case of disease management (such as in the case of an epidemic), or maternal mortality (34-35).While disease and maternal mortality are naturally occurring phenomena, no one would take that as a reason they should be accepted rather than prevented. Overall suggests that the reason we are willing to accept these arguments in the context of ageing is our internalized age ideology and ageism (18)

 Historically the concept of ‘the natural’ has been used as a means to oppress many marginalized groups. Consider, for example, the defence of homophobia by claims about the ‘natural’ order of sexuality. While we are finding that same-sex coupling is in fact not that uncommon in the animal kingdom (Mooallem), for a long time the claim that homosexuality is unnatural and that heterosexual relations are the ‘natural’ order of sexuality has been used to justify many homophobic behaviours and policies. Another example might be the naturalization of femininity as a means of justifying policing women’s behaviour. It is still a popular sentiment that women are naturally more caring and naturally want to do more care work. Here, the concept of the ‘natural’ has been used to keep women in traditional gendered labour caring roles. Because of these precedents, I am inclined to trust Overall when she suggests that arguments to uphold the ‘natural order’ are embedded in oppressive and hierarchical ideologies, in the case of apologism, in ageism.

 Age ideology is a complex of beliefs that disadvantage old people. Overall explains that part of this complex is that old people are disproportionately associated with death. Because age ideology associates age with decline, sickness and death, death at old age is normalized as expected, acceptable, and less tragic than other deaths (35-36). Overall briefly illustrated this ideology in a thought experiment, saying

it seems just as practical to call on those with disabilities or severe illness to pass on, or perhaps those who carry genetic liabilities, or those who cannot prosper because they are too poor to afford food and medical care. If these suggestions seem morally outrageous, as they should, I invite you to ask yourself whether it is not similarly outrageous to expect people of seventy-five or eighty years to accept death for the sake of alleviating population pressures, opening up jobs, or reducing medical costs. The very fact that old people are expected, without further need for argument, to accept their deaths and not struggle to prolong their lives—an expectation that is not foisted on other social groups—is indicative of the deep, naive, and unquestioned ageism that lies at the heart of many of the claims on behalf of apologism. (56)

With this comparison Overall does an excellent job of showing how we have internalized death in old age as something that is ‘normal’ and should be accepted with complacency. Thanks to age ideology, we are out of touch with the reality of old people confronting death as the tragedy it is. Any end-of-life policy that is informed by this ideology will only further alienate and oppress old people.

 Ageism also leads us to make other errors in reasoning about death and death acceptance. For example, we tend to homogenize old people (57). We assume they are all the same, and because of this we make several mistakes in reasoning about old age. For example, many people believe the burdens of old age must be unbearable, that ageing means one cannot have a happy or fulfilling life, but while some old people do have a difficult time in their later years (a problem that can be improved with appropriate support and resources) many do not. Some people are very healthy in their old age and have busy, exciting lives. Another assumption that stems from homogenization is that old people have already lived fulfilling lives, but this is not true for every old person either. Many people did not have the resources or opportunities in their youth to have the kind of enriching experiences we would expect to have in a fulfilling life. So, to say either that old people could not tolerate old age and so should accept death or that old people have had fulfilling lives and so should accept death is both out of touch with the reality of loss old people experience (a result of age ideology) and rests on a spurious homogenization of old people. Furthermore, to assume that we know what it is like to be old and can tell people when they ought to accept their deaths is very paternalistic (41-44, 47-51)

 So, as Overall explains, Callahan’s entreaty to accept death passively rather than fighting it through medical technology is problematic. Not only does acceptance not entail a rejection of technological mediation of the body, but his appeal to nature as a justification is questionable. Furthermore, his acceptance of the natural ideal is strongly laced with a toxic age ideology that perpetuates the marginalization of old people. If we are to espouse some kind of receptivity to the limits of nature and the body, understanding that receptivity as acceptance in Callahan’s sense raises many problems. I believe returning to an interpretation of Callahan’s work as a reply to a medical ideology that relies on dualism will help us to see how this understanding is problematic and help us build a better understanding of what receptivity should be.

3.2) Reversal and Other Inadequate Strategies

 In this section, I want to show how Callahan’s solution to the problem of the medical ideology of the body is insufficient, not just in terms of the objections Overall raises (as discussed in the previous section), but also in terms of how Callahan manipulates the conceptual structures he identifies. Callahan’s conception of receptivity as acceptance, which advocates letting natural limits dictate health policy--in other words, submitting to the limits nature sets on our lifespan--is what Plumwood would describe as mere reversal, rather than a successful response to dualist hierarchies.

Plumwood characterizes reversal as a re-arranging of the components of a dualistic hierarchy accompanied by a failure to acknowledge “the identity-forming functions of colonization” (61). An example of reversal in Plumwood’s sense is shown in the Simpson episode *Girls Just Want to Have Sums*, where Lisa Simpson attends a school that focuses on a feminine approach to math. The curriculum is dictated by what her educators assume to be a feminine approach to math: they discuss their feelings surrounding numbers, use movement and lighting, and refuse to talk about ‘problems’ (Groening). This system is a reversal because it unquestioningly relies on concepts of the ‘female’ mind that are founded in relation to patriarchy and holds them up as the ideals mathematics curriculum should be based on. Rather than questioning how the feminine identity has been formed through patriarchy, this identity is simply affirmed.

Though Callahan recognizes that modern medicine is characterized by the subjection of the body to the needs of the mind, and the manipulation of nature to the will of humanity, he does not realise that the identity of these categories (mind, body, nature, human) is formed in the context of the dualist power relation that structures them. Feminist philosophy has struggled with the question of how to resolve hierarchical dualism in ideology, specifically patriarchy, in a similar way, and feminist philosophers have explored how categories like ‘male’ and ‘female’ are constructed within this hierarchy. Examining the work feminist philosophers have done in analysing how hierarchy shapes concepts like masculine and feminine can help us to more easily see how concepts like mind and body are affected by their hierarchized relation, and how, because of this, a reversal strategy is insufficient.

The meaning of femininity is grounded in its exclusion from masculinity (Lloyd, 105). In Plumwood’s language, our concept of femininity is built on backgrounding, hyperseparation, and instrumentalization. Masculinity is taken as the focus and default, and femininity is taken as the exception. The two are seen as opposites, and the traits that we associate with femininity such as being stylish, nurturing, or attractive all imply instrumentalization. Similarly, the backgrounding, hyperseparation, and instrumentalization of the body have been built into how we think about the body. To simply hold up femininity, or for that matter the natural state of the body, as an ideal, without investigating these concepts critically, won’t overcome the hierarchized, dualist structure identified. In fact, it is likely to support and perpetuate it. Consider, for example, the way in which the valorization of traditional femininity has encouraged women to maintain the status quo in terms of gender expression:

There has been no lack of male affirmation of the importance and attractiveness of ‘feminine’ traits--in women--or of gallant acknowledgement of the impoverishment of male Reason. Making good the lacks in male consciousness, providing it with a necessary complementation by the ‘feminine’, is a large part of what suppression and the correlative constitution, of ‘womankind’ has been all about. (Lloyd, 105)

While recognizing the value of femininity and traditionally female traits as important, one must bear in mind that encouraging women (and only women) to comply with a monolithic standard facilitates their oppression. Similarly, a valorization of the natural body will not overcome the ideology Callahan recognizes. Both cases demand an investigation of the intellectual structures that facilitate dualism. Both cases require a deeper critical approach. Callahan does not re-evaluate the meaning of the natural body that was established in relation to the logic of medicine and science but rather upholds this identity. In this way, Callahan has maintained but reversed the values in the dualistic structure underlying the ideology he finds problematic.

The fact that Callahan has preserved this dualism by simply advocating for a reversal of the hierarchy (an approach that advocated submitting to the natural body rather than dominating it) is the root of Overall’s most serious criticism levelled against him. As discussed previously, Callahan advocates accepting our universal vulnerability in place of trying to uphold the impossible liberal value of the self, such as self-determination, self-control, and self-direction. He is correct in recognizing a problem that needs to be addressed, but upholding receptivity as submission is too simple. He fails to see that this submission also does serious harm to those who are particularly vulnerable, specifically old people.

Earlier I pointed out Overall’s reluctance to accept nature as a basis for bioethics policy, and I added that nature is often used as an excuse to put down those who are marginalized, such as in arguments surrounding the ‘naturalness’ of women’s roles in care work, and the lack of ‘naturalness’ of gay marriage. Here we see how Callahan’s appeal to nature as a guiding force of policy again suppresses marginalized people. Overall pointed out that we normally would not condone injunctions for other groups of people to accept death but we would expect so much from the elderly because of our internalized ageism and age ideology. Nature is exploited as a resource as the dominant party sees fit, but when marginalized groups seek to trespass nature, then nature is held as inviolable. Nature is only seen as a force whose boundaries must be respected when those boundaries also correspond with the interests of the master. Nature is both itself a dominated party and appropriated as a tool to oppress others. We see this pattern again and again: the poor colonist in the new world, the trans-exclusive feminist, the dominated groups are used as a tool to oppress others. The dominant group divides the dominated groups and pits them against each other as a means of preserving its power.

Clearly an understanding of receptivity that is based in reversal is not an appropriate solution to the problem of medical ideology. Here, I would like to take a moment to acknowledge and set aside some other failed strategies that have been used in the past to address other hierarchical dualistic ideologies. If we can recognize and eliminate some strategies we know do not work, it may help us in building a better approach.

One approach we see when subjugated parties recognize the dualism they are subjugated by is that the subjugated party may try to show somehow that they are like the dominated party (Plumwood, 59). We see this a great deal in feminists of the 19th and 20th century. Women attending universities are thought of as being ‘just like the men’ as women's liberation movements prioritized the goal of being able to participate in a man’s world. It wasn't until more recently that we see mainstream feminism suggesting that everyone ought to value the traits traditionally associated with femininity (which is also a reversal strategy). We also see this in mainstream hip-hop culture, when artists put on immense displays of wealth, power and violence as a way of showing they are different from other racialized and impoverished people who do not have social or economic capital. The reason this attempt to adhere to the culture of the dominant group does not actually work is because it fails to resolve this dualistic thinking. It may persuade some of the occasional exception to the rule, such as the promising female university student who is as intelligent as any man, or it may glamourize the dominating class and its domination as something desirable to achieve, as is the case in mainstream hip-hop culture, but it does not create a dissolution of the dualism in place.

Another approach we sometimes see is the dissolution of identity (Plumwood, 62-64), in which the identity of the party is purported to be meaningless. We hear such dissolution in catch phrases such as “I don’t see colour” or “everyone is disabled when you think about it”. The subjugated party in question is taken to not actually be a recognizable party. This is often done by some intellectualization and abstraction of the defining characteristic of the dominated group. Firstly, this approach fails because while it may be the case that race, disability and other such defining characteristics of subordinated groups are social constructs, they still affect the daily lived experiences of the people in that group. Whether or not race is socially constructed, racialized people still experience racial discrimination, whether overtly or systemically. Furthermore, such an approach makes it impossible to talk about a marginalized group and their needs. If we talk about accessibility without explicitly discussing who faces accessibility issues and why, and giving the people who face these problems the attention they need, then taking action is going to be extremely difficult.

 We should be on our guard, then, for any approach to the ideology of medicine which fails to recognize the importance of the physicality of the body in its own right, or any approach which tries to dissolve our concept of the body into something we cannot meaningfully talk about. Unfortunately, Callahan’s approach, holding up receptivity as a reversal of the dualist hierarchy of mind over body that underlies modern medicine, is insufficient. When his thoughts are articulated through Plumwood’s theories, it becomes clear that a more sophisticated solution is necessary. I believe there is something I can contribute here.

3.3) An Alternative Understanding of the Body

Develloping an appropiate understanding of receptivity as an alternative to an attitude of domination toward the body requires overcoming the conceptual structures that underlie that domination. As I begin this project of reformulating the way we understand the body, I want to keep certain goals in mind. Whether these goals are met will be the measure I set for myself of the adequacy of my approach.

Overall bases the value of life in "the prospect of ongoing opportunities for experiencing and doing, competence and creation" (Overall, 102). In other words, she emphasizes the value of living life well, of the capacity to live well. It is on these grounds that Callahan pronounced the ideology of medicine as problematic, as he believed the pursuit of medical control was an obstacle to living well. One goal I set for myself in this reconceptualization of the body, then, is that it ought to encourage, or at the very least be compatible with, a well-lived life.

Furthermore, because the goal of this reconceptualization is to overcome dualist hierarchical ideology as Plumwood describes it, I want to avoid old patterns of backgrounding, hyperseparation, and instrumentalization. Plumwood believes "a non-hierarchical concept of difference requires a move to systems of thought, accounting, perception, decision-making, which recognize the contribution of what has been backgrounded, and which acknowledge dependency" (60). Therefore, one of our priorities must be to acknowledge our dependence on the body and recognize its importance. With regard to overcoming hyperseparation, Plumwood claims, "a non-hierarchical concept of difference affirms continuity, reconceives relata in more integrated ways, and breaks the false choice hyperseparation presents in reclaiming the denied area of overlap." (60) To overcome hyperseparation, then, this new conception of the body must recognize the integrated nature of the mind and body. The final and perhaps most challenging goal in reconceiving the body will be overcoming instrumentalization, as "a non-hierarchical concept of difference implies recognizing the other as a centre of needs, values, and striving on its own account, a being whose needs and ends are independent of the self and need to be respected." (60) We must be able to see the body not as a chaotic organism that must be tamed for our own ends, but view it with respect, recognizing its complexity, its ability to maintain itself, and to see it as having needs independent of the good we try to extract from it. With these goals in mind as the measure of my success in this project, I will be prepared to assess and correct my work.

Of course, I do not believe any reconceptualization of the body can sever itself completely from the problematic traditions that come before it. As I have emphasized before, there is no space outside ideology, and all constructions have to be recognized as socially and historically situated. Plumwood recognizes this when she says the feminine identity needs to be treated as "an important if problematic tradition which requires critical reconstruction, a potential source of strength as well as a problem" (64). She emphasizes that reconstruction of identity will have continuity and difference with traditional ideals. The project of constructing radical understandings that depart from past ideology can be illustrated in the image of Neurath's Boat, the allegory of a boat which must be repaired piece by piece as it floats because it cannot go ashore (Lovibond, 17). There is no shore for us: we may only work with the materials on hand to build something we hope can float better than before.

As discussed earlier, the discourse of medicine conceptualizes the body as a knowable object. Traditionally, science and medicine have been based in an epistemic approach that took the examination of medium-sized physical objects as their model. Plumwood asserts that what is needed to revise the identities that have been affected by dualist structures, however, is "recognition of both continuity and difference. This means neither alien to and discontinuous from the self nor assimilated to or an extension of the self" (Plumwood, 6). Lorraine Code's epistemic paradigm, which relies on human relationships as a model (Code, 37), has excellent potential here.

 Code explains that knowing other people has great potential as an epistemic model because of its complexity. Knowing other people admits of degrees because we can know people more or less, whereas with objects we either know they have the properties they do or we do not (37). Knowing people develops, operates and can be interpreted at different levels (37). Knowing people can involve many dimensions and perspectives (37) and demands an ongoing communicative and interpretive process (38). Because of this complexity a model of knowing based on personal relationships wards off dogmatism and rigidity, and demands we recognize our knowledge is never fully complete, always changing and growing (38). Other people are both transparent and opaque to us to varying degrees at different times (38), and the knowledge that we have of others is both subjective (the way I know any individual will always be uniquely mine) and objective (on the other hand, we can certainly say there are facts that are concretely true and false about that person)(39). Furthermore, knowing other people is reciprocal. In traditional models of knowing involving objects, the subject actively obtains the knowledge from the passive object, portraying "nature as dumb, needing to be tortured to reveal *her* secrets" (Code, 152, author's emphasis). In a relationship-based model, "Objects of study are indeed separate from the researcher…objects of scientific investigation [such as the body] are as much sources of surprise, frustration, and unexpected discovery as they are of predictability and potential control" (Code 153). In other words, in a relationship based model objects of scientific knowledge assert themselves as independent by being able to withhold or yield knowledge. Perhaps most interestingly, relationships with people are different from knowing medium sized objects because even if we could know all the facts about one individual, we would never be able to say we know *who they are* (40). One cannot seek to know an individual perfectly, only as well as possible (41).

What if receptivity is better understood as establishing a positive relationship with one’s body rather than acceptance as Callahan describes it? Certainly a life in which one has a positive relationship with one's body is a better life, and recognizing the complexity of knowing the body as more than mere facts but as a dialectical relationship of respect for the mystery of the other would lead to a richer understanding of the body. A discourse that frames the way we understand the body in terms of a relationship has a great deal of potential.

Firstly, a focus on one's relationship with one's body has excellent potential in terms of overcoming backgrounding. If we recognize the goal of medicine in terms of a healthy relationship with the body, and part of that goal as pursuing non-exploitative relationships, then we must acknowledge our vulnerability and dependence on the body. Feminist philosophy has repeatedly emphasized that we are not atomistic and autonomous but rather that who we are is constituted through the relationships we are so dependent on. (Sherwin, 53) The bodily relationship is frequently dismissed as unimportant and yet it is one of the most essential.

It is important to note, of course, that the language of 'relationships' often implies two distinct and separable parties. Clearly I do not mean that one's 'self' and one's 'body' can really be understood as two distinct components. This way of speaking only facilitates hyperseparation. Rather, I am talking about a positive and respectful attitude or approach toward the body, or, to borrow language used by the phenomenologists, who strive to avoid such hyperseparation, a healthy 'embodiment' (Goldenberg, 2628). To speak of embodiment is to avoid a language of bodily experience that encourages the hyperseparation of body and mind. We could speak of experience 'in' one's body, 'with' one's body, perhaps even 'about' one's body, but we are constantly reinforcing dualism with this language. To explain embodiment in accurate terms can only lead to further abuse of language (the being-bodyness? the experience of bodying!?) so I must take a leap of faith that my reader can grasp what I am trying to point to through this negative definition.

Part of this newfound respect for the body and the recognition of our dependence and vulnerability must be a movement away from instrumentalization. To realize how much we owe to our embodiment must entail a recognition of and reverence for the body's incredible power and ability, of its complexity. The intricate processes that go on without our awareness are amazing: the secret language of cell signalling chemicals, the incredibly complex feat of metabolism, and the mystery of perception are just a few examples of everyday processes our body undergo without our conscious reflection. We are only beginning to understand how these systems operate. To do this amazing work, however, the body needs us to work with it, to provide for its needs. Embodiment is a relationship of mutual dependence where these incredible capacities are offered up only when we can provide the nutrition, exercise and care to maintain the relationship. Thus, part of a healthy embodiment is a departure from seeing our body merely as a resource that can give us what we want, but also as a centre of its own needs.

Some health movements that I believe represent a healthy embodiment and strive for a positive relationship with the body are the body acceptance movement and practices which focus on health empowerment rather than crisis management (Sherwin, 94). Rather than struggling against the body to manage it when it becomes 'unruly', or to 'fix' it when it is broken, these movements emphasize building a positive relationship and working with the body over time. They encourage bodily understanding and a patient co-operation with natural forces.

How can we build a positive embodiment? How can we form a radical relationship with the body? What practice can allow us to access a new understanding of embodiment? My response is to look at the way liberation movements of the past have built radical relationships: through listening.

When we look to movements that have fought ideology in the past, a common tool used for overcoming ideology has been allowing the marginalized group in question to speak for itself. That is, to create a space wherein marginalized groups can participate in discourse and share their worldviews and experiences, bringing the experiences of the underside from the background to the foreground as a means of reconstructing an identity independent of the ideology that framed it. These movements, however, have focused on the marginalization of conscious human subjects. Listening to the body as a means of reconstituting its identity will be more complicated.

In the past, oppressed groups have tried to reconstruct identities outside the dominant ideology by creating “oppositional communities of intersubjective agreement” (Gruen, 126-129). These groups serve as safe spaces where marginalized people can work together to share experiences and build new, radical understandings of themselves, as well as finding an appropriate vehicle for political expression, articulating their interests, needs and desires, and forming political consciousness (Scully, 134-135). In a community of dialogue, experiences that were previously ignored or interpreted through a narrow, ideological lens are brought into discourse, creating knowledge and values within the community (Gruen, 129-130). Shared experiences are the material out of which these communities can acknowledge wrongs that have happened, recognize experiences and practices, and reconstruct their identities (Gruen, 49). One example of a community of intersubjective agreement might be a gay-straight alliance, where members come forward with their stories and experiences, and instead of being silenced or misinterpreted through a heteronormative lens, they are listened to. This gives the members of the community opportunity for self-reflection and self-understanding in a way that is less constrained by ideology.

The body cannot speak for itself in this way. However, there have been some movements, whose example I will follow, that have attempted to build communities and attend to the ‘voices’ of those who cannot speak, bringing these mute subjects into discourse, namely animal rights and ecological movements (Gruen, 131). Despite the fact that the body cannot speak in any literal sense, I believe the idea of ‘listening’ to the body can be useful in coming to understand what our bodies are outside of the domination of medical ideology.

To listen to the body would require an openness. It would involve what feminist epistemologists call methodological humility, which “requires that one operate under the assumption that there may be some concept or event that cannot be immediately understood. It is a process that encourages people to temporarily withhold judgements, to learn to listen, and to see [oneself] relationally” (Gruen, 133). Here, I think a phenomenological approach would be useful. Phenomenology is a philosophical approach that attempts to understand human experiences while avoiding traditional dualisms of philosophy such as mind/body (Scully, 84). By opening ourselves up to certain experiences, we can cultivate the kind of positive embodiment needed to overcome the ideology of medicine. Below are some examples of the kind of phenomenological narrative which, when launched into the discourse of the body, may help to counteract the backgrounding, hyperseparation and instrumentalization of the body that is so problematic:

i) The Eye

Look deeply into a mirror, deeply into your eye. As you concentrate more and more on the eye, the thought of it as *your* eye becomes less present. It is no longer a part of you, nor something you control. Perhaps even the thought of it as an eye vanishes: it is merely a chunk of colourful, watery flesh. In this dissociative state, the eye cannot be instrumentalized because it is no longer seen as your own. Its complexity and detail is captivating. It demands reverence and respect as the strange and incredible object it is. It might at first appear that this way of seeing the eye does not emphasize your relationship to it. Indeed, quite the opposite, it appears to distance and alienate the eye as something foreign and other. But as Code notes, friendship is contingent on recognizing the other as a second person, which includes recognizing their separation and independence (95). When the eye becomes present as something in its own right which is not merely our own, something that has mystery and can only be partly uncovered and explored, it creates the possibility of establishing a conscious relationship to it, rather than its being backgrounded.

ii) Breath

Close your eyes, relax your body as much as you can and breathe deeply. In. Out. In. Out. There are muscles moving that you hardly ever notice, that you take for granted. Muscles that move every day, completely reflexively, so that you can live. You have breathed millions of times without thinking about what your body was doing. You have been absent from this something so complex and so essential to your existence. What were you thinking about before this moment? Was it anything anywhere near as important as your breath? You have relied on and depended on your body, and it has been there for you. Focus on your breath, to this moment, feeling all the fibres in your body. In this moment, being present to your body, being sincerely embodied, the hyperseparation dissolves and you are simply you.

iii) Dance

You put some upbeat music on while doing some mundane task: washing the dishes or folding laundry. You go about your business, perhaps daydreaming to yourself, when a song you love and haven’t heard in a while comes on. Maybe you sing along or at least find yourself bobbing your head or wiggling your shoulders, but the happiness is infectious and you are by yourself, so you throw the tea towel aside and start facetiously prancing around the room. Another great song comes on, and you are so caught up in the moment you decide to dance with abandon. If you think about it, sometimes it seems as though you are the one moving, but other times it feels as though your feet know what to do by instinct. Sometimes it feels as though you are happy so you are dancing, other time it feels as though you are happy because you are dancing. But soon enough there is no mind or body in charge of what is happening, you are simply succumbing to music and movement and joy. There is a feeling of thankfulness, as if you have been given a gift.

iv) The Fire Rescue

A house is on fire. A man knows his child is in danger and rushes into the home, operating almost reflexively through intense heat, choking smoke, and paralyzing danger. He has been “surprised” by his body, which has given him the strength to survive an incredible perilous situation. We are confronted by the importance of this man’s dependence on his body. Furthermore, we see the body as having some kind of agency, some unknown potential, which cannot be reduced to consciousness. We see the body as some Other who has just shown some unexpected side of themselves. The man is grateful to his body and is thankful for it.

v) Illness

A woman falls intensely ill and is bedridden. In her exhaustion, she is forced to acknowledge how dependent on her body she is. Her body is present as a centre of its own needs but also as intimately tied to her mind, as she cannot think: her mind is constantly absorbed with the urgency of her suffering and exhaustion. Some phenomenologists believe that the presencing of the body that happens during sickness and suffering, the shattering of “unselfconscious being” (Goldenberg, 2629) is what medicine should aim to cure, because it is a problematic embodiment in which the body is alien to the self (2629). I only agree partially here. I think “taken-for-grantedness” (2629) of the healthy body is the expression of backgrounding. The rupture that is experienced in sickness, if we are attentive to it, can teach us to appreciate the body. The re-integration that medicine should have as its goal is not a return to backgrounding, but a return to an unseparated unity that is respectful and harmonized. Medicine should aim for an embodied relationship that transcends the body dualism, rather than collapsing it into an unequal and one-sided focus.

Given my use of discourse as a framework for understanding how ideology emerges and how discourse can be used as a tool for shaping ideology, some might be surprised by my choice to implement phenomenology as a tool. After all, these two approaches have important points of contrast. However, I believe their differences in focus lend them strength when they work in tandem, compensating for their respective lacks.

Discursive theories tend to emphasize social and cultural influence on the individual. For example, 'body image' is the understanding of one's body that is derived from one's sociocultural environment and consists of internalized unconscious perceptions, concepts, and beliefs (Scully, 88). Essentially, body image is an internalized understanding of how one is seen by others (James, 36). This sociocultural environment is a product of our cultural discourse. While discursive theories are able to highlight how social and cultural norms are internalized by the individual, they have difficulty showing how individuals push back, shaping the discursive environment.

Another problem for theories of discourse is that they run the risk of alienating themselves from the physicality of their discursive subjects. We cannot reduce the body to merely the linguistic and symbolic construction of it. Physicality will resist discourse, insisting itself on the limits of our socially constructed understanding. For example, consider the discourse of the body surrounding dieting and weight loss: language and symbolic association repeatedly present the body as an object that can be controlled and manipulated provided one has enough willpower. But the physicality of the body persists despite this construction–the weight loss plateau still happens regardless of the messages in the sociocultural environment. Thus, a definition of the body which only focuses on discourse misses an important part of what the body is.

Phenomenology, however, is fundamentally individualistic and intimately tied to the sensory experience of physicality. Thus, it avoids the pitfalls of cultural discourse in that the experience of the individual is taken as the central truth, and the immediate reality of physical existence insists itself. However, because of this phenomenology must confront its own obstacles:

Some criticise the phenomenological approach, saying that not only is experience necessarily selective and partial, but also that the construction of stories about that experience must be selective and partial (Scully, 13). Therefore, we cannot have a full account of what the body is through this method. I believe this criticism sets an unattainable epistemic standard. We can never have access to brute reality, but we can gain understanding from phenomenological narratives while acknowledging their epistemic limitations (Scully, 14). A second criticism calls into question how the unique experiences of specific individuals can be universalized to a broader audience or even to the level of institutional understanding (Scully, 15). However, discourse is predicated on the belief that any experience is embedded in a common world and therefore must be communicable to some extent, however imperfectly (Scully, 15).

Phenomenology shows its strengths in the immediate, the individual, and the physical. A discursive approach emphasizes the social, cultural, conceptual and constructed. If we want a discourse that acknowledges the physical immediacy of the body, one way is to take the strength of both of these approaches. The phenomenological listening to the body that brings the experience of the body to the individual reveals what discursive theories cannot access. Phenomenology can act as a bridge, bringing the content of the physicality of the body into the realm of culture, where discourse can then use these resources to shape new understandings. The individual, in listening to the body, can take their experiences into culture, share them through language and symbol, cultivate a revolutionary understanding of the body within oppositional communities of intersubjective agreement (both established communities and new ones), and shape the discourse of the body.

Through this inquiry we obtain a more robust understanding of what receptivity as a component of a good death might look like. Rather than acceptance as Callahan describes it, mere submission to the limits of the body, receptivity properly understood in the face of an analysis of the ideology of the body must overcome the conceptual structures that facilitate the domination of the body. I believe this can best be done through cultivation of a positive embodiment with the tools I have described here.

3.4) Returning to the Question of Prolongevitism

In my search to reply to the question of prolongevitism, I have responded to the ideology of medicine with a more robust concept of receptivity, which, rather than being understood as the negation of domination in the form of acceptance and submission, is informed by theories of discourse and phenomenological attentiveness in the cultivation of positive embodiment. How this new understanding of receptivity applies to the practical question of coping with mortality and making decisions about life-extending technology remains to be answered.

Popular discourse surrounding a good death and living in the face of mortality frequently invokes the rhetorically powerful concept of dignity. However, when bioethicists try to excavate the meaning of dignity they are often frustrated by the ambiguity of the term (Chochinov et al., 5520, Jordan, 180). It is tempting to say that dignity is simply a shorthand for living up to a culturally instilled set of values, which is why it is used to describe such diverse phenomena from dying well to dressing and speaking according to norms of class and gender to showing emotional restraint in specific contexts. Certainly dignity is intimately tied to internalized norms, self-perception, and the cultural discourse in which we are immersed.

But dignity's relation to social discourse does not mean dignity is simply meaningless. Dignity and a perceived lack of dignity can be incredibly powerful: prior studies of dignity and end-of-life care have shown a strong association between an undermining of dignity and depression, anxiety, desire for death, hopelessness, feeling of being a burden on others, and overall poorer quality of life (Chochinov et al, 5520). Whether the values that one internalizes under the title 'dignity' are socially constructed or not, they still have a very real power to affect our happiness and well-being. This is why dignity can have such a profound effect on existential well-being (Chochinov et al., 5521). Dignity in the face of death is intimately connected to existential meaning, and finding that meaning (in the form of recognizing values, virtues and goods) is central to our well-being, particularly when faced with our own finitude. But the recognition of values, virtues and goods takes place through the symbolic and linguistic activities of discourse. By participating critically in discourse, we can critique current values and seek out new ones. This is why being critically aware of one`s discursive environment and engaging in the discourse of a good death are so central to living well in the face of mortality.

One of the most prominent discourses of dignity, and the one that underlies many prolongevitist arguments, is the discourse of dignity as autonomy. We see recurring messages that suggest a dignified death is one in which one has autonomy over their body. Callahan has shown, however, an emphasis on autonomy as the central component of dignity can be very problematic because, as finite human beings, we cannot maintain complete independence, and we must inevitably submit to being vulnerable and dependent on others. Essentially by holding autonomy up as the basis of dignity we set ourselves up for failure. This is why radical transhumanist prolongevitists express such an unhealthy embodiment: they equate dignity with control of the body.

My reply to the problems of such a discourse has been to advocate for the cultivation of receptivity through attentiveness to build a positive embodiment, which can inform one’s participation in discourse. One model for supporting the dying that I think has great potential here is dignity therapy. In dignity therapy, participants create narratives through a series of interviews, creating existential meaning and reflecting on their values by describing their lives, their relationships, and what they hope their loved ones take away from the lives they have led. If dignity therapy were to focus on embodiment as one of the important relationships that need to be evaluated and reflected on in the process of meaning making, it may help participants come to terms with feelings of shame, frustration, and betrayal that arise from a discourse of dignity as bodily domination, and help participants cultivate a new discourse of receptivity.

By combining language and symbol to build new narratives about one's relationship with the body, participants can create a new discourse of the body`s role in end-of-life dignity. Instead of thinking of the body as an object which is instrumentalized to produce life-time as a resource, or thinking of the body as something separate from and inessential to the self, or thinking of the body as less important than or subject to the 'cognitive' side (the mind, science, technology) of a dualist system, participants can build respect for and appreciation of the body as part of themselves and strive to create a positive relationship. Even in the decline of the bodily relationship in the face of mortality, one can choose to have a relationship of gratefulness and thankfulness and appreciation rather than a relationship of shame, frustration and betrayal from a body that no longer can support what once was.

An approach to supporting those facing their mortality must also overcome hyperseparation by focusing on a more integrated, holistic, conception of human flourishing. With this in mind, Callahan is right to recognize that an appropriate approach to supporting those who are dying and their loved ones must involve blending social, medical, and personal support. Death is not strictly a bodily or medical problem: medicine should aim to help the whole patient. The distress of the dying is not something merely physical and cannot only be attended to through technological intervention. To assume otherwise is to reinforce a false separation between the mind and body. Chochinov is also correct in highlighting how treatment of the dying has compartmentalized well-being as either bodily or mental and has neglected the existential suffering involved:

"there are few nonpharmacologic interventions specifically designed to lessen the suffering or existential distress that often accompanies patients toward the end of life. The rationale of most interventions is to make the sufferer less aware of his or her suffering. Thus, strategies are invoked to render patients less aware of their suffering or distress until it either improves or, more commonly, death ensues. As such, they offer the equivalent of emotional analgesia without necessarily addressing the source or cause of the underlying psychic pain." (Chochinov et al., 5524)

This emphasis on the whole person must then entail a departure from the epistemic norms of evidence-based medicine. By this, I do not mean an outright rejection: empiricist approaches to the body have offered us many good and useful things that need to be preserved. A new emphasis, however, on more qualitative, subjective methods of understanding the body can empower individual patients to build a healthy relationship with their body and a positive understanding of themselves, not just in terms of the physicality of illness but in terms of the existential and phenomenological journey of illness and mortality.

Chochinov's studies of dignity therapy, for example, try to summarize the effects of therapy in terms of numerical data by showing percentages of increase or decrease in variables such as "willingness to live" on surveys, but where the value of this work shows is in qualitative, subjective reports on the effectiveness of the therapy, and this qualitative, subjective evidence needs to be recognized as important and useful to medical research alongside quantitative data. One powerful example of qualitative data which shows us far more than statistics and numerical ratings is the following quotation from a 36-year-old woman dying of metastatic breast cancer regarding the benefits of her treatment in dignity therapy:

"I'm very happy to have participated in this project. It's helped bring my memories, thoughts, and feelings into perspective instead of all jumbled emotions running through my head. The most important thing has been that I'm able to leave a sort of 'insight' of myself for my husband and children and all my family and friends." (Chochinov et al., 5523)

If helping others cope with death and dying demands that we avoid hyperseparation and operate on a more holistic model of what people are, then we must acknowledge physical, mental, phenomenological and existential aspects of human beings as intimately connected. The epistemic models of medicine must adjust according to our model of what human beings are, and this means a greater emphasis on qualitative data.

It may seem that many of the suggestions I have made so far are fairly sympathetic with Callahan's position. But this relationship with the body that is not based in autonomy as control and domination of the body is not submission either. Living well and having a healthy embodiment does not entail choosing to refuse treatment in old age on the basis of acceptance of death. It is possible for someone to establish a positive, respectful, and holistic relationship with their body and still choose life-extending treatment in ways that work with the body rather than struggling to control it and extract life-time as a resource. Thus, Overall is correct in asserting that fighting death does not entail a denial of mortality (Overall, 34). However, such a denial is possible, as is the case in the radical prolongevitism of the transhumanists. Any project that treats the body as disposable and inessential to human flourishing, such as those projects that aspire to upload brains or transplant them to artificial bodies cannot be striving for a healthy embodiment, and any project that strives for life extension without limits cannot possibly achieve receptivity, as receptivity entails the acceptance of some necessary limit.

While the ideology of medicine that emphasizes a domination of the body should be called into question, prolongevitists need not fear receptivity as a component of a good death when it is properly understood not merely as surrender but as a kind of relationship one can build with one's body. After developing this more robust understanding of receptivity, I have realised there is a diverse array of non-dominating end of life options. Rather than prescribing specific medical and technological solutions to how one ought to face the end of one's life, I believe what matters for a good death is the values and motivations behind these decisions, and through projects like dignity therapy we can empower those who are struggling with their mortality to build new discourses of embodiment, better lives, and better deaths.

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