EUTHANASIA, ASSISTED SUICIDE, AND THE PHILOSOPHICAL ANTHROPOLOGY OF KAROL WOJTYLA

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ABSTRACT

In this dissertation, I show that the philosophical anthropology and Thomistic personalism of Karol Wojtyla (Pope John Paul II) provides a suitable basis for rebutting four arguments in favor of euthanasia and physician-assisted suicide (EPAS): (1) the Argument from Autonomy; (2) the Argument from Compassion; (3) The Argument from the Evil of Suffering; and, (4) the Argument from the Loss of Dignity. The Introduction describes the current EPAS debate and the crucial philosophical questions left unanswered. Chapter I focuses on an evaluation of Wojtyla’s personalism, articulated in The Acting Person (1969). By tracing his philosophical influences, and critique of the moral theories of Immanuel Kant and Max Scheler, I demonstrate how Wojtyla comes to arrive at a synthesis of Thomistic metaphysics and Schelerian phenomenology. It is in recognizing oneself as agent (causal efficacy), that one comes to understand moral responsibility, and in doing so allows the moral act to transform the person. This has significant implications for the Argument from Autonomy. Chapter II will show how the Argument from Compassion fails because it places the subjective element of the ethical act at the
core of morality, to the neglect of duty. In Chapter III, I demonstrate that the Argument from the Evil of Suffering does not account for suffering’s true purpose: acknowledging the vulnerability of persons and its link to human flourishing. In Chapter IV, I argue that the Argument from the Loss of Dignity rests on a confused definition of dignity, since intrinsic dignity exists in humans because they are incommunicable persons. Finally, in Chapter V, I offer an approach to the problem of EPAS that is rooted in the community. Participation in a community is essential to human fulfillment, while the experience of alienation is detrimental. Therefore, I propose that one solution to the EPAS dilemma begins with a steadfast commitment to palliative and hospice care, affirming the value of another precisely because we see “the other” as we see ourselves (another “I”). This will offer a model for the doctor-patient relationship, one that ought to engender a great respect for life, simply because one is a person.
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Love takes up where knowledge leaves off. (St. Thomas Aquinas)

I would like to dedicate this work to my wife, Shruti, whose love, support, and sacrifice for me throughout this process has been nothing short of extraordinary. She has been a living example of the divinely-inspired love which Karol Wojtyla describes in marriage, and in motherhood; I simply could not have written a word without her. I also thank my son, Arav Karol Joseph, my “little buddy,” for making it so easy to “de-stress” by enjoying fatherhood. May he follow his Wojtyla’s example in holiness and intellect—I am sure he already has the “drama” part down!

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Finally, with thanks to God, sine qua non.
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It is not obvious that any argument can demonstrate, once and for all, why murder is bad or why doctors must not kill. No friend of decency wants to imperil sound principles attempting to argue, unsuccessfully, for their soundness. Some moral matters, once self-evident, are no longer self-evident to us. When physicians themselves—as in Holland—undertake to kill their patients, with public support, intuition and revulsion have fallen asleep. Only argument, with all its limitations, can hope to reawaken them.

--Leon Kass, MD

Introduction: Euthanasia and Assisted Suicide: The State of the Question

The State of the Question

Euthanasia and physician-assisted suicide (EPAS) are acts that strike at the heart of what it means to be human—the moral acts that make us who we are, or better, who we ought to be. This subject is so well known in the twenty-first century, that most people outside the field of Bioethics have at least a rudimentary understanding of the major arguments in favor of, or against, EPAS. My intent in this study is not to reiterate these arguments; rather, I will engage the debate from the perspective of the person, and what the action of EPAS might mean for her ontologically and ultimately for society.¹ ²

¹ Because this study focuses primarily on issues surrounding the agent (patient) who requests accelerated death, euthanasia and assisted suicide are treated similarly. The main difference between the two is in the role of the physician in the patient’s death. In euthanasia, it is the physician who kills the patient; in the latter, it is the patient himself. It is also assumed here that euthanasia is “voluntary,” and “active”; although I use these terms for clarity’s sake, I am neither endorsing them, nor attempting to deliberately gloss over the debate surrounding their meaningfulness. It is interesting to
Debates about the ethical permissibility of EPAS go back (at least) as far as ancient Greece and Rome, where euthanasia was practiced regularly. It was the Hippocratic School that ultimately rejected the place of EPAS in medicine. Christianity found this philosophical and practical prohibition compatible with Revelation, which taught that a person had invaluable worth because they were made in the image and likeness of God. By the 15th century, most European physicians had rejected euthanasia, and this remained the case until the 20th century with the rise of Nazi Germany’s involuntary euthanasia programs during the Holocaust.

note, that while there are clearly important academic distinctions made between euthanasia and assisted suicide, the American public generally does not recognize them, supporting both euthanasia and PAS in equal rates. Dutch physicians also do not recognize a difference between the two; in contrast, American physicians tend to support PAS much more than euthanasia, although in most surveys this support is less than fifty percent, even for PAS. [See Emanuel, Ezekiel, “Euthanasia and Physician-Assisted Suicide: A Review of the Empiric Data from the United States,” Archives of Internal Medicine, Vol. 162, Jan. 28, 2002: 144-146 [Henceforth, Emmanuel (1)]; See also Willems, D., et. al., “Attitudes and Practices Concerning the End of Life: Comparison Between Physicians From the United States and From the Netherlands,” Archives of Internal Medicine, Vol. 160, Jan 10, 2000: 63-67.

The notion of death itself is also important to clarify at this juncture. By “death” I mean the cessation of the biological existence of the human person on earth. I will not engage in the debate over brain death, what constitutes a precise definition of death, whether there is life or existence after death, or what the significance of the “philosophy of death” debates are at the present time. EPAS is meant to take the life of the person on earth and therefore end his earthly existence. For a brief but provocative discussion of philosophical conceptions of death, see Ramsay, Hayden, “Death: Part I,” New Blackfriars, Vol. 86 (1001); 2005: 94-100, and the subsequent three essays. Some supporters of EPAS, including Christians, have made the argument that active killing might be a good for the person by bringing about a better future life. (See Mark J. Cherry’s examples in, “Foundations of the Culture Wars: Compassion, Love, and Human Dignity,” Christian Bioethics, Vol. 7 (3); 2001: 299-316, especially 303-304.) For a brief history of the Christian conception of death (and suffering), see Henry, H. Andrews and Murrell, K.J., “Psychospiritual Care of the Dying Patient: The Impact of Being a Christian,” Linacre Quarterly, Vol. 63 (2); August 1996: 81-94, especially 84-85.

Ezekiel Emanuel points out that debates about EPAS in the United States and Britain during the late 19th and early 20th centuries are reminiscent of those today, both in terms of their content and their ferocity. He speculates that interest in euthanasia arises historically and predictably when (1) economic recession or pressure coincides with a movement toward Social Darwinist policies intending to remedy this downturn; (2) physicians are engaged in a struggle with society over their authority and control of their own profession; and (3) terminating life-sustaining practices become part of standard medical practice, and there is a desire to then extend this to active euthanasia.

Arguably, all three conditions were met by the end of the 20th century. The rise of managed care, the dramatic increase in health care costs, and the growing number of uninsured patients (independent of recession) places strong economic and political pressure on individuals (and governments) to find a cost-containment solution. Furthermore, since at least the 1970s, the medical profession has been faced with the dominating principle of patient autonomy as a challenge—first to medical paternalism, and then extending even to the principle of beneficence; the Internet has expanded the ability of patients to have instant access to an enormous amount of information about disease previously thought “too technical” or even privileged;

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4 Emanuel (2), 797-801.
5 Emanuel (2), 799.
increasing government regulation and litigation have sought to curb the power and authority of physicians. Finally, with the Karen Anne Quinlan case (1976)\(^7\) that permitted the withdrawal of life support out of respect for a patient’s autonomy, the push to allow EPAS has become progressively louder in many academic, medical, and legislative circles.

In 1994, Oregon voters passed the Oregon Death with Dignity Act (reaffirmed by a large margin in a referendum in 1997), which exempted “from civil or criminal liability physicians who, in compliance with specific safeguards, dispense or prescribe (but not administer) a lethal dose of drugs upon the request of the terminally ill patient.”\(^8\) To this day, this remains the only state in the US which allows physician-assisted suicide (PAS).\(^9\)

\(^7\) Supreme Court of New Jersey, *In the matter of Karen Quinlan, an alleged incompetent*, 355A, 2d, (1976).

\(^8\) Gostin, Lawrence, “Physician Assisted Suicide: A Legitimate Medical Practice?” *JAMA*, Vol. 295 (16): April 26, 2006: 1941. This article (pages: 1941-1943) provides one legal analysis of the Supreme Court’s 2006 decision (*Gonzales v Oregon*) which denied the US Attorney General the ability to effectively stop physicians from prescribing medicine to help patients kill themselves under the Controlled Substances Act. Gostin’s article concludes that PAS is a “legitimate medical practice,” but the philosophical justification provided is scant.

\(^9\) At the time of this writing, Belgium and the Netherlands are the only two countries in the world where euthanasia has been legalized; in addition, Switzerland and Estonia allow PAS and the Netherlands permits PAS and pediatric euthanasia. The Northern Territory of Australia attempted legalization of assisted suicide and euthanasia in 1997; this was subsequently overturned by the Australian Senate. A comprehensive comparison of the laws in the Northern Territory, Netherlands, and Oregon can be found in Little, Traci R., “Protecting the Right to Live: International Comparison of Physician-Assisted Suicide Systems,” *Indiana International and Comparative Law Review*, Vol. 7(2); 1996-1997: 433-466. The empirical problems encountered in all of these countries—ranging from medical complications to underreporting of deaths (about fifty percent) to involuntary euthanasia (over 1000 per year)—are too vast to recount here. (See Onwuteaka-Philipsen, B., et. al, “Dutch experience of monitoring euthanasia,” *BMJ*, Vol. 331, 2005: 691-693; Groenewoud, J., et. al., “Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands,” *NEJM*, Vol. 342 (8), Feb 24, 2000: 551-556.) For additional resources on the current
In 1997, the US Supreme Court ruled in a landmark case that although there was no constitutionally protected right to PAS, the states were permitted to pass laws allowing it.\(^\text{10}\) Thus, the issue remains one widely open to philosophical, political, and legal challenge.\(^\text{11}\)

Public support for EPAS in the US, however, has not increased dramatically in surveys since the mid-1970s. Support for PAS in a recent poll showed a deeply divided public, with 46% approving of PAS laws, and 45% opposing them.\(^\text{12}\) In an earlier extensive review of the empirical literature, Emanuel indicates that Americans remain roughly divided on support for EPAS, with roughly one-third supporting it without qualification, one-third opposing it without qualification, and another one-third of Americans supporting it under some conditions and opposing it under others.\(^\text{13}\)


\(^{12}\) Pew Research Center, \textit{Strong Public Support for Right to Die} (January 5, 2006). Available at: http://people-press.org/reports/display.php3?ReportID=266. Despite the title of this report, the results are more equivocal. The report and polling numbers do not clarify what is a “right to die,” nor are there clear answers as to the public’s understanding of the distinction between killing and letting die. Much of Emanuel’s (1) critique of PAS public surveys is evident in this report.

\(^{13}\) Emanuel (1), 142-144.
Preliminary Philosophical Considerations

The lack of consensus in American society today on the ethical question of EPAS could be attributed solely to the incredible complexity and gravity of the issue. But such a characterization would be only part of the story. After all, if moral philosophy is to be useful, it must confidently seek to clarify and refine even the most serious questions, so as to make them more penetrable to human reason, and thus lead us to truth. We must ask ourselves, then, if clarity eludes us, whether we are failing to ask the right questions as philosophers, or starting our inquiry from the wrong place.

In this study I will suggest that part of the problem with the arguments that advocate euthanasia is that they fail to begin at the proper starting point. Unlike abortion or brain-death discussions, the euthanasia argument does not turn on “questions” of whether the human is a person. The patient who requests suicide is considered by all parties to be a rational agent with full moral standing in the community. But what does it mean to be a moral agent? Proponents of euthanasia frequently cite, for example, patient autonomy and compassion as justifications for their point of view, but without justifying a corresponding notion of the patient as person. The “anthropological question” is thus critical to any discussion of EPAS. Edmund Pellegrino, in a recent essay, noted rightly that “we must know the nature of ourselves, others, and the world, otherwise there is no template against which to measure the moral status of our thought and action. The persistence of the anthropological question is a reminder of both our continuing puzzlement and our
need to base our moral lives on some concept of the good for humans, that which advances our humanity.”

For Karol Wojtyla, the late philosopher and pope, ethical action finds meaning only in an *authentic* understanding of the person; but it is through acting (*actus humanus*) alone that the human person reveals himself, in living experience. With this fusion of Aristotelian-Thomistic metaphysics and Schelerian phenomenology, Wojtyla has contributed something rather original to the history of ethical philosophy; he has given us a way of fundamentally incorporating a *normative* element into our understanding of the person in act. Knowing what the person is, and what he ought to be, cannot be divorced from what he ought to do; for Wojtyla, the structure of the ethical “do”—the act itself—comes first. Herein lays our solution to breaking the impasse in the debate over EPAS. For with deliberately hastened death, the person does not experience himself as the author of his own action. Responsibility, the core of ethical action, is not realized, and true freedom therefore not exercised.

This paper will focus on four arguments popularly used to justify assisted suicide and euthanasia: (1) the Argument from Autonomy, (2) the Argument from

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14 Pellegrino, Edmund, “Toward a Richer Bioethics: A Conclusion,” in Taylor, Carol R., and Dell’Oro, Roberto, ed., *Health and Human Flourishing*, (Washington, DC: Georgetown University Press), 2006: 250. Pellegrino goes on to divide anthropologies into those which are anthropocentric (in which philosophical anthropology proper is considered), and theocentric. Theocentric anthropologies have God or a supreme force of some kind which lays down norms for man. Seen in this light, Wojtyla’s anthropology is a sort of hybrid—a theologically inspired philosophical anthropology; it acknowledges God as the origin of truth, but engages and critiques purely philosophical anthropologies in secular language.
Compassion, (3) the Argument from the Evil of Suffering, and (4) the Argument from the Loss of Dignity. I am aware that there are other arguments offered in favor of EPAS from a variety of philosophical, and even theological, points of view. I have chosen these four arguments specifically because, first, they are the most commonly proffered. Second, these broad philosophical justifications correlate with much of the empirical data collected over the past decade regarding the reasons that patients choose EPAS. For example, in Oregon, (the only state at the time of this writing to have legalized PAS), the 2007 annual report on the “Death With Dignity Act” cited the three most frequent “end of life concerns” for persons choosing PAS were loss of autonomy (100%); decreasing ability to participate in activities that made life enjoyable (86%); and loss of dignity (86%). Pearlman’s study (2005) identified (1) illness-related physical experiences, (2) loss of sense of self, and (3) fears about the future, as the primary motivations for patients considering PAS. A retrospective study of patients in the Netherlands found that the three most frequent reasons patients themselves say they request EPAS are (1) pointless suffering, (2)

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loss of dignity, and (3) weakness. Finally, the four arguments above allow me to reasonably limit the study. It is conceivable, of course, that the application of Wojtyla’s philosophy to other issues beyond the scope of this study would be possible and desirable; thus it is my hope that my arguments here will serve as the beginning of a rigorous (re)examination and critique of the unspoken philosophical anthropologies which underlie many issues in bioethics, including EPAS.

I will seek to answer each of the four claims from the perspective of Karol Wojtyla’s philosophical anthropology. Much of this will come from his defining work in pure philosophy, *The Acting Person* (1969)\(^{19}\); however, a collection of his scholarly essays from Wojtyla’s early Lublin lectures\(^{20}\) will be of great value in furthering our insight into human ethical action.

Can one further develop and defend an opposition to EPAS based upon an anthropology that is a synthesis of two such disparate anthropologies as Immanuel Kant and Max Scheler? Is such a project possible? I believe that it is. In agreement with Pellegrino, I submit that we must attempt such dialogue between radically different anthropologies because, first, all anthropologies “grasp some essential aspect of man’s existence”; and secondly, because, given the increasingly polarized


debate which surrounds EPAS in academic circles and bedsides around the world, 
“Not only are we moral strangers, but we are in danger of becoming moral enemies 
as well.”

Chapter I of this enterprise will focus on Wojtyla’s philosophy of action and his 
response to Immanuel Kant’s formalism. From his response, I will construct an 
argument based in philosophical anthropology, which undercuts the very premise of 
the Argument from Autonomy. In Chapter II, I will focus on Wojtyla’s critique of 
Max Scheler’s emotional intuitionism and the Argument from Compassion. In 
Chapter III, I will shift to the late Pope’s ideas of suffering and alienation, which will 
be crucial to an understanding of why, on Wojtyla’s anthropology, the Argument 
from the Evil of Suffering fails. Chapter IV will examine the Argument from the 
Loss of Dignity and the recent philosophical assault on the concept of dignity itself 
and show that neither argument accurately reflects the nature of the person at the end 
of life. Finally, in Chapter V, I will suggest some positive solutions to the ostensible 
stalemate over the euthanasia debate, again drawn from Wojtyla’s idea of human 
fulfillment through participation with the other, and with the community itself.

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21 Pellegrino, E, in Taylor, Carol R., and Dell’Oro cited above, 262.
I slept and dreamt that life was a joy. I awoke and found that life was a service. I acted, and 

behold, service was a joy!

--Rabindanath Tagore

Chapter I: Actus Humanus: The Ethical Act and the Argument from Autonomy

Defining Ethics: Wojtyla’s Philosophical Influences

Karol Wojtyla is concerned with the state of the ethical act in philosophy. In his “The Problem of the Separation of Experience from the Act in Ethics,” (1955-57) he begins:

Ethics, as we know, is the science of human actions from the point of view of their moral value—of the good or evil contained in them. Every human action involves a particular lived experience that goes by the name ethical experience...This whole lived experience has a thoroughly empirical character...

It is prudent to take careful note of this definition, for it reveals several influential philosophical strains of thought. First, we see that Wojtyla defines ethics as the “science of human actions,” which have “good or evil contained in them.” The use of “science” implies that there is a sense of order, rationality, and objectivity that can be studied empirically. This view is Thomistic in nature. The influence of the thought of

22 See “Figure 1: The Structure of a Free Act” which follows this chapter.

23 For a more extensive historical and biographical reading of Wojtyla’s three main philosophical influences (Thomism, phenomenology, and personalism), see Beabout, Gregory R., et. al., “Karol Wojtyla on the Acting Person,” in Chapter 2 of Beyond Self Interest: A Personalist Approach to Human Action, (Lanham, Maryland: Lexington Books), 2002: 34-73, especially 34-47.

24 PC, 23.
St. Thomas Aquinas on the late Pope’s thinking is undeniable and has been written about extensively elsewhere.  Wojtyla expressly acknowledges Thomism’s influence in the Preface to *The Acting Person*, and, in a 1967 essay entitled “Ethics and Moral Theology,” he called Thomism a system of “monumental proportions…capable to this day of arousing the admiration of anyone who only takes the effort to understand and evaluate it.”

St. Thomas Aquinas not only held that all knowledge begins with experience, but also that the search for the objectivity of moral action can only occur within the context of “being and becoming, with categories of potentiality and act.”

Furthermore, Wojtyla’s definition makes clear that ethics does not primarily study behaviors, thoughts, intuitions, or emotions—it studies *human* action. He does not want to banish these former elements from ethics—they surely play a critical role. Here is where he parts with phenomenology (and Max Scheler); we see a strong personalist influence (a subjective focus) that is inseparable from truths about moral action (an objective focus). This is precisely why Wojtyla speaks of the “good or evil

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25 See, for example, Modras, Ronald, “The Thomistic Personalism of John Paul II,” *The Modern Schoolman*, Vol. 50, January 1982: 117-127. Modras goes so far as to flatly call Wojtyla “a Thomist.” This is controversial, since Wojtyla departs and even criticizes traditional Scholastic thought in key areas (125). His synthesis of phenomenological and natural law ethics into a Christian personalism allows Wojtyla to avoid being easily categorized into one particular philosophical “peghole”; it also allows supporters (such as Modras) to “claim” him as their own.

26 Modras, 125.

27 Modras, 120.
contained in” ethical actions (a Thomistic view), rather than the good or evil “appearance” of ethical actions (a phenomenological view).²⁸

The normative character of the act is therefore derived from the philosophy of being—the Aristotelian-Thomistic notion of potency and act.²⁹ St. Thomas Aquinas saw that the will, an integral part of the person, is directed toward the good—the good submitted by right reason. Thus, reason’s object is truth. Because reason presents goods to the will to choose from, human freedom is necessarily rooted in truth. There are goods that man ought to choose—goods that lead to the transformation of the person. When chosen, these goods allow him to actualize his being—to move from potency to act, from what he is, to what he can (or ought) to be.³⁰ For Aristotle and St. Thomas, “the very essence of human action consists in the actualization of the will acting under the direction of reason.”³¹

But it is the person who acts who occupies the central role in ethics—not categorical imperatives or consequences. What then does St. Thomas have to say

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²⁸ Modras, 119. Phenomenological approaches such as Scheler’s assert that the subject knows the good as it appears intuitively or emotionally; Thomistic thought posits that the good is real (has being), and evil is a therefore a privation. Hence, human action necessarily becomes a metaphysical question of imperfect being moving toward perfection or away from it.

²⁹ An excellent, more detailed discussion of the metaphysics of Wojtyla’s ethics can be found in Schmitz, cited above, particularly 48-57. It is necessary for brevity’s sake to provide but a brief summary here.

³⁰ Schmitz, 47-53. “Reason in its practical mode knows the truth, just as the same reason knows the truth in its theoretical mode, but in its practical mode it knows the truth from the viewpoint of action and the good.” (Schmitz, 53)

³¹ PC, 24.
about the person who acts, if anything? Ronald Modras has analyzed Wojtyla’s 1961 essay, “Thomistic Personalism,” where Wojtyla looks at Aquinas’ writings for a personalist element. Essentially, Wojtyla identifies four specific characteristics, rooted in Thomistic thought, that enrich our understanding of what it means to be a person. These four characteristics of the person will play a major role in our analysis of EPAS.

First, a person is one who thinks (i.e., has a rational nature) and therefore creates. But, unlike in Kant, “human thought does not create its own world of concepts and judgments distinct from reality. Rather, a person is creative precisely in extracting truths from reality.”

Second, a person is a creature who acts in freedom, but this is not merely a “freedom to choose.” As I will demonstrate, Wojtyla develops his notion of freedom as one tethered to the truth, so that freedom is authentic only when one chooses what is (objectively) true, or good, or (ontologically) real. Third, a person is one who loves. Loving another and being loved are part and parcel of existence; it is self-giving through love—both as a terminally ill patient and a physician—that is the key to overcoming suffering at the end of life. In loving, we continue the path to perfect our being for which we were

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32 PC, 165-176.

33 See Modras, 121-124. Aquinas discusses personhood with respect to the Trinity, rather than man. The nature of the “perfection” found in created persons must begin with the true perfection found in their source: God.

34 Modras, 123.

35 Here I mean “loving” in the normative sense, having the capacity—as part of being human—to love.
created. Finally, and just as vital to our discussion of EPAS, *a person is one who acts within a community* for the common good of other persons. He may even be called to sacrifice for the common good, but he may never be violated as a person for it.

Despite the strong Thomistic or metaphysical element that gives moral action is objectivity, the last part of Wojtyla’s definition of ethics (“Every human action involves a particular lived experience that goes by the name *ethical experience*”) shows the influence of Max Scheler’s phenomenology on his thinking. Phenomenology is the study of human experience as a way of understanding ourselves and the world; for Wojtyla, it reveals the metaphysical reality of the subject (human person). It is only through experience that one can gradually understand human goods and grasp the objectivity of the moral law. Dell’Oro elaborates:

…nonformal universal binding principles of natural law, are grounded in an inductive process of discovery whereby the meaning of fundamental human good is progressively recognized and appropriated as essential to the realization of personal identity. From a transcendental perspective, the objectivity of the natural law is reduced to a transcendental subjectivity. Moral norms of natural law owe their normative force to freedom because they serve the true fulfillment of freedom…

Thus, Wojtyla sees ethics as an intimacy between natural law and experience: normative and yet fundamentally rooted in a subjectivity that truly makes freedom one’s own.

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One Problem of Modern Ethics: Kant

The problem of modern ethics, Wojtyla believes, is that since Kant, the ethical experience has been separated from the ethical act: the totality of the *actus humanus*—one that engages the entire human person—has been torn in two. A fundamental change in philosophical thinking occurred with Kant, who claimed (in the *Critique of Pure Reason*\(^{37}\)) that how we know objects has only to do with the knowing subject, not the object itself.\(^{38}\) Nature and its objects, Kant believed, had for too long constrained human freedom by making our knowledge dependent upon “extracting secrets” from it. The scholastic metaphysics of being was “dogmatic” and extra-mental, and could be rejected as a source of knowledge, for it went beyond human consciousness.\(^{39}\)

Kant’s major objective, which is clear from his later ethical theory positing a “self-legislating will,” was to assert reason’s dominion over the conditions of its own knowledge—all aspects of knowledge must have the form of reason. Thus it was that *universal reason, as subjected to universalizability*, became the criteria for moral


\(^{38}\)It should be pointed out from the very beginning, that I make no claims to be a Kantian scholar. My analysis of Kant relies on my own humble reading and interpretation of English translations of various texts and treatises, and of course, on commentaries from a wide array of Kantian experts. A full explication of Kant’s ethical theory is obviously not necessary or possible here. I rely primarily on summarizing Wojtyla’s careful analysis, although I am aware that at certain moments he departs from the “standard” interpretation of Kant.

\(^{39}\)PC, 26.
action. The categorical imperative, the law as “the a priori product of reason,” alone governs the goods which humans strive for. Experience was not needed for moral knowledge; ontological transformation was abandoned:

Metaphysics has accordingly lapsed back into the ancient time-worn dogmatism, and so again suffers that depreciation from which it was to have been rescued...It is a call to reason to undertake anew the most difficult of all its [reason’s] tasks, namely, that of self-knowledge, and to institute a tribunal which will assure to reason its lawful claims, and dismiss all groundless pretensions, not by despotic decrees, but in accordance with its own eternal and unalterable laws.

With this rejection of the metaphysics of being—the transcendent norm of human action—the actualization of the subject was alienated from ethical experience, and our desires, feelings, and experiences are considered irrelevant to human freedom.

What is the role of the will in ethical action?

Only when the will turns entirely and exclusively toward the form of the law, when the law as such becomes the primary motive as well as its object, when the law is fulfilled because it is the law—only then does the will act morally.

Wojtyla’s principal objection is that Kant has “removed the very essence of the ethical life” from personal experience and banished it to a world outside of the

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40 Wojtyla also intends to present (and I intend to defend) a “universalized” theory of moral action. Like Kant, the construction of an authentic philosophical anthropology requires reason and is applied in all cases equally.

41 Kant, cited above, 8-9 (Preface to First Edition, Ax-Axii).

42 PC, 30.
empirical. Kant’s ethics is the purely rational act, stripped of the emotional element which is characteristically human.\textsuperscript{43} The form of the act is of sole concern for Kant.

\textit{The Argument from Autonomy Defined}

We now turn to the various justifications for euthanasia and assisted suicide offered by its proponents. The Argument from Autonomy, briefly, claims that rational people have a fundamental right to the disposition of their bodies, and that, given the differing perceptions of “good” in a pluralistic society, they ought to have the freedom as patients to choose the timing and manner of death.\textsuperscript{44} The most famous proponent of assisted suicide, Jack Kevorkian, claimed:

\begin{quote}
In my view the highest principle in medical ethics—in any kind of ethics—is personal autonomy, self-determination. What counts is what the patient wants and judges to be a benefit or value in his or her own life.\textsuperscript{45}
\end{quote}

More mainstream proponents of euthanasia, such as John Lachs, argue that the “function of the principle of autonomy is to affirm a value and to shift the burden of justifying infringements of individual liberty to established social and governmental...

\textsuperscript{43} PC, 31.

\textsuperscript{44} See, for example, Brock, DW, “Voluntary active euthanasia,” Hastings Center Report, 22, 1992:10-22. “If self-determination is a fundamental value, then the great variability of people on this question makes it especially important for individuals to control the manner, circumstances, and timing of their dying and death.”

powers…in the end, our lives belong to no one but ourselves. The limits to such self-determination or self-possession are set by the demands of social life.”

In a classic paper, Dan W. Brock outlines the Argument from Autonomy (although he does not specifically call it this) in this way:

The central ethical argument for euthanasia is familiar… [The two fundamental ethical values that support the right to euthanasia] are individual self-determination or autonomy and individual well-being. By self-determination as it bears on euthanasia, I mean people’s interest in making important decisions about their own lives for themselves according to their own values or conceptions of a good life, and in being free to act on those decisions. Self-determination is important because it permits people to form and live in accordance with their own perception of the good life, at least within the bounds of justice and consistent with others doing so as well. In exercising self-determination people take responsibility for their lives and for the kinds of people they become. A central aspect of human dignity lies in people’s capacity to direct their lives in this way. The value of exercising self-determination presupposes some minimum of decision-making capacities or competence, which thus limits the scope of euthanasia supported by self-determination…

Several interesting points should be made about Brock’s formulation, which can be said of many formulations of the Argument from Autonomy. First, Brock equates self-determination and autonomy, the significance of which will be crucial to our discussion below. Wojtyla’s account, which I defend, will be much richer than a

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mere equation of these terms. Second, Brock carefully weaves the Argument from the Loss of Dignity into his account (or, at least ties dignity to autonomy); as we will see in Chapter IV, dignity itself has been used by both proponents and opponents of EPAS to buttress their claims. Third, Brock clarifies that we speak only of those with decision-making capacity—thus I will limit my own remarks to voluntary, active euthanasia.\textsuperscript{48} We must begin, then, with an examination and critique of the roots of this sort of argument.

\textsuperscript{48} It should be obvious to the reader that I deliberately gloss over one glaring objection to the Argument from Autonomy that is often made in the literature: the “slippery slope” argument. The argument goes that allowing a (usually marginally acceptable) practice opens the door legally, psychologically, pragmatically, and morally to other, more unacceptable or unwanted practices. For example, opponents of PAS might argue that Oregon’s statutes legalizing PAS say nothing, even with “safeguards,” of what a provider must do if an autonomous suicide is “unsuccessful.” It is presumed that, from a practical standpoint, euthanasia would need to be employed to respect a patient’s autonomy. Other classical arguments have stated that voluntary active euthanasia opens the door to nonvoluntary active euthanasia (e.g., children, the disabled) and finally to involuntary euthanasia. Proponents of EPAS have tried to show philosophical flaws in the argument. Both sides have used empirical data from the Netherlands or Oregon to buttress their claims. [See, for example, Foley, Kathleen, and Hendin, Herbert, ed., \textit{The Case Against Assisted Suicide: For the Right to End-of-Life Care}, (Baltimore: Johns Hopkins University Press) 2002: especially the collection of essays in “Practice versus Theory,” 97-209. For the opposing view supporting EPAS, see Quill, Timothy, and Battin, Margaret, ed., \textit{Physician-Assisted Dying: The Case for Palliative Care and Patient Choice}, (Baltimore: Johns Hopkins University Press) 2004: especially “Part Three: Open Practice in a Legally Tolerant Environment,” 165-241. ] After reviewing the body of literature I find the slippery slope argument convincing, and a \textit{prima facie} reason to oppose EPAS, ironically, because autonomy is not being respected in practice. The most recent and convincing analysis supports the notion that patients are having their lives ended without consent on a small, but regular, basis. (See Reitjens, Judith A.C., et. al., “Using Drugs to End Life without an Explicit Request of the Patient,” \textit{Death Studies}, Vol. 31; 2007: 205-221.). A full debate about the philosophical merits of the slippery slope argument is beyond the scope of this work. I wish to argue against the Argument from Autonomy in an idealized way, from the point of view of the argument’s philosophical anthropology.
Kantian Autonomy and Anthropology

It is utterly impossible to discuss autonomy in bioethics without some reference to Kant. Allen Wood, for example, in an effusively positive assessment of Kantian anthropology, notes that “[Kant’s] conception of human nature is an authentically enlightenment conception, just as Kant’s critical philosophy as a whole is the greatest and most characteristic product of the intellectual and social movement known as ‘the Enlightenment,’ which remains the unique source in the world for all progressive thought and action…” Wojtyła understood all too well Kant’s impact in the West on moral thinking, and particularly the (impoverished) view of freedom and autonomy which Kant proposed.

The Argument from Autonomy presumes the presence of Kant’s “rational agent,” the creator of law by the very fact of his own consciousness. Reason outlines for itself the scope of law, and submits to itself. If we are to understand how a person acts freely, must we not also understand (as a matter of priority), the nature of the person in action?

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49 For the most part, the claims I make regarding Kantian ethics are either uncontroversial (e.g., that the Argument from Autonomy is based in the notion of a self-legislating will) or are buttressed by a preponderance of scholarly interpretation (e.g., that Kantian anthropology is not equivalent to a moral or philosophical anthropology).


51 I deliberately leave the debate over whether Kant himself would have supported EPAS to Kantian scholars. There are differing views on this subject (See Gunderson, 2004, cited below). Although interesting from a historical point of view, the more critical discussion is how Kantian-inspired ethical and anthropological thinking underpins the Argument from Autonomy in contemporary bioethics.
Kant’s direct attempt at understanding human nature through anthropology has an interesting and controversial history. Kant began lecturing in anthropology in 1772 at the Albertina in Königsberg, a course he continued until 1796. In 1798, his students published notes of this course (his most popular) under his name, with the title, *Anthropology from a Pragmatic Point of View.* Kant’s anthropology was meant to be a course in an empirical science—not at all the *philosophical* anthropology that Wojtyła would develop. For Kant, moral philosophy could only be articulated by “abstracting from all specifically human characteristics”; the term philosophical anthropology “would strike [him] as an oxymoron, given his critical view that philosophy is an entirely rational and non-empirical enterprise, while anthropology is completely empirical.” Yet, many scholars believe that despite the controversy over the precise place of *Anthropology* in the Kantian corpus, it does shed light on Kant’s ethical thinking; he himself wishes to make some connection between anthropology and ethics. For our purposes here, this helps to illuminate Kant’s overarching view of man, and to contrast his conception of ethical acts with that of Scheler and Wojtyła.

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52 The controversy begins here. Many scholars rejected the work initially as not really Kant’s, or poorly executed Kant even if genuinely reflecting his thoughts—some even going so far as to suggest it was a product of Kant’s age. In addition, *Anthropology* was not even widely available in the West in the 20th century (due to Cold War politics), and not available in any English translation until 1997. (For a detailed history see Brian Jacobs and Patrick Kain’s “Introduction,” in *Essays on Kant’s Anthropology*, Jacobs, Brian and Kain, Patrick, ed., (Cambridge: Cambridge University Press); 2003:1-19. For an extensive discussion of the conceptual problems involved with *Anthropology*, see Reinhard Brandt’s “The Vocation of the Human Being,” in Jacobs and Kain: 85-93.)

53 Jacobs and Kain, cited above, 2-3.
What Kant wishes to do is provide an account of how human beings use their mind to act, and how this can inform our investigation of ethical action. Werner Stark astutely notes that in an introductory passage to an ethics course from 1774-5, Kant writes:

The science of the rules concerning how a human being ought to act is practical philosophy, and the science of the rules concerning his actual behavior is anthropology; these two sciences are closely connected, and moral philosophy cannot endure without anthropology, for one must first know of the agent, whether he is also in a position to accomplish what is required if him, that he should do.  

Here, although Kant makes a connection between anthropology and ethics, his view differs from Wojtyla’s in a number of ways. First, Kantian anthropology precedes ethics; studying human behavior provides a context from which to engage in and understand the abstraction necessary for true ethical thinking. In this sense, anthropology is purely descriptive. Anthropology is a background or an adjunct, while ethics is an a priori enterprise. However understanding the context in which a pure abstraction (ethical thought) takes place does not therefore make the act practical. Second, Kant’s study of the behavior of human beings and human experience is one embarked upon from outside man himself. Thus, his anthropology views freedom as indemonstrable or unrecognizable—for when one views human action (from outside the person), it appears to the rational mind as purely

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deterministic. That is, an action proceeds necessarily from the antecedent conditions given it—we just cannot know at any one moment an exhaustive list of those conditions.

By contrast, Wojtyla’s philosophical anthropology is one in which the experience of love plays a prominent role in defining a person’s nature (what they ought to be). Thus, anthropology and ethics are intimately connected, and philosophical anthropology takes on a decidedly prescriptive meaning. A person’s acts (particularly the inter-subjectivity of interaction) continue to change her, define her, and allow her to fulfill her purpose. In addition, Scheler and Wojtyla would not view human action from outside the person. Rather, their view is one of an interior perspective—how a person changes or becomes, through the ethical experience of the subject. Freedom is therefore describable and definable, for when a person chooses the good, she understands herself as the author of her own action; self-determination and integration (discussed below) allows the person to grasp her own freedom.

This is not to say that Kant’s overarching anthropology, which provides the context for his ethics (and his view of autonomy), is without a teleological element. As Richard Brandt points out, in Kant’s summary of Anthropology he elucidates:

…the human being is destined [bestimmt] through reason to live in a society of human beings, and in this society, through the arts and sciences, to cultivate himself, civilize himself, and moralize himself. No matter how great his animal instincts may be to abandon

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55 Wood, cited above, 43.
himself passively to enticements of ease and comfort, which he calls happiness [he is still destined] to make himself worthy of humanity by actively struggling with the obstacles that cling to him because of the crudity of his nature (VII: 324-5).\textsuperscript{56}

Kant seems to be saying that man acts toward a final destiny of some kind, born out of Kant’s rather unique Christian conception of providence (as Brandt calls it, “Christian-Stoic teleology”\textsuperscript{57}). It is the wise or virtuous person who knows the good by \textit{a priori} reasoning (alone) and acts toward it. Again, there is no room here for love, or any emotional element—there is no room here for a person who acts \textit{for another person} based (even in part) on \textit{the experience of love}. Kant’s view is that the common good is only achieved when people act within themselves for the sake of reason; Wojtyla’s view is that the common good is best achieved when people act from a deep interior experience, but project that outside of themselves, in accord with reason, for the sake of love and in solidarity with another.

\textit{The Rationality of Suicide and Attitude Ambivalence}

We must briefly consider at this point, another argument: namely, the possibility that requests for EPAS, purportedly made by a rational agent, is temporally confounded by serious psychological and psychiatric elements that call into question the authentic freedom of the agent in question. There is, of course,

\textsuperscript{56} Kant, Immanuel, quoted in Brandt, Reinhard, “The Vocation of the Human Being,” in Jacobs and Kain, cited above, 93.

\textsuperscript{57} Brandt, cited above, 102.
much argument over whether a suicide can ever be a “rational” choice, both medically and philosophically. Kant held that it was impossible—a violation of the categorical imperative—that a rational agent should wish to destroy himself because in doing so he would wish to destroy the only thing of value to him (his mind).\textsuperscript{58}

Despite Kant’s own words proscribing suicide as contrary to reason, there is considerable debate in the philosophical literature about whether a Kantian view might support \textit{physician-assisted} suicide, or even euthanasia.\textsuperscript{59} Both Hobbes and Locke also opposed suicide on the grounds that one’s exercise of liberty was tied to the preservation of the vehicle that made that liberty possible (i.e., one’s bodily self). By contrast, Hume supported suicide as a purely rational choice.\textsuperscript{60}

Yet, the mental state of the patient, so intimately tied to his physical state, cannot be ignored when considering the Argument from Autonomy. There is significant evidence that terminally ill patients, being subject to profound physical suffering, anxiety, and even depression, have underlying mental health stressors that


\textsuperscript{59} See Gunderson, Martin, “A Kantian View of Suicide and End of Life Treatment,” Journal of Social Philosophy, Vol. 35 (2); Summer 2004: 277-287. Gunderson, for example, concludes that a Kantian view supports euthanasia for the permanently unconscious, if the person had signed a “living will” indicating that choice prior to the state of unconsciousness.

call into question the “pure rationality” of the decision to die which proponents of euthanasia hope to establish.\textsuperscript{61,62,63,64}

Emanuel’s review of the empirical literature on EPAS showed a preponderance of evidence verifying what he calls “the depression thesis”: “Most, if not all studies that have examined this question [patients’ motivation for EPAS] reveal that psychological distress, including depression and hopelessness, are significantly associated with patients’ interest in hastening their own death through euthanasia and/or PAS.”\textsuperscript{65}

In addition, we must consider that there is no widely accepted definition of what constitutes the “end of life,” despite some arbitrary laws and regulations (e.g., hospice regulations or the Oregon statutes) defining it as a period of six months. Lorenz et. al., in a large review of the literature, identified three “trajectories of late


\textsuperscript{62} Suarez-Almazor, Maria et. al, “Attitudes of Terminally Ill Cancer Patients About Euthanasia and Assisted Suicide: Predominance of Psychosocial Determinants and Beliefs Over Symptom Distress and Subsequent Survival,” \textit{Journal of Clinical Oncology}, Vol. 20 (8); April 15, 2002: 2134-2141.

\textsuperscript{63} van der Lee, Marije, “Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients,” \textit{Journal of Clinical Oncology}, Vol. 23 (27); September 20, 2005: 6607-6612; See also, in the same issue, the Editorial by Emmanuel, Ezekiel, “Depression, Euthanasia, and Improving End-of-Life Care,” \textit{Journal of Clinical Oncology}, Vol. 23 (27); September 20, 2005: 6456-6458. [Henceforth, Emmanuel (3).]

\textsuperscript{64} The studies listed above are only a small sampling of empirical data supporting the link between psychological factors such as depression, and the desire for EPAS in the terminally ill. Brief philosophical discussions can be found in Barry, Robert, “The Paradoxes of ‘Rational’ Death,” \textit{Society}, 29, July/Aug. 1992:25-28; and Anronheim, Judith, et. al., editors, \textit{Ethics in Clinical Practice}, 2\textsuperscript{nd} ed., (Gaithersburg, MD: Aspen Publishers), 2000:274-275.

\textsuperscript{65} Emanuel (3), 6456; see also Emanuel (2), 150.
These include (1) high functioning patients who have an illness (usually cancer), that leads to a rapid decline in physical and mental health leading to a prolonged death; (2) mid-functioning patients with episodic declines in health (usually heart and lung failure) that lead to a rapid death; and (3) low-to-mid-functioning patients (usually dementia) with a slow and steady, prolonged decline in health until death. Such evidence indicates that pinning down a patient’s mental status and declaring it “autonomous” at the end of life is much more complicated than simply asking what her preferences are.

Attitudes toward EPAS among the terminally ill shed additional light as to the truly autonomous decision purportedly made. A small but important study of terminally ill cancer patients in a palliative care unit suggested that attitudes toward EPAS fluctuate among these patients, often within a single interview. The study authors define this as “weak attitude strength,” with participants holding “attitude ambivalence,” where patients seemed to simultaneously hold positive and negative feelings toward EPAS. They conclude:


67 Lorenz, cited above. See especially Appendix Figure, W-28.


69 The authors use attitude theory to evaluate their sample interviews with 18 terminal cancer patients in Norway. They define attitude as a “rational evaluation of objects, and of other people’s opinions of the same object.” (Johansen, 458)
Given this ambivalent nature, it is permissible to presume that this wish [for EPAS] reflects other meanings than a genuine desire to die. Rather it might represent the need to control pain, feelings of hopelessness, and/or a way to cope with the fear of suffering unbearable pain.”  

Another recent qualitative study found that those patients requesting PAS are motivated by a “desire for control” and a “loss of a sense of self”: 

Patients expressed concern about losing their personality, their ‘source of identity,’ or ‘essence.’ Without the ability to maintain aspects of their life that defined them as individuals, life lost its meaning and personal dignity was jeopardized.  

Other studies support this finding. For example, Wolfe et. al. showed that a significant minority of cancer patients enrolled in their study changed their attitude toward EPAS over time. No identifiable indicators predictive of attitudinal change could be found. Marcoux et. al. found that those patients (in the Netherlands) who changed their mind after making an explicit request for EPAS had poorer mental health status overall and were more likely to have anxiety or depression.  

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70 Johansen, 458. Interestingly, the authors take pains to point out that wishes for EPAS should not be taken to mean requests for EPAS. To confuse one with the other on an irrevocable action is to court disaster. Rather, they suggest that when such wishes are conveyed to the physician, that efforts to understand the attitude behind the wish (e.g., fear, hopelessness, etc.) should be undertaken.

71 Pearlman, 237.


et. al. documented that 11% of patients in Oregon who requested PAS changed their mind by the end of the 15-day waiting period.⁷⁴

These facts present a profound objection to the Kantian-based Argument from Autonomy. Kant views the rational person as the sole arbiter of his will. Self-consciousness is critical in order to use reason and to understand by abstraction what the moral law demands of us. The important ethical query when considering the Argument from Autonomy, in light of the preceding empirical evidence, is that when a patient’s views are wavering—particularly under conditions where mental health is also deteriorating—is it “respecting autonomy” to grant their chronologically last request to die?⁷⁵ Why should we trust this request, or even two requests made fifteen days apart (the purported “safeguard”), under the same conditions? Can autonomy be exercised authentically under conditions in which one’s very sense of self is deteriorating or unstable?

If the answer is “no,” this leaves us with two possibilities: either Kant’s view of the person and her autonomy is inaccurate, or, if Kant is correct about autonomy, then a terminally ill person requesting EPAS has a high probability that they are not acting in freedom. If the Kantian-based Argument from Autonomy is wrong, and Wojtyla is correct that killing oneself does not lead to human fulfillment through the exercise of free acts, then whether a person is rational or not when they “choose”


⁷⁵ I thank Alexander Pruss of Baylor University for pointing out this helpful objection.
EPAS becomes irrelevant. The choice is a false choice. Although proponents of EPAS argue that honoring the patient’s request for death respects their autonomy, given empirical evidence indicating that a “rational” request for EPAS is suspect, we cannot be certain that acting upholds autonomy—it may in fact, do the opposite.

Two Objections (and Answers)
At this time it would be prudent to answer two obvious objections. First, suppose one were to grant that the terminally ill who request EPAS are at high risk for depression and other mental problems that may cloud their rational abilities. A proponent of EPAS might suggest a waiting period, and a requirement for a consistent, persistent wish to hasten death, followed by a thorough psychiatric evaluation if needed. Indeed, both the Oregon Death with Dignity Act, and the euthanasia laws of the Netherlands require such “safeguards.” The Oregon law specifically requires two oral requests, separated by (an arbitrary) 15 days; a written request given by the patient, in the presence of two witnesses; an additional consulting physician must verify diagnosis, prognosis, and competence; and a psychiatric evaluation must be provided only if either physician believes the patient’s judgment is clouded by a “psychiatric or psychological disorder.” 76 In the

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Netherlands, only 3% of patients who undergo PAS are evaluated by a mental health professional.77

Let us say a patient’s request for euthanasia or PAS has been consistent and is verified by two physicians over the requisite period of time. Should we not respect his autonomy now? There are several answers. First and most obviously, if this were the case, we might still question the Argument from Autonomy on other grounds (e.g., on the philosophical-anthropological grounds elucidated above—that the concept of “freedom” upheld in killing does not respect the true nature of the person). Second, there is considerable evidence demonstrating that physicians are poor at screening for or recognizing depression in the terminally ill in the first place.78,79 Marcoux explains that “it is often difficult to differentiate between the ‘normal’ features of the dying process that some call lack of ‘appropriate sadness’ and depression, and the non-disclosure by patients of their own mood.”80 Our patient faces considerable barriers to getting the psychiatric evaluation and treatment he might need. Third, from a practical point of view, it seems unlikely that physicians who support EPAS and detect depression would stop the process for weeks or


80 Marcoux, et. al., cited above, 1272.
months (to give anti-depressants and psychotherapy a trial), and then re-evaluate. Indeed, in doing so the physician might risk further deterioration of the patient’s mental status, perhaps beyond the point of rationality. Furthermore, for many who support EPAS, the demands of respect for autonomy should be fulfilled and freedom “unencumbered.” Indeed, some authors argue against mandatory psychiatric evaluations because they would be too burdensome, despite the fact that they acknowledge the significant role of depression in requests for euthanasia. Yet, trials of anti-depressants or psychological therapy have been shown to change the mind of 11% of terminally ill patients requesting PAS in Oregon. Finally, as indicated above, two requests separated by 15 days still does not give us absolute confidence that a person acts in freedom; we are only accepting their chronologically last two requests and equating that with their authentic request.

In summary, even if one accepts the premise of the Kantian autonomy argument, there is still a danger that the depressed or anxious terminally patient would be at considerable risk of having their autonomy trampled by physicians acting on wishes that may not reflect the patient’s authentic beliefs.


82 Ganzini (2), et. al., cited above, 562. Tellingly, the authors state that “Only 11 percent” [my emphasis] of patients changed their mind about PAS, a number that is actually quite significant!
The second objection is as follows: suppose, as some have suggested, the person—prior to becoming terminally ill—makes a “living will” of some kind, requesting euthanasia or PAS if they should ever become terminally ill and incapacitated. The patient does so when they have all their rational powers and no signs of depression. Does this justify EPAS based on a “rational suicide” upholding the principle of autonomy?

The first response to this objection is that simply because a person is rational (not depressed) at the time a future request is made for EPAS, does not mean they will remain so after they receive a diagnosis of terminal illness—after suffering and pain and grief have taken their toll, or after (presumably) medical interventions have been tried and failed. Mental health, like physical health, is a dynamic—not a static—process. Although depression can exist prior to a terminal diagnosis, it often is manifested afterwards; some studies have shown an increase in suicide risk in the immediate period after a cancer diagnosis, for example. This is not, of course, a broadside against all living wills. The person who writes a living will to not have life-sustaining treatment continued if he were to ever fall into a persistent vegetative state, for example, can predict neither his physical or mental state at the time he should become persistently vegetative. Here the presumption lies with the person’s prior autonomous decision. However, in the case of EPAS, we have good reason to

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83 See Gunderson, cited above.

believe that terminally ill patients are particularly vulnerable to sadness, hopelessness, anxiety, and depression. The living will requesting EPAS would still need re-evaluation at the time of the request, in light of the questionable mental status of the patient. Secondly, supporters of EPAS consistently rank factors such as “unremitting pain” to be the primary reasons for support of EPAS; however, most studies “suggest that the intensity of pain and of most other somatic symptoms does not have an impact on [terminal] patient attitudes.” Thus, fears and motivations for the person in a rational state who desires EPAS in the future may not accurately reflect their wishes when ultimately given a terminal diagnosis.

Benedict Ashley and Kevin O’Rourke’s “Principle of Inner Freedom,” a principle they claim is a fundamental part of the structure of healthcare ethics, is instructive here. Just as external factors can call into question whether an act is truly free, so too a person’s inner state—sometimes afflicted with addiction and fear—can be detrimental to liberty. In order for man to be truly free to exercise his conscience, he must be devoid of “phobias” that might hinder prudent decisions about his own welfare. The empirical evidence suggests that fears of death and a loss of sense of self, as well as frank depression often weigh heavily on the minds of many of the terminally ill—and this hopelessness becomes a primary reason for

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85 Suarez-Almazor, cited above, 2139. See also Emmanuel (2), (3); also see the subheading “Pain,” below, in Chapter III.

support of EPAS. This is not to say that some fears (e.g., fear of death and loss of self) are always irrational phobias, but when fear feeds hopelessness, and indeed, in these cases, a wish for death, fear becomes pathological. Fear becomes a hindrance to the exercise of freedom. How can one argue, then, that EPAS buoys and *expands* the freedom of the person?\(^87\)

*Freedom in Action and the Structure of Consciousness*

Wojtyla offers a refreshing counter example of authentic freedom contained in the structure of human consciousness. It is clear from Wojtyla’s view of ethical action that *actus humanus* engages the whole person, and that one’s rational power and autonomy cannot be separated from the metaphysical reality of the transcendent person. As Pope in *Evangelium Vitae* (1995), he argues that autonomy divorced from truth is a false freedom:

> …but when freedom is made absolute in an individualistic way, it is emptied of its original content, and its very meaning and dignity are contradicted. There is an even more profound aspect which needs to be emphasized: freedom negates and destroys itself, and becomes a factor leading to the destruction of others, when it no longer recognizes and respects its *essential link with the truth*.\(^88\)

\(^87\) EPAS in fact, by killing the person, certainly prevents the exercise of *future* freedom.

We must turn, then, to *The Acting Person*, and investigate the philosophical underpinnings of authentic freedom in Wojtyla’s thought.

The Introduction and first chapter of *The Acting Person* deal primarily with the structure of consciousness itself, a topic which, while important, must unfortunately be dealt with briefly here.89 Wojtyla needs a theory of consciousness if he is to make the bold claim (later) that the center of ethical action, and thus of human personhood, involves the realization of oneself as the actor. Wojtyla claims that consciousness is but an aspect of ethical action—it is primary, but not (as we have seen in Kant) absolute.90 A person is not equivalent to his consciousness (Descartes), nor is consciousness a mere accident of the person’s being. Rather, consciousness is separate from the cognitive process; it *mirrors* it, penetrates it, and illuminates it—but cognition is different altogether. 91

Consciousness does nothing itself—it is a kind of conduit, which allows the subject both to grasp the unity and simplicity of his experience (an insight called *induction*) and interpret that experience (*reduction*).92 This structural outline recalls other phenomenological methodologies, most notably Edmund Husserl’s notions of

89 For an excellent summary of Wojtyla’s vision of human freedom and personalism, see Kupczak, Jaroslaw, *Destined for Liberty: The Human Person in the Philosophy of Karol Wojtyla/Pope John Paul II*, (Washington, DC: Catholic University of America Press), 2000.

90 AP, 30.

91 Kupczak, 81-83.

92 See AP, Chapter 1 and the Introduction, esp. 14-17.
epoche and reduction.\textsuperscript{93} Induction grasps the \textit{unity of the person}, and reduction fills in and articulates the person fully; both are integral and essential parts of the self. The totality of human experience must therefore be understood without separation, and this can only be accomplished through the human act.

\textit{Reflexive} consciousness, Wojtyla claims, is what binds human experience together: we not only cognize objects of our action, but we \textit{recognize ourselves as subjects} originating our own acts, and \textit{experience ourselves} as the “I” of action.\textsuperscript{94} It is in this way consciousness is relativized for Wojtyla. We act, and we experience, but in this dynamic process we experience ourselves as responsible for the action, as good or bad. Wojtyla needs no elaborate proof of this “fact of life”; he would simply say that reflexive consciousness is something every rational person must admit to whenever he knows he is responsible for an act. Thus consciousness is not absolute; yet, despite each person’s subjective experience of moral action, the act in its totality (\textit{actus humanus}) reveals the person in the order of objective being.\textsuperscript{95}

\textsuperscript{93} Husserl, Edmund, \textit{Ideas: General Introduction to Pure Phenomenology}, (New York: Collier Books), 1962: 100-101. Epoche refers to the ability to suspend or “bracket” an object apart from knowledge gained through the natural sciences, in order to grasp the appearing “object” as it appears in the act intending it; reduction is transcending the facts of the thing to grasping the essence of it. For an extremely comprehensive “guide to Husserl,” see Natanson, M., Edmund Husserl, \textit{Philosopher of Infinite Tasks}, (Evanston: Northwestern University Press): 1972.

\textsuperscript{94} AP, 35-45. Here Schmitz again provides helpful analysis. Three distinctions can be made: (1) being a subject (\textit{suppositum}), which is grasped by metaphysics; (2) to be cognized as subject (objectivized) in the realm of cognition; (3) to \textit{experience} oneself as subject, which is accomplished through reflexive consciousness. (74)

\textsuperscript{95} AP, 58-59. Wojtyla explains this as the difference between subjectivism, which characterizes the modern view that leads to absolute autonomy, and the subjectivity of the person, i.e., his realization of himself (self-knowledge) as acting person.
Thus, human action has what Wojtyla calls in Chapter 2 a moment of “human efficacy,” due to the reflexive and recursive nature of the act itself. This is when the agent realizes that he is the “cause of his own causation”: the critical moment where man knows himself to be the efficient cause of his action.\(^{96}\)

Wojtyla argues that there are processes in a person that she is unaware of—vegetative processes for example—that are not mirrored in consciousness. He claims that there are two kinds of activity—conceptually distinct but unified from within. The first are “man acts,” \textit{actus humanus}, the moral acts which involve the conscious subject and reveal human efficacy (\textit{agere}). Only these acts change man, because he understands his responsibility in them. The second type of human activity are “acts happening in man,” \textit{actus hominis}, passive activity revealing human subjectiveness, “without efficacious participation of my ego” (\textit{pati}).\(^{97}\)

Two examples will help to clarify these distinctions. The first is an example given by Wojtyla himself in an early essay on Catholic sexual ethics.\(^{98}\) Wojtyla argues that in marriage, the moral interaction between persons is evident through love. Sexual urges, emotions, and attractions are certainly part of the character of both persons but do not comprise the act itself. In a real and strict sense, a sexual urge or an emotional feeling of love is not an “act” at all:

\(^{96}\) AP, 66-67.

\(^{97}\) Kupczak, 102-103. Kupczak points out that Wojtyla’s distinction between acting (\textit{agere}) and happening (\textit{pati}) is critical to his theory of human agency; this distinction was made in Wojtyla’s early writings on marriage dating to the 1950s.

Nature itself does not act; it is the suppositum that acts (\textit{actiones sunt suppositorum}), and this \textit{suppositorum} is a person. Here we are interested in activity connected with sexual properties and the sexual urge. Our knowledge of the animal world convinces us that this urge has its own natural purpose, namely, to foster reproduction, or procreation. The sexual urge also operates in human beings for the same purpose. This is a purpose of nature. People do not create it, but find it already present in their total structure. But since human beings are persons, they must possess the sexual urge on the level of a person and use it in a manner proper to a person…[the marriage union] arises from a mutual choice…the interpersonal relationship expressed and realized in this choice ought to be true love (I emphasize \textit{ought to be}).

This is the difference between mature love (\textit{actus humanus}) and the emotion of love (\textit{actus hominis}). As will become clear below, the Argument from Compassion confuses \textit{agere} and \textit{pati}. There is nothing wrong with the feeling of compassion, but such a feeling does not constitute a justification to act; both sexual urges and compassion may invite action, but both need to be elevated to the level of human acts. It is how one acts on the urge that is crucial.

A second example is as follows. A man is constantly and consistently harassed by his colleagues and superiors at the post office. He develops feeling of frustration, anger, and occasionally even violent thoughts. These thoughts and feelings which happen in him or to him are part of him, but they are not moral acts. The moral act comes later, when the man decides to take a shotgun to the post office and kill his colleagues. In the instance when he thinks “I could, but I may not (…or

\textsuperscript{99} PC, 285.
maybe I will!” the man has acted as a person, in this case for the worse. He understands himself to be the author of his action, and he is responsible for it. That responsibility will change him, and each act taken afterwards will do the same.

Neither *actus humanus* nor *actus hominis* ought to be rejected; but they should also not be confused either. Wojtyla sees the need for a synthesis. A comprehensive personalism must reflect the authentic experience of living man; he is not simply reducible to one vision (the cognitive) or another (the emotional).

In his critique of Max Scheler (see Chapter II), Wojtyla makes a point of saying that man as the efficient cause of his action is the only value that could be called ethical. In *The Acting Person*, he tells us:

> It is man’s actions, his conscious acting, that make him *what* and *who* he actually is. The form of the human becoming thus presupposes the efficacy or causation proper to man...The qualitative moments and virtualities of actions, inasmuch as they refer to the moral norm and ultimately to the dictates of the conscience, are imprinted upon man by his performing the action. The becoming of man in his moral aspect that is strictly connected with the person is *the* decisive factor in determining the concrete realistic character of goodness and badness. ¹⁰⁰

Wojtyla’s concept of freedom does not begin with the will—with choosing as a rational agent. Rather, Wojtyla begins on a more fundamental level, with *ontological freedom*, with *being* as freedom itself. When one follows through in action, and realizes his human efficacy (the experience of responsibility for one’s

¹⁰⁰ AP, 98-99.
own action), he tastes authentic freedom in the move from potency to actuality. Again, *self-perfection* is critical to the notion of freedom because the very goal of freedom itself is to bring about perfection in the *suppositum*. To be free is a part of the efficacy of the agent, the self-consciousness of becoming through action, good or bad—and this has an objective, normative element built into it. On this view, Roberto Dell’Oro notes, “every moral claim is an expression of the agent’s moral autonomy: the person is *in himself or herself* by nature, but becomes *for himself or herself* through the exercise of freedom.”

What is missing in the Argument from Autonomy, of course, is any reference to a moral norm outside the individual’s own consciousness. “Freedom” here is truly a pseudo-freedom, precisely because it lacks the human element of self-transformation. “Freedom” to do whatever one wishes with oneself is not human freedom, for it makes no reference whatsoever to the *person* who acts; only “freedom and efficacy together determine not only acting or action itself...but their moral goodness or badness, that is to say, the becoming of man morally good or bad as man.”

101 Dell’Oro, Roberto, “Theological Anthropology and Bioethics,” in Taylor, Carol R., and Dell’Oro, Roberto, cited above: 23

102 AP, 99.
Self-possession, Self-governance, and Self-determination

In Chapters 3 and 4 of *The Acting Person*, Wojtyla deals with a concept often equated with autonomy, that of self-determination. What does it mean? To proponents of euthanasia and assisted suicide, self-determination is a power—the ability to choose death when one wishes. If self-determination is merely a power to choose, then the idea that the deterioration of the body compromises self-determination is plausible. In a recent essay, Alisa Carse alludes to this prominent view when she describes that in severe illness “we become the diseased body, the victimized person, or ‘survivor,’ the ‘walking wounded,’ as illness, assault, injury, or grief fix our and others’ attention.”

She points out that suffering and pain, by undermining bodily integrity and function, can compromise a person’s sense of self-determination and control. However, this is true only if self-determination is the same thing as willing.

Now, if actual loss of one’s bodily integrity is proportionate to their loss of self-determination, then we are left with a very vulnerable and poverty-stricken notion of the will. But Wojtyla immediately repudiates this interpretation of self-determination resting in the will alone:

> A complete description of the will cannot refer simply to the moment of ‘willing’ alone, neither to the exercise nor the experience of ‘I will,’...Every action confirms and at the same

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104 An exception to this is the loss of one’s mental faculties. In this case, a loss of self-determination would occur, because the person would not have the ability to engage in the dynamism between the will and the person.
time makes more concrete this relation, in which the will manifests itself as a feature of the person and the person manifests himself as a reality with regard to this dynamism that is properly constituted by the will. It is this relation that we call ‘self-determination.’

It is critical to note Wojtyla’s use of the word “relation” to describe self-determination: it is a relation between the self and the will, not a “one way street” of the self willing. Choosing or willing does not “give you” self-determination. Having a “right to EPAS” does not enhance self-determination. Instead, to Wojtyla, self-determination rests in the suppositum, the existing essence of the person; the person is revealed through the will, because the will is a property of the person. The significance of this philosophical claim cannot be overstated. Wojtyla is not merely claiming that through action, we gain a deeper insight into the (moral) behavior of man, as if the personalist project was nothing more than glorified sociology or social anthropology. Rather, through an act of free will, a person communicates his very self to another. One cannot act as another. He can only act as himself, recognizing his action as originating from within, and literally revealing his being in the process. Human action is truly “an act of existence.”

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105 AP, 105. Wojtyla uses the word “dynamism” to refer to intangible “energies” that cooperate and interact with one another to describe the true nature of man. There is a vegetative (physiologic) dynamism, a psychic (emotional) dynamism, and a dynamism of free human acts—actus humanus. It is within this last dynamism that self-possession, self-governance, and self-determination operate.

106 AP, 107.

other antecedent properties of true autonomy—self-possession and self-governance—are revealed.\textsuperscript{108}

*Self-possession* is the property of the act that allows the person to recognize and understand himself to be “the seat” of his own actions, where authority and control rest with him.\textsuperscript{109} Self-possession demonstrates to the person mastery over himself. Such mastery need not apply to the virtuous man alone; even the man who acts badly knows he is the author of the action. He, as Joseph Seifert claims, “possesses himself and is possessed by himself.”\textsuperscript{110} However, self-possession should not be taken to be the modern notion of absolute mastery, without reference to truth. Wojtyla claims that self-possession is the subject’s consciousness of the origination of his action in him, rather than the auto-normativity of whatever he cognizes. In addition, persons may lose varying degrees of self-possession.\textsuperscript{111} A person who says hateful things to another under the influence of alcohol might remark, “I don’t know what possessed me—I wasn’t myself,” for example. The language is revealing, for

\textsuperscript{108} AP, 106-107.

\textsuperscript{109} Beabout et. al., cited above, provide a helpful note on the etymology of the word “possession.” It comes from the Latin “potis” (to be able) and “sedere” (to sit). With respect to land, for example, he notes that the functional meaning is “I sit down here and this is my own land.” But with respect to the self, the meaning is the equivalent of “I am the seat of my own actions,” which is to say that my actions flow from me and me alone. (51)


\textsuperscript{111} Beabout, cited above, 51-53 provides other excellent examples.
the person both recognizes that he was not “self-possessed,” and that in lacking self-possession, he was not himself unless and until he possesses himself.\textsuperscript{112}

What of the terminally ill person who requests suicide or euthanasia? The empirical evidence suggests a significant reason that people contemplate EPAS is due to a perceived loss of control\textsuperscript{113}; circumstances and environment (suffering, medications, isolation etc.) may convey to the dying that they are not the person they once were, and cannot control what happens to them. Given this scenario, one of two things must now be happening: either (1) the person has really lost self-possession (a pre-requisite for self-determination), or (2) the person has not lost self-possession, but only perceives it to be lost through terminal illness and suffering.

If (1) is true, then we must push proponents of EPAS to justify the Argument from Autonomy when the person’s very notion of a free self is being eroded. If a person has truly lost the capacity to know that they are the originator of ethical action—or even if self-possession is simply being eroded—can they know that the act of killing themselves “restores” this ability or even rectifies their prior loss? Is their autonomy actually being respected when they no longer have the necessary capacity for it? If (2) is true, terminal illness and intractable suffering cannot truly remove self-possession, since it is a property of the human act, as a person acting.

\textsuperscript{112} Wojtyla is not claiming that all people are self-possessed at all times, but rather, that all have the capacity for self-possession as a consequence of their being persons. The goal of the \textit{actus humanus}, the moral act, is to perfect oneself by doing the good while being self-possessed, self-governed, and self-determined.

\textsuperscript{113} See Pearlman, cited above, 234-239.
The act of EPAS may be perceived as a reminder to the patient that they are the author of at least *this one action*—the taking of (or consent to take) his very life—even if everything else around him is chaotic and overwhelming. Here we find problems as well; for the action of EPAS is final—so final that the person never significantly experiences the restoration of self-possession, nor the lived awareness of the experience of the action he has taken. Second, if it is the *perception* of self-possession that is lost, then it is a much safer bet from a moral point of view to change the circumstances that allowed the perception to occur than to eliminate the *person* himself.

Here one might raise this objection: there is a distinction between the acting and the effect of an act:

Suppose that a nurse gives a life-saving treatment to an ER patient that he never sees again, because his shift is ending. Then he experiences the *acting* in giving the treatment. But he may not experience the effect of the acting. Yet the action is not deeply deficient because of this. Likewise, the person killing himself might experience the acting—the swallowing of medication, say—without experiencing the effect.\(^{114}\)

Initially the objection appears persuasive, until one considers the rather unique circumstances of the act of EPAS. A nurse who acts with a “life-saving treatment” knows prior to the treatment that the act is good and has a good effect both for himself and the patient. How? He has prior *experience* of the effect of the act, either by witnessing it, or by acting himself; or, perhaps he has trusted the word of others.

\(^{114}\) I thank Alexander Pruss (Baylor) for playing the devil’s advocate here.
who have experienced it as good (e.g., studies in peer-reviewed journals). He gives the treatment to the patient and experiences the good as a change in being. On the other hand, a person who acts to kill himself, or commands a surrogate to do so, acts with no possible knowledge of the effect of the act in himself; he may have seen a suicide or an act of euthanasia and (mis)perceives a “good” is accomplished, but no person has lived through a successful euthanasia to experience the change in being that accompanies the act.115

Let us consider another response to this objection in light of reasons, enumerated above, as to why people themselves consider EPAS. The most common causes include a perceived loss of autonomy or control, a perceived loss of dignity, and the idea that they are undergoing needless suffering. Dissecting these reasons a bit more, it seems that what people really want is not to end control or autonomy and never experience it again, but rather, they wish to regain it. They do not wish to end their dignity; rather, they wish to restore it. They do not wish to end suffering without qualification; instead, they wish to end or decrease suffering but to experience the fullness of that change through living.

*Self-governance* has a richer meaning than simply “self-control,” for it relates to the “inner personal structure” of a human being. In *The Acting Person*, Wojtyla

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115 Alexander Pruss also made this interesting point in correspondence: “This reminds me of a comment in the submission of Izabela Z. Schultz, a Canadian psychologist, in response to the Canadian Senate’s investigation of the possibility of legalizing PAS (they decided not to). Dr. Schultz wrote that a necessary component of informed consent in medical settings is being given scientific information about the sequelae of the treatment. But there is no scientific information as to what happens after death. Hence, informed consent is impossible.”
discusses self-possession before self-governance because he believes that self-governance is predicated upon having self-possession. Only a person who recognizes himself as the origin of his actions can properly mediate those same actions.  

Each person’s life is acted upon and within by a variety of forces—environmental or external, but also introspective or internal. These influences interact in an incredibly complex way in the assessment of a particular choice, whether or not we are aware of such interactions. Hence, each ethical act is a highly personal one—in fact, it is a unique one, since the various internal and external dynamisms that come together in the act inside this person cannot be precisely repeated. No one enters our minds and makes decisions for us. No one could make us believe we are not the originator of our free acts, nor can we truly cede control of our actions to another. The regulation of these free acts by an individual is truly “a government of the person, by the person, and for the person.”

Self-determination, in turn, is dependent upon self-governance. Wojtyla characterizes self-determination as the element of human action which reveals freedom as a character unique to the person. In willing his own course of action “[f]reedom thus manifests itself as connected with the will, with the concrete, ‘I

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116 AP, 106. See also, Beabout, cited above, 54.

117 This is true under ordinary circumstances. There are certain extraordinary events or conditions, such as Tourette Syndrome, or even demonic possession, that provide helpful counterexamples. A person with Tourette’s may have sudden outbursts of profanity in public that embarrass him and are clearly undesirable. In this case, the man has self-possession (he understands himself as the origin of action), but he lacks self-governance; therefore his action of uttering profanity cannot be considered a “free” act.
will,’ which includes, as noted, the experience of ‘I may, but I need not.’”

“I may but I need not” is a descriptor of how a human being freely chooses. To be free does not mean to simply be able to choose. A free act means that one must be able to recognize choices in front of her (implied by “I may” choose X, Y, or Z). These are choices that can be good or bad for the person. But one also must freely will the choice to act over and above the intellectual grasp of options (“but I need not”). This characterization shows, as Beabout puts it, “ultimately it is the will that is decisive, not the intellect”; but also, “[I]t is not the intellect or will that acts, but the person.”

Therefore, the structure of self-determination involves a personal, subjective element wherein the acting person recognizes himself as the fount of the moral act—an act shaped and molded by no one other human person. In acting, we also recognize an objective element as well: a person is normatively (metaphysically) transformed by his act. This is a bold and profound statement. A person, in choosing the good, becomes (literally!) better; in choosing bad, the reverse happens. Now, this could only happen if all “man-acts” were tied to the notion of objective truth. For in doing good, a person’s very being is moved to a new place, an ontological place where he has not been before, a place closer to actualizing his being. Unlike the

\[118\] AP, 115.  
\[119\] Beabout 56.  
\[120\] This “place” is ultimately fulfilled, for Christians, in the beatific vision in heaven. Another parallel can be found in Hindu metaphysics. Achieving nirvana or moksha (liberation from the life-cycle) is a process. As a man detaches from the world, his soul “moves” in a direction of unity with Brahma.
contemporary notion of autonomy, we “do not turn to the ego as object,” Wojtyla cautions:

\[ W \]e only impart actuality to the...ready-made objectiveness of the ego which is contained in the intra personal relationship of self-governance and self-possession. This imparting of actuality is of fundamental significance in morality, that specific dimension of the human, personal existence which is simultaneously both subjective and objective. It is there that the whole reality of morals, of moral values, has its roots.\(^\text{121}\)

Self-determination in Wojtyla’s account is much deeper than the account which merely equates it with autonomy.\(^\text{122}\) This is where proponents of EPAS, such as Dan W. Brock in our formulation of the argument above, miss the mark: to be free is not merely to be able to choose, but to choose the good.

It may be prudent at this point to provide additional real-world examples from the field of clinical psychiatry to demonstrate how one might conceptualize the different elements of self-possession, self-governance, and self-determination in isolation. These examples are meant to be extraordinary. They underscore the idea that while all persons have the capacity for self-determination by virtue of the fact that they may act \textit{(actus humanus)}, it does not mean that all persons are self-determined all the time.

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\(^{121}\) AP, 109.

\(^{122}\) AP, 119.
Let us imagine first a patient with schizophrenia or multiple-personality disorder in a psychotic state. Such a person might act viciously toward family members and friends when assuming one personality, while being mild in another. The person is not aware of herself as the originator of the bad acts (assuming the mild personality is her baseline)—she therefore lacks self-possession. She can neither claim self-governance nor self-determination. A person with Tourette Syndrome, on the other hand, may have sudden outbursts of profanity in public that embarrass him and are clearly undesirable. In this case, the man has self-possession (he understands himself as the origin of action), but he lacks self-governance; therefore—and this is an important implication—his action of uttering profanity cannot be considered a “free” act. Finally, imagine a person in the throes of deep depression, a person who is absolutely hopeless to the point of being amotivational. Such a person has both self-possession and self-governance but lacks self-determination precisely because they have lost the ability to determine their own course.

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123 Demonic possession, though obviously not a psychiatric illness, would provide another clear example of a person who lacked self-possession.

124 Another example, again not borrowed from psychiatry, is as follows: a man in a concentration camp is forced by his guards to shoot another prisoner or else they will kill ten other prisoners. In this example, the man understands himself as the origin of action (self-possession) and realizes that he can control his action by either performing the act or refusing and facing the consequences (self-governance), but what he cannot say if he shoots the prisoner is “I may, but I need not,” since he also understands, through integration, that there is an outsider who determines the destiny of his action.
Self-Determination and the Incommunicability of Persons

Finally, it is here, within the discussion of self-determination, that Wojtyla makes clear the powerful notion of the incommunicability of persons. Each person that has ever been in existence cannot be repeated; his fundamental uniqueness is revealed as a consequence of his human action and the way in which he becomes through that action:

Because of self-determination every man actually governs himself; he actually exercises that specific power over himself which nobody else can exercise or execute. In virtue of this self-determining agency man is encapsulated, closed within his own ‘reasons.’ This network of exclusively his own ‘reasons’ for life decisions makes him incommunicable to his fellow man…Man owes his structural ‘inalienability’ (incommunicability) to the will to the extent to which self-governance is realized by the will, and in acting this is expressed and manifested as self-determination.\(^{125}\)

Of course, there are many ways “incommunicable” can be taken,\(^{126}\) but Wojtyla begins here to tie a person’s value to her own uniqueness, a theme repeated throughout his philosophical anthropology. If the “incommunicability of persons” is ultimately the source of the value of persons, what does it mean to be incommunicable, and why do we need it as part of a comprehensive philosophical anthropology?

\(^{125}\) AP, 107.

Peter J. Colosi, following John Crosby\textsuperscript{127}, expounds on the notion of incommunicability, seen through the lens of love of another:

The quickest way to get to the notion of incommunicability is to ask why it is you love a person whom you love. The answer is not a communicable trait…There is something utterly unique about each person, which is indeed expressed through traits common to all persons (‘communicable traits’), and intimately united with those traits, but which is not accounted for by listing those traits. One needs to distinguish between the fact of incommunicability and the really existing incommunicable essential content of some person (Crosby 2001: 300). Each person is incommunicable, yet that fact is communicable in the sense that it is proper to persons as such to be unique.\textsuperscript{128}

Colosi argues that without an incommunicable source of the worth of persons, we are left the supposedly impossible task (proffered by Singer) of justifying the value of persons on the basis of common human traits—particularly against the “rationality” of the utilitarian calculus.\textsuperscript{129} However, when we contemplate the experience of love of another (compared with mere “admiration,” for example), “then we keenly

\textsuperscript{127} Crosby, John F., “The Two-fold Source of the Dignity of Persons,” \textit{Faith and Philosophy}, Vol. 18 (3); 2001: 293-306. Crosby characterizes incommunicability as a “mysterious yet knowable” aspect of a person. (298) [Henceforth, Crosby (1)]

\textsuperscript{128} Colosi, Peter, J., “The Intrinsic Worth of Persons: Revisiting Peter Singer and His Critics,” \textit{Journal of Interdisciplinary Studies}, Volume XV; Issue 1-2; 2003: 3-22. [Henceforth Colosi (2)]

\textsuperscript{129} Colosi rightly points out that Singer and other utilitarians want to claim that intrinsic worth boils down to speciesism.: “all claims to intrinsic sources of equality in persons can be reduced to a hollow claim that mere species membership makes all human persons equal, but that species membership lacks anything substantive about it to ground such a claim.” [Colosi (2): 18-19]
experience…the ineffability, the unutterability of the incommunicable,”¹³⁰ and hence the dignity of the human person.

Incommunicability adds a crucial philosophical twist to Wojtyla’s anthropology: the value and dignity of a person rests not with the fact that all human beings have a certain type of sameness; rather, the dignity of a person, created through human action and recognized through love, is based in the fact that she is a unique entity—different from all others. Because she is equally different from all others, the person also has a certain equality with all others.¹³¹ Much more will be said on human dignity in Chapter IV.

Transcendence, Integration, and Conscience

The self-determined person is a person now free to act in truth, but he must do so in a way in which he “comes out of himself” and grasps the reality of his action. Phenomenologists such as Husserl and Scheler had spoken of opening oneself to something exterior—but Wojtyla speaks of a more profound transcendence.¹³² This is not a religious transcendence. Rather, Wojtyla’s view sees an intrapersonal transcendence through self-determination, one that is realized only through the


¹³² “For Husserl, this would involve opening oneself to the experience of a thing in such a way that the external thing reveals its essence. For Scheler, this would involve opening oneself to the experience of value in a different way.” (Beabout, 58)
exercise of the will in freedom. Thus, Wojtyla terms this intrapersonal movement “vertical transcendence” because it grasps at something higher than the person. As Kenneth Schmitz would put it in conversation, vertical transcendence describes “crossing an inner threshold” toward truth. The will is attracted to the good; therefore, the person is also—but attraction is not the same thing as incorporation or absorption. This is obviously a controversial claim. Wojtyla assumes that persons do not have a “neutral attitude” toward all values, “a kind of indifference to their attractiveness and to their visible hierarchy in the world, lurking somewhere deep at the bottom of the person, at the origin of all the dynamizations that are proper to the will. On the contrary, it lies in the very nature of the ‘I will’—which is always object-oriented and consists in an ‘I want something’—that it is constantly prepared to come out towards a good.”\textsuperscript{133}

All free acts which perfect the person therefore require the person to go beyond the will; they require “his consent to be attracted by positive, authentic values…to be drawn and absorbed by them.”\textsuperscript{134} One recognizes through transcendence that the object which the will is attracted to is good is true and chooses it freely. Conversely, the person who rejects the good the will is drawn to fails to go beyond himself.

\textsuperscript{133} AP, 128.

\textsuperscript{134} AP, 127.
Vertical transcendence is distinct from a horizontal transcendence of intentionality, a transcendence toward an end or object (e.g., appetite, cognition). The will is involved in the fullness of the human act—an inner transcendence in which the person opens herself not toward essences or values, but toward truth. Because of this connection to truth, vertical transcendence has to do with the power of the intellect (to choose to know or to grasp) rather than mere consciousness (to think about or discern possibilities).  

The subjective measure of our authentic freedom is the task known as integration: the “degree to which we have succeeded in [coordinating] the complex strands of our consciousness and the various dynamisms within our whole being as concrete persons.” Integration” as Wojtyła means it is not far from its technical usage in medicine, where diverse physiologic systems are ideally seen as functionally unified. Thus, for example, when a person becomes frightened, there is a cognitive recognition of a fear-stimulus, which generates an increase in adrenaline, which causes an increase in heart rate and blood supply to large muscle groups in the legs capable of fleeing, etc. Despite the separate, identifiable systems involved, there is an overarching “understanding” the human body has—from the molecular level to organ systems—of the condition at hand that permits the body function as one. Through the process of integration—where our free acts are recognized by ourselves

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135 Kupczak, 127, in footnote 35.

136 Schmitz, 84. Note the etymology of the word “integration” is from the Latin, “to make whole.”
as acts which make us a better person—a self-possessed, self-governed, and self-determined person reaches outside himself toward truth and knows he has done so.\textsuperscript{137}

It is prudent to reflect for a moment on the state of the terminally ill person contemplating EPAS. Here is a person whose body is likely in an irreparable state of disintegration. He may be suffering pain, feeling isolation from loved ones, internalizing guilt and hopelessness. In experiencing the loss of control, he experiences the opposite of integration—disintegration. The recognition of this experience ought to make us reflect, not on the killing of that person, but on his re-integration instead. The terminally ill person, like all persons, by nature seeks integration. What then will truly heal this person and make them free? What is our task as persons?

The answer appears almost paradoxical at first glance. Wojtyla insists that such an inner transcendence and integration can occur only in the context of a community of self-giving persons. In sharp contrast to Kant’s view (exclusively occupied by the “self-legislating will”), Wojtyla believes that only in the relationship between subjects can one have knowledge of the truth—the truth of the self and the truth of world. Many years later in \textit{Fides et Ratio} (1998), he would argue:

\begin{quote}
It should be stressed that the truths sought in this interpersonal relationship are not primarily empirical or philosophical. Rather, what is sought is the truth of the person—what the person is and what the person reveals from deep within. Human perfection, then, consists not simply
\end{quote}

\textsuperscript{137} As Beabout succinctly puts it, “In transcendence, the person goes beyond himself. In integration, the going out is brought back upon oneself. (59)
in acquiring an abstract knowledge of the truth, but in a dynamic relationship of faithful self-giving with others. It is in this faithful self-giving that a person finds a fullness of certainty and security. At the same time, however, knowledge through belief, grounded as it is on trust between persons, is linked to truth: in the act of believing, men and women entrust themselves to the truth which the other declares to them.\textsuperscript{138}

Integration has meaning only in the context of a community of persons, an argument I will elucidate more powerfully and pragmatically in the last section of this paper. Not only is this view consistent with human experience (for one never truly “acts alone”), it also specifically highlights at least two critical lessons to be learned in the debate over EPAS.

First, the terminally ill person who chooses to kill herself is a person who acts to either withdraw from the community or ignore it (on the Kantian autonomy model) rather than to act from within it.\textsuperscript{139} Now, one could object that a person may actually choose EPAS as a means of “benefiting” the community—for example, to reduce the strain on the resources of her family or society. However, such an objection turns the value of persons upside down. The community exists for the person, not the person for the community.\textsuperscript{140} If integration can only occur in relation


\textsuperscript{139} A physician who chooses to perform euthanasia on a patient is a person who accepts, aids, and abets another’s withdrawal from the community.

\textsuperscript{140} Again, more on this below, in Part V. The objection does not apply to the rare instances of a person giving his own life in a heroic sacrifice for another’s life. Here I think of the example of St. Maximilian Kolbe (1894-1941), a priest who sacrificed himself for a stranger in the Auschwitz death camp. In this case, it is the very value of another person that is at the heart of the sacrifice, and obviously, Kolbe was murdered rather than choosing suicide. I might also highlight this morally troubling (rather than heroic) scenario: Suppose a family is living on welfare and the mother decides
to another—in self-communication—it is a contradiction to destroy one’s life in an attempt (however altruistic) to benefit society. An authentic community brings together persons of value; the patient’s attempt (and doctor’s cooperation) to act alone prevents integration and therefore transcendence through true self-determination. Rather than build associations between persons, EPAS severs them by accepting this state of affairs.

Second, the society which promotes EPAS as a viable solution to terminal illness and participates in it, abandons the communal model of person; in doing so, they also negate the freedom of the terminally ill, rather than promote it. Humans do not exist for themselves (radical individualism), nor do they exist solely for use by others (e.g., totalitarian or communist governments).\textsuperscript{141} Ideally, ethical human action is for one’s perfection and full integration but always in communion with others. To attempt to justify EPAS is therefore to fundamentally misunderstand human persons and human actions, and constitutes a grave existential rejection of the vulnerable person.

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\textsuperscript{141} In the final chapter of \textit{The Acting Person}, Wojtyla’s reflections turn toward the community and the person’s place within it. More will be said on this below. It is clear that his life experiences under totalitarian governments, as well as philosophers such as Jacques Maritain, profoundly influenced his thoughts on the distortion of the person in both radical individualism, and what he calls “totalism.”
If the subject’s realization of freedom comes through integration and transcendence, then the objectivity of freedom is realized through conscience, which “opens the person out unto the genuine, objective good of that person and opens the person to that which is common and universal, that is to say, to what is human, and beyond that even to what is ontological in that good.”

Joseph Seifert has described conscience, as articulated in *The Acting Person*, as a “reflective” element of consciousness; Kenneth Schmitz has called it a “bridge within consciousness” that connects freedom to the object presented through cognition. Conscience allows us to internally recognize an action as good or bad—to distinguish the true from the untrue, and to experience moral duty.

Conscience is not merely and solely “the little voice inside one’s head,” a view that is popular in contemporary culture. Such a view allows one to invoke one’s “conscience” to act in any way one wishes. Instead, conscience for Wojtyla has a cognitive and a normative element. The cognitive element measures the goodness (or

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142 Schmitz, 84.

143 Seifert, 536-537. Seifert recognizes Wojtyla’s distinction between a person being “conscious” of performing intentional actions, and “consciousness,” which has a more reflective meaning. Conscience is but one aspect of consciousness. The other aspect or function of consciousness is to “mirror” our intentions, thereby making us aware of them—as elucidated above: reflective consciousness.

144 Kupeczak, 127-129.

145 For example, the organization Catholics for a Free Choice—which actively promotes abortion, euthanasia, embryonic stem cell research, and artificial contraception (and asks supporters to fight the Church hierarchy on these matters)—has named their official journal *Conscience.*
badness) of an action and reveals efficacy; the normative element obliges the subject to act according to moral duty—and makes him aware it if he does not.\textsuperscript{146}

It should be noted that conscience, which functions as a “mechanism of recognition” (of the good or the bad), can change as the person acts for good or bad. The idea of a man “becoming good” or “becoming bad” necessarily involves a mechanism for distinguishing good from bad. As a person acts, she changes (metaphysically). The more a person changes for the bad, for example, the harder it is for the person to recognize the good from the bad. For instance, take the hardened dictator who murders people “without conscience.” We seem to feel that such a person simply cannot see the good the way we do (and perhaps this is true). Again, we all find the parable of the Prodigal Son\textsuperscript{147} compelling, in part, because of the contrast between the incredible debauchery of the younger son on the one hand, and his overcoming such a life through regret and penance on the other hand. The story may not be as vivid if it did not seem, somehow, \textit{more difficult} to “come back to the father” after having made so many bad choices. Then there are saints (in many religions—but here we might think of someone like St. Therese of Lisieux) who just seem to have a “knack” for doing the right thing and choosing well.

Wojtyła’s important inclusion of conscience as integral to the exercise of true human freedom weds the “ethics of duty” in Kant and the “ethics of value”

\textsuperscript{146} Kupczak, 14.

\textsuperscript{147} Luke 15: 11-32.
(discussed below) in Scheler. Such a rich conception of the moral act underscores what the Argument from Autonomy lacks: (1) the necessary objectivity of human action rooted, not in consciousness *per se*, but in truth, which essentially permeates the operation of conscience\(^{148}\); (2) the *unity* of the ethical act and experience within the totality of the person, and the revelation of the whole person through this act; and (3) the notion that, derived through freedom, man gains efficacy (the experience of self as efficient cause) in and through willed action. Against such a theory of moral action, demanding the right to EPAS based on a Kantian-inspired autonomy argument—however well intentioned—appears to sell humanity and its intrinsic value short.

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\(^{148}\) AP, 165.
FIGURE 1: THE STRUCTURE OF A FREE ACT

Self-possession:
Man is the origin of his actions

Self-governance:
Man can control his actions

Self-determination:
Man determines his own course—“I may, but I need not.”

Horizontal transcendence: reach outside oneself toward an object of intention, using cognition and will

Vertical transcendence: reach outside oneself toward truth

Integration: grasp of oneself as reaching outside oneself toward the truth
In a real sense all life is inter-related. All men are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever effects one directly affects all indirectly. I can never be what I ought to be until you are what you ought to be, and you can never be what you ought to be until I am what I ought to be. This is the inter-related structure of reality.

--Martin Luther King, Jr.

Chapter II: The Argument from Compassion

Another Problem of Modern Ethics: Scheler

Having broadly sketched Wojtyla’s view of the workings of human action and authentic freedom, we may turn to the Argument from Compassion. The phenomenologist Max Scheler (1874-1928)\(^{149}\) represents historically the reaction to this excessive formalism that many (including Wojtyla) have found in Kant. Wojtyla’s philosophy is heavily influenced by Scheler, as is clear from The Acting Person; his first philosophical thesis was entitled, The Possibility of the Foundation of Christian Ethics on the Philosophy of Max Scheler. Although Wojtyla’s ultimate answer to this question was “no,” it is clear that Wojtyla’s interest in Scheler began with Scheler’s focus on the experience of moral action from the point of view of the

\(^{149}\) Again, a comprehensive analysis of Scheler is unnecessary here, and beyond the scope of this work. We are primarily interested in how Wojtyla views Scheler, and hence a summary of the relevant aspects of Scheler’s thought, as well as Wojtyla’s own interpretation, is provided. For an excellent resource on Scheler’s philosophy, including a brief biography, see Frings, Manfred, The Mind of Max Scheler, (Milwaukee: Marquette University Press) 1997.
subject. To Wojtyla, this approach was a crucial adjunctive element to understanding moral action precisely because it was consistent with actual human behavior.

Let us begin then, with a brief exposition of the ethics of Max Scheler. Scheler’s main work in ethics was titled *Formalism in Ethics and Non-Formal Ethics of Values. A New Attempt toward the Foundation of an Ethical Personalism* (1916). It is both a repudiation of Kant’s abstraction of ethics to human consciousness alone, and equally important, an attempt to build ethics with the nature of the human person at its core.\(^{150}\)

Scheler believes that emotions play a decisive role in moral action, a role which Kant has entirely ignored. These emotions are triggered through lived experience. The experience of reality is not neutral, nor is it something from which we can pull ourselves apart to ponder morality in the vacuum of consciousness. Rather, the experience of reality involves an attraction to an object (a *value*), or a repulsion by an object (a *disvalue*). Instead of Kant’s rigid formalism, the point of reference of personal experience is the “individuality of values.”\(^{151}\)

What then, is a value? Values, as Scheler defines them, are “peculiar contents [of experience] inseparably tied in with feelings or emotive experiences.”\(^{152}\) They are not properties of things, nor are they themselves things, nor can they be logically

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\(^{150}\) Frings, 21.


\(^{152}\) Frings, 21.
abstracted. Rather, values, as Frings explains, functionally exist—that is, they must enter into a function with something else to become objectively extant. Here Scheler gives an analogy to colors. A color exists only in function with another visible object, but, we can also easily see that the color perceived is not an inherent property of the colored object. Hence, values are independent of objects but are tied to our actions nonetheless.\(^\text{153}\) Of course, one can have a misperception about color, just as one can have a misperception about value. Therefore, Scheler importantly leaves the possibility open for a deception in value experiences.

Therefore, whenever one makes an “ought” statement in ethics, one presupposes a value that inheres in the “ought” proposition. For example, the proposition that “one ought to have compassion for the sick” represents a pre-rational attraction to a value. The difference between Scheler and Kant is clear:

[Scheler] claims there is a primacy of the givenness of contents of values over any other acts of consciousness. Feeling values is basic to the mind’s acts; emotive experiences are not internal chaos (Kant) but are suffused with an order of contents of values very different from the laws of logic pertaining to reasoning and thinking. Scheler’s argument is like this: just as colors can be given to us ‘in’ seeing them, so also are values given to us only ‘in’ the feeling of them. Without ‘seeing’ there are no colors. Without ‘feeling’ there are no values. The priority of feelings over thinking and willing…is one of order, not one of sequence.\(^\text{154}\)

\(^{153}\) Frings, 23-24.

\(^{154}\) Frings, 25.
Scheler goes on to list a “hierarchy of values” to which humans are drawn to, and the opposing disvalue which humans avoid.\footnote{A full explication of this hierarchy is beyond the scope of this work, but an excellent summary can be found in Frings, cited above, especially pages 22-35. The ranks Scheler describes include, from highest to lowest, the value-rank of: (1) the holy and unholy; (2) values of the mind, including a) juridical values, b) aesthetic values, c) values of knowledge; (3) life values (the noble and ignoble); (4) utility values (useful and not-useful); and (5) sensible values (comfort and discomfort).} The hierarchy of values is \textit{passive}—that is to say, one does not \textit{choose} one value over another. Rather, one has a “pre-rational preference” for one over another. Here Scheler further posits that persons have a preference for higher values, both vertically (i.e. preferring the “holy” to the “comfortable” for example), and horizontally (preferring “holy” to “unholy.”) Frings provides this example: in the category of the “sensible values” (see footnote 155), it is impossible for one to prefer pain over pleasure. Even the sadomasochist in seeking pain is actually seeking an “invisible” pleasure value. Thus, the “feeling of values has its foundation in preferring and not in choosing.”\footnote{Frings, 30. “Preferring” is the best word that many English translators have been able to come up with to capture Scheler’s meaning. Frings believes it is understood to be more like “attracted to” (37-38), while Buttiglione uses the term “following” (55-56). Again, all of these terms emphasize the passive nature of the experience.}

Where do such preferences come from? For Scheler, there is an “emotional \textit{a priori}” that reaches far beyond the empirical \textit{a priori} of Kant. Frings explains:

\begin{quote}
While the \textit{a priori} in its classical formulation refers to data ‘prior to’ empirical experience, the phenomenological \textit{a priori} is more radical in that it pertains to any experience occurring in consciousness. This means that the traditional formal \textit{a priori} is restricted to empirical experience and therefore, fails to incorporate experiences in ‘consciousness-of-something.’
\end{quote}
This ‘something’ is, phenomenologically, anything consciousness has awareness ‘of,’ including values of emotive consciousness.\textsuperscript{157}

This means that the immanent feeling present in the emotional experience \textit{is} truth. The highest value is simply the one which the person responds to the most intensely.\textsuperscript{158} Without a theory of metaphysics which links action to a change in being, we are left to accept things as they are. Here we begin to see where Scheler’s ethical theory can become pernicious, for the person is unaware of her change, the causal efficacy in action that must be tied to truth.

Now, one might object that a person may try to claim a ground for objectivity based in the emotional \textit{a priori} (e.g., “one may come to be aware of more values with growth in moral sensitivity—in the way in which a painter comes to be aware of more colors”).\textsuperscript{159} However, this is an awareness not truly based on a \textit{passive} attraction to value as Scheler suggests. The painter who grows in sensitivity to colors as he “grows as a painter,” is a person who learns and chooses. To say an artist “grows as a painter” is to imply that he becomes “better” at what he does. Thus, in each piece he produces he recognizes himself as the author of that work. Thus, such a change, while containing an emotive element, is nevertheless a change rooted in being. Likewise, a person who “becomes more aware of values,” is a person who grows in moral sensitivity precisely because he knows that what he himself does is

\textsuperscript{157} Frings, 35.

\textsuperscript{158} Buttiglione, 57.

\textsuperscript{159} I thank Dr. Alexander Pruss for bringing this point to my attention in correspondence.
good. On Scheler’s view, a painter may be drawn to certain colors, but we have no explanation of why he moves from one to another, or prefers some colors to others; the mechanism that makes him “better” is absent.

Yet, Scheler saw what Kant failed to see—that consciousness is not the entirety of ethical experience, and that values and feelings have a pervasive character in human acts. In this sense, Wojtyla sees Scheler as an improvement on Kant. For Scheler “value, not duty, is the essential element of ethical experience.” Values are therefore the objective content (the real material) of ethical experience in this sense:

Values are objective; they inhere in objective reality. Emotional experience allows each of us to make personal contact with them and in this contact to live by them, by their specific content, which does not manifest itself in its true essence outside of emotional experience.

In addition, Scheler rightly situates the person centrally as the “place where value is experienced.” He goes beyond this and claims that the main experience of values is to be found in personal relationships—in the value of the person. Thus, empathy and sympathy—so crucial to compassion arguments on both sides of the EPAS debate—offer one person the opportunity “to experience the reality which is another.”

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160 See, for example, Chapter I, especially sub-sections “One Problem for Modern Ethics: Kant,” and “Kant’s Autonomy and Anthropology.”

161 PC, 32.

162 PC, 35.

163 Buttiglione, 56. Persons are attracted to the value in another.

164 Buttiglione, 56-57.
The colloquial use of the term. It ought also to trigger a critical question for proponents of the Argument from Compassion: is true compassion to be found in the relationship with another, whereby we experience his value as the ultimate human value? Or, does compassion rest in “feeling sorry for another” and wishing to end his suffering by killing the person whom we purportedly value?

Wojtyla’s Critique of Scheler

Despite its positive elements, we can already see why Wojtyla will not be wholly satisfied with Scheler’s explanation for human action. As a phenomenologist, Scheler is not concerned with the metaphysical basis of action—things are accepted as they are in the experience of feeling. Human choice, so crucial to Wojtyla’s theory of human action, is missing. For Wojtyla, it is in choosing that man recognizes himself as the efficient cause of his action. It is in choosing the good that we have freedom. Scheler actually deprecates conscience, the means by which we can judge the choices we make prior to action. He therefore has no means to authenticate the values in question.

Scheler’s intuitionist approach therefore does not dig deep enough to the underlying “metaphysical anchor” which Wojtyla seeks in order to give action a rigorous normativity grounded in truth. Scheler ultimately rejects the ethics of duty altogether. But in doing so—in replacing the formal a priori with the emotional a

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165 Buttiglione, 58.
priori—Scheler also leaves himself open to the possibility that one’s preference, or feeling, or a priori emotional experience is misperceived, wrong, or taken to an extreme, to the neglect of other values. As will be shown below, this danger is prominently displayed in the Argument from Compassion.

Reason in Schelerian phenomenology, plays a much less prominent role:

According to Scheler, reason only apprehends being; it does not apprehend the good. Only the ‘thing-like’ structure of objects manifests itself to reason. This structure is, however, neither the most important nor the most fundamental. The primordial element of objective experience is value, and we grasp value in a proper and adequate way only by emotional experience.¹⁶⁶

Neither does the will, as an intellectual faculty, will the good directly. For Scheler, one feels values and “aspires to values.”¹⁶⁷ In doing so, one has an experience of the good in aspiring to the highest values, but the good itself is not an object of volition. The subject is passive, a composite of his emotional experience; he is drawn to values, and duty is thus excluded from ethical life.

It should be clear that Wojtyla can accept neither the absolutization of consciousness (the “autonomous self”) in Kant, nor the exclusion of duty and the primacy of emotional intuition found in Scheler. For him, Kant’s split between the a priori element and the psycho-sensory or emotional element of the ethical act “is at flagrant odds with experience. The facts of ethical life cannot be reduced to logic and

¹⁶⁶ PC, 35.

¹⁶⁷ Buttiglione, 70.
psychology because ethical experience is a personal whole, whose specific properties cease to be themselves apart from this whole."  Duty is not merely respect for the law, as Kant would like us to accept; duty involves a self-perfecting, transformative quality because it contains a good within it. This can only be understood in light of a philosophy of being, one consistent with ethical experience.

Therefore, Scheler's view is also imperfect. For Scheler does not believe that the person “becomes good” or “becomes bad” through action. The judgment of value is in relation to a single act—not to the whole person, a view Buttiglione calls ontologically inconsistent:

For Scheler, the highest value is always that which the subject responds to the most intensely. But is it possible for us to say that in every case the value which receives the most intense response is also that which the person must choose in order to realize his own moral perfection?... In accordance with his emotionalist presuppositions, Scheler denies that the good of the person can be the end of action...[Scheler] contradicts the moral experience of the person as it is revealed by unprejudiced phenomenological analysis. If it is an emotional perception which motivates the person, this perception must undergo a judgment which recognizes and clarifies the truth, before the value, which emotional experience presents, can be accepted as authentic.  

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168 PC, 40. Could we, after all, know what the adapted and specialized structures of the gills are, without any reference to the fish as a whole? Likewise, moral acts are distinctively human, and as such they cannot be dissected outside of the context of the whole person.

169 Buttiglione, 59.
Thus Wojtyla realizes that the normative element provided by a metaphysically grounded ethics must organize and present values to the will. \footnote{PC, 41.} Boldly he argues:

> We are standing here in the presence of the phenomenologist’s fatal mistake. Scheler fails to perceive a most elementary and basic truth, namely, that the only value that can be called an ethical value is a value that has the acting person as its efficient cause...And this is also where the very core of ethical experience lies. \footnote{PC, 38.}

There are limits, therefore, to the phenomenological method. The person is both subject (brings an action into being) and object (“registers in himself the effect of an act”); an action changes both the external reality and the person. \footnote{Buttiglione, 64-65.} Reason does not submit to itself (Kant), nor is man drawn passively to a hierarchy of values (Scheler). Reason subordinates itself to a conception of the good outside of itself, and when it does, a human being moves closer to what he ought to be. He changes.

We often observe, but rarely ponder, the real, experiential phenomenon of a person “becoming a good person,” when he does good things, or acts in a way which reflects a change of heart. Our language, as impoverished as it may be at times, speaks of men and women “becoming better,” or “becoming worse” over time. It is this “becoming,” a metaphysical transformation which all of us have experienced,
that Wojtyla seizes upon to ground moral action. Only in this way are the normative and emotional elements of ethical experience wedded, the totality of the human act preserved, and the self-actualization of the person realized.

The Meaning(s) of Compassion

What is “compassion?” The term has many meanings and usages, and a full account of compassion goes beyond the scope of this work. I will confine myself here to its most common meaning and use in bioethics. Colloquially, it is defined as a “sympathetic consciousness of others’ distress together with a desire to alleviate it.” According to Lauren Berlant, “There is nothing clear about compassion except that it implies a social relation between spectators and sufferers, with the emphasis on the spectator’s experience of feeling compassion and its subsequent relation to material practice.” Authors across the philosophical spectrum—as varied as George Will, Martha Nussbaum, and Kathleen Woodward—have described

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174 See, for example, Berlant, Lauren, ed., Compassion: The Culture and Politics of an Emotion, (New York: Routledge Press) 2004. This compilation of essays by professors of English and Philosophy has a decidedly liberal political agenda; nevertheless, it presents with admirable scholarship (at least, of a left-leaning view) much of the debate over the use of the word, and the social and legal implications of its uses.


176 Berlant, Lauren, in “Compassion (and Withholding),” in Berlant, cited above, 1.
compassion as essentially a “feeling,” but with radically divergent obligations derived from it.\textsuperscript{177}

In particular, I would like to reflect briefly on Nussbaum’s contribution to the meaning of compassion in her essay “Compassion: A Basic Social Emotion” (1996). Much analysis has been written of this essay, and I will not recap that body of literature here.\textsuperscript{178} Nussbaum’s project is to rehabilitate an Aristotelian notion of pity or compassion (she equates them as a “single emotion”\textsuperscript{179}), as “a central bridge between the individual and the community.”\textsuperscript{180}

Aristotle, according to Nussbaum, felt that pity is “a painful emotion directed at another person’s misfortune or suffering,” that requires three beliefs: (1) the suffering is serious (an impediment to human flourishing); (2) the suffering is not the suffering person’s own fault; (3) the pitier’s own possibilities are similar to the sufferer.”\textsuperscript{181}


\textsuperscript{178} I credit Kathleen Woodward’s provocative essay, cited above, for inspiring the direction I have taken here.

\textsuperscript{179} Nussbaum, 29.

\textsuperscript{180} Nussbaum, 28.

\textsuperscript{181} Nussbaum, 31.
One critical aspect of her essay is her claim that compassion can be a type of *reasoning* or “a certain sort of *thought* about the well-being of others.”[my emphasis]¹⁸² She rejects the dichotomy between reason and emotion—in particular (from the historical perspective) the more recent dismissal of compassion from debates in public policy, philosophy, and law. I agree with this analysis. In this way she too is supportive of Wojtyla’s “project”—to synthesize reason and compassion into an accurate view of the ethical act.

Her approach is not strictly phenomenological, of course. She argues that one can feel pity for another *without* experiencing a “twinge or a pang,” or perhaps “no feeling of any sort.”¹⁸³ How? In effect, by *learning* sensitivity and incorporating the experience of the feeling of compassion into one’s being, one’s “equipment” for making rational decisions. (Nussbaum spends much time in this essay on emphasizing the importance of the tragic narrative in this process, as we will examine below). One is then motivated not by the sentimentality of the moment, but rather by a *dispassionate* understanding of compassion.¹⁸⁴ There are two crucial points I wish to make here. First, Nussbaum’s account is consistent with the idea that compassion needs reason too, and that the emotion of compassion must be weighed in the context of the *truth* about the good life (and suffering’s effect on it). Second,

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¹⁸² Nussbaum, 28.

¹⁸³ Nussbaum, 55.

¹⁸⁴ Nussbaum, 38.
by way of preview, I wish to state here, and I will defend this further in Chapter III, that the *experience* of the suffering of a human person reveals the truth about that person’s value more fully to another person, and it is through that revelation we move beyond merely *feeling* compassion (a sentiment, however intense) to truly understanding it.

Finally, etymologically, “compassion” derives from the Latin for “to suffer (endure) together with another.”\(^{185}\) However, Marjorie Garber notes a second meaning—“an emotion felt *on behalf of another who suffers*.”\(^{186}\) The two usages have come to be at odds, particularly in the debate over EPAS. More will be said of this below. For now, I will define compassion as “a (virtuous) feeling or emotion which calls a person to move beyond empathy, and to journey with another through suffering, out of love.” A justification of this definition will reveal itself from the arguments which follow.

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**The Argument from Compassion Defined**

The Argument from Compassion\(^{187}\) is, plainly put, as follows: we feel compassion for the sick and dying, and we wish (and have an obligation) to relieve

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\(^{186}\) Garber, Marjorie, in “Compassion,” in Berlant, cited above, 20.

\(^{187}\) I have chosen to use the phrase “The Argument from Compassion” because the feeling of compassion (used in common language) is the most accurate descriptor for what gives the argument its power. A literature search for “the Argument from Compassion” as articulated above, or presented
them of that suffering by taking their life or allowing them to take their own. EPAS therefore becomes an act of mercy. The morality of such an action was classically formulated by the philosopher Marvin Kohl in 1975:

First, since [voluntary beneficent euthanasia] is kind treatment, and since society and its members each have a prima facie (though not equal) obligation to treat members kindly, it follows that beneficent euthanasia is a prima facie obligation…This argument neither says nor means to suggest (a) that kindness alone will do or (b) that the obligation to be kind is only limited to acts of mercy killing…As to (a): Unless the weight of a kindly act is overridden by other rights or similar considerations, a kindly act is a moral one…As to (b) Acting kindly in cases where the patient’s death is imminent requires that there be relief of pain, relief of suffering, respect for the patient’s right to refuse treatment, as well as the provision of adequate health care. 188

As stated here, Kohl’s formulation presupposes that ending the life of another innocent person, provided she consent, can be included in “kindly acts,” as an act of compassion, and is part of her “basic human needs.” His (a) above is crucial for the discussion. Proponents of this argument, in fairness, would not automatically support, for example, non-voluntary euthanasia, as they would certainly want to at least look at “other rights or considerations” that might override compassion. Thus, the Argument from Compassion is an argument which adds inherency or gravitas to

in an analytic form, for example, will yield few results (surprisingly). Much of the content of the argument in the bioethics literature can be found in analyzing the language, assumptions, and appeals made in case studies and personal narratives, some of which have been cited below.

the overall case for EPAS. It is one other reason to support such a right, and, it is a
prima facie reason to do so. However, although perhaps one of many reasons,
compassion is believed by proponents of EPAS to carry significant—even
decisive—weight.

Sissela Bok, using the phrase “the argument from mercy,” adds, for example,
“Far from it being morally wrong to accede to such a request, it would be cruel in the
extreme to stand by without coming to the aid of the person pleading for
release…This is especially the case…when patients are physically unable to take
their own lives unaided, or when they have no access to the medication or other
means that they would need in order to do so.”189 Bok’s argument also presupposes
acting on account of compassion. I am in agreement with Kumar Amarasekara when
he describes this argument as the “most persuasive (and certainly the most emotively
appealing) argument in favor of voluntary euthanasia.”190

Thus, the question arises, what exactly we are weighing against these other
“rights and considerations?” Is it the abstract concept of “a duty to kindness” or an
“obligation of mercy?” Or, is it a powerful, emotive response that from experience,
leads us to a moral conclusion? Perhaps it is a little of both. Berlant beautifully

189 Bok, Sissela, “Euthanasia,” in Dworkin, G., Frey, R.G., and Bok, Sissela, *Euthanasia and

190 Amarasekara, Kumar, and Bagaric, Mirko, “Moving from Voluntary Euthanasia to Non-Voluntary
captures what I believe is the mechanism by which compassion operates in many people when we think of the terminally ill:

When the response to suffering’s scene is compassion—as opposed to say, pleasure, fascination, hopelessness, or resentment—compassion measures one’s value...in terms of the demonstrated capacity not to turn one’s head away but to embrace a sense of obligation to remember what one has seen, and, in response to that haunting, to become involved in a story of rescue or amelioration: to take a sad song and make it better. [my emphasis]¹⁹¹

The use of the word “haunting” is telling, for it implies a deep interiority that pushes us to act. The way in which we respond to a suffering person’s anguish, whether motivated by feelings of sympathy, empathy, love, or mercy¹⁹² is the heart of the issue.

My goal in this chapter is modest. I plan to show that one way (although perhaps not the only or definitive way) the Argument from Compassion fails is that it takes an emotionally-rooted desire to be kind (a virtuous feeling) and weighs it definitively as if it were (in and of itself) a decisive moral principle. If our phenomenological experience is not tempered by reason—if the sentiment of compassion has no limits or qualifications (or we have no justification for placing

¹⁹¹ Berlant, 7.

¹⁹² There are obvious differences between sympathy, empathy, love, and mercy, although seldom made in the bioethics literature. Some important distinctions will be made below. Kathleen Woodward, in her analysis of four author’s views of compassion, notes that the word is called “empathy, pity, compassion, and sympathy.” (See Woodward, cited above, 63.) Marjorie Garber, in tracing the etymology of the word, notes that the use of the word “compassion” has at different points in its history, emphasized self-benefit for the non-sufferer, pity, mercy, a divine attribute associated primarily with God, and love. (See Garber, cited above, 20-23.) For an excellent and moving exposition of the Christian philosophical and theological bases of love, see Pope Benedict XVI, God Is Love: Deus Caritas Est, (San Francisco: Ignatius Press): 2006.
limits)—then we are faced with Scheler’s “fatal mistake”: a philosophical anthropology devoid of reason’s obligation to truth, and one at odds with human experience. My argument is that compassion itself is not a reason (to do or not do X), but it involves reason in an intimate way. Nussbaum puts it eloquently:

Compassion is in this way intimately related to justice. It is not sufficient for justice, since it focuses on need and offers no account of liberty, rights, or respect for human dignity…Although compassion does presuppose that the person does not deserve the (full measure of) the hardship he or she endures, it does not entail that the person has a right or a just claim to relief. Further argument would be required to get to that conclusion.193

The phenomenology of the Argument from Compassion bears examination at this juncture. Let us take, for example, a classic case from the bioethics literature, that of Dax Cowart:

In 1973, “Dax” Cowart, age 25, was severely burned in a propane gas explosion. Rushed to the Burn Treatment Unit of Parkland Hospital in Dallas, he was found to have severe burns over 65 percent of his body; his face and hands suffered third degree burns and his eyes were severely damaged. Full burn therapy was instituted. After an initial period during which his survival was in doubt, he stabilized and underwent amputation of several fingers and removal of his right eye. During much of his 232 day hospitalization at Parkland, his few weeks at Texas Institute of Rehabilitation and Research at Houston, and his subsequent six month’s stay at University of Texas Medical Branch in Galveston, he repeatedly insisted that treatment be discontinued and that he be allowed to die. Despite this demand, wound care was continued, skin grafts performed and nutritional and fluid support provided. He was

193 Nussbaum, 37.
discharged totally blind, with minimal use of his hands, badly scarred, and dependent on others to assist in personal functions.\textsuperscript{194}

Dax, in fact, requested that the farmer who found him at the accident scene shoot him. He also requested euthanasia on a number of occasions (beginning with the ambulance team who arrived to take him to the hospital) and tried to commit suicide several times.\textsuperscript{195}

My own personal experience with exposure to Dax’s case, first as a medical student and then as a teacher of medical ethics, is that the case is often presented (both in writing, film, and lectures) in a way to make one more sympathetic toward the case for EPAS.\textsuperscript{196} How? First, in order to arrive at the Argument from Compassion, we must \textit{imagine} Dax and his suffering and identify with him. Next, we \textit{feel} something which moves us. What makes the case so powerful thus far (and his request so persuasive) is \textit{not} the rational argument which Kohl and Bok present. The summary of Dax’s case above, in fact, presents no “argument” at all; it merely states the facts. Kathleen Woodward argues similarly that Harriet Beecher Stowe’s \textit{Uncle Tom’s Cabin} was an immensely significant cultural force for change against slavery because of an appeal to the emotion of compassion:

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\textsuperscript{196} Ironically, Dax Cowart is still living, was rehabilitated, became a lawyer, was married (and divorced), and supports assisted suicide. (Cowart, cited above, 744)
\end{flushright}
The reader is prompted to identify empathetically with a character that is suffering (generally through the medium of another character), and this response is read as an experience in moral pedagogy. A spontaneous burst of feeling leads to a change of heart; the emotions and morality are linked…Compassion inspires conversion.\textsuperscript{197}

From here, we might pick up on Kohl’s, or Bok’s or many others’ analyses, who take this emotion and insert it into a rational framework, or scale, if you will, to make a case explicit for EPAS based in compassion.\textsuperscript{198} However, some also might not use a “rational analysis” at all. For many, the experience of the emotion is sufficient, which is precisely why authors such as Timothy Quill make their case in a narrative format.\textsuperscript{199} Woodward again adds a possible insight into this phenomenon (although she is not referring specifically to EPAS) as a product of post-modern culture: “Once relatively stable, discourses of the emotions are now circulating at a relatively rapid rate…In a culture dominated by the media, much of our emotional

\textsuperscript{197} Woodward, cited above, 62.

\textsuperscript{198} Many other instances of “compassionate killing” exist, most recently the killing of elderly patients in a nursing home during Hurricane Katrina. (See Lugosi, CI, “Natural disaster, unnatural deaths: the killings on the life care floors at Tenet's Memorial Medical Center after Hurricane Katrina,” \textit{Issues in Law & Medicine}, Vol. 23 (1), 2007: 71-85.)

experience, once understood in terms of a psychology of depth and interiority, has been reduced to intensities and sensations.200

What’s wrong with this, one might ask? Nussbaum, after all, defends the importance of tragic narrative and drama as crucial to understanding compassion. If it was okay to use emotion to justify the abolition of slavery—to allow compassion to inspire conversion—why may one not use it for EPAS? My answer is as follows: first, it is precisely because things which some justify with appeals to compassion are deemed universally true (slavery, racial segregation) while others are not (euthanasia of the handicapped, forced sterilization, abortion), that we should worry about weighing such appeals so heavily. Second, I would argue that to use compassion as an emotional justification alone would be intellectually dubious, for then we are left with Scheler’s mistake. We are drawn emotionally, through experience, to certain values, but we have no way of truly knowing whether the values we are attracted to make us better through our actions. The compassionate feelings elicited from reading Uncle Tom’s Cabin just happened to reveal something true about the condition of slavery. The truth about slavery was discovered with the emotion of compassion, but not on account of it. Compassion, as Nussbaum rightly notes, does not even address conceptions of duty or justice, and therefore it cannot alone justify the need to end suffering; rather, such analysis is done rationally, carefully, with the experience of compassion incorporated into our mental machinery but taking into account what we

200 Woodward, cited above, 60-61.
know of the “good life,” what we know of truth. With respect to EPAS, the “jury is still out” for some on what truth compassion reveals; however, the fact is that appeals to compassion (as an emotion) will not suffice—we must follow compassion to its logical (and etymological) end, which means a compassion guided by reason.  

Phenomenologically, we might say then, that the Argument from Compassion begins with an emotion. The strength of that feeling is weighed, as Kohl suggests, against other interests and considerations. There are some feelings and desires, which, when acted upon, are virtuous. Having a desire to be kind to another, for example, turns a compassionate act into a positive good. Yet within the structure of the Argument from Compassion, an emotional experience precedes (both temporally and by way of priority) reason. The core of the argument—its power—rests on something that is not thought or weighed initially but felt. The feeling of compassion

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201 Alexander Pruss made this excellent point to me in correspondence: “If one is playing with emotional appeals, two can play the game. There is good reason to think human beings have a very strong revulsion against killing fellow human beings (e.g., it is known that in WWII, only a minority of US infantry would discharge their weapons at the enemy). This emotional revulsion is present in the case of euthanasia as well. After all, one doesn’t need a physician to kill someone instantly and therefore painlessly—a gunshot of sufficient caliber to the head suffices. This could be administered by any “friend” or family member, if the law allowed it. But nobody is advocating for such a law, as far as I know. Why not? I think it is because people are repelled by the idea of family members shooting terminally ill relatives. Instead, there is the desire to medicalize the killing, so as to get around the negative emotions that killing fellow persons generates. Thus, people’s feelings are in fact conflicted. They feel compassion, and compassion moves them to seek the patient’s death, but they also feel a strong emotional opposition to killing when it is obvious that it is a killing (as in the gunshot case). Hence, emotion cannot settle the issue.”
strikes us as it is in reality, but it is our rational response to the emotive stimulus that either finds the truth or misses the mark. 202

This is not to say that this emotional element of moral decision making is to be denigrated in any way, nor to suggest that rational (and persuasive) treaties about its operation and significance are to be brushed aside. On the contrary, we have seen, of course, Martha Nussbaum’s careful analysis of pity as presented above. Furthermore, Husserl, Scheler, and Edith Stein, for example, have all written extensively on the subject of empathy; for many phenomenologists, including Wojtyla, empathy plays a critical role our in understanding of “the other”—a necessary conscious step which allows us to fulfill our moral obligations to her. 203

Scheler (and, following Scheler, Crosby) distinguishes empathy from sympathy in this way: “empathy is primarily a mode of experiencing another…whereas sympathy contains a moment of love for the other. It presupposes empathy, but surpasses it by the gesture of love proper to it.” 204

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202 Even if a utilitarian argument is used as the mechanism of justification for the Argument from Compassion (“EPAS achieves the greatest [feeling of] happiness for the greatest number of people, rather than the [feeling of] happiness achieved by (merely) keeping the patient alive”), the sympathy which we weigh in the utilitarian calculus is antecedent to the calculation.

203 Haney, Kathleen, “Empathy and Ethics,” Southwest Philosophy Review, Vol. 10 (1); 1994: 57-65. Stein considered empathy as a “sui generis conscious process through which we make sense of others in their self-experience.” (58-59). A full explication of Husserl’s and Stein’s views on empathy is beyond the scope of this work. However, the use of empathy on both sides of the EPAS debate remains a fertile ground for future research.

204 Crosby, John F., Personalist Papers, (Washington DC: Catholic University of America Press); 2004: 39 [Henceforth, Crosby (3)]. These are not the only definitions of empathy and sympathy, of course. Warren Thomas Reich, for example, while positing a similar definition of empathy to Scheler’s, simply defines sympathy as “the ability to understand and share the feelings of other human beings.” He goes on to say that sympathy has the potential to allow a person to become “over
sympathy is actually founded on empathy, since one could not feel compassion without first understanding the experience of another. Sympathy also has a closer meaning to compassion etymologically: from the Greek *sym-* and *-pathos*, to “suffer together.” Yet, one can have empathy without sympathy—and here Crosby gives the example of a sadist—demonstrating that having empathy, while often a virtuous feeling, does not automatically make the action “good” or “right.”

Both proponents and opponents of EPAS will use compassion, or even love, to buttress their respective arguments. As I have noted, words such as “compassion,” “love,” “empathy,” “sympathy,” and so forth are used both in the popular and philosophical literature interchangeably, loosely, and without proper distinctions. The principal distinction I wish to make is that there is a difference between *compassion as a feeling* (found in EPAS), and *compassion as a virtue—as an expression of the mature love of the person*. The former is rooted in a noble emotion but acts on this emotion without the input of conscience or an objective criterion of correctness. The latter one is the offering of the presence of self to

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205 For example, a sadist may well need to feel empathy for the person he inflicts pain on, but yet does not possess the “moment of love” necessary for authentic sympathy.

another. The physician or family member who opts not to kill the loved one, but rather, to value the person through companionship, tempers the emotive response with an openness to truth.\textsuperscript{207}

The exercise of true compassion—moving beyond empathy to sympathy and love—is an action which remains authentic to compassion’s original etymology. “Compassion,” as I have stated above, literally means “to suffer or \textit{endure with},” but it has also meant something like to “experience suffering at the same time as another.” A way to think of it is as follows: to suffer \textit{with another} is different than to suffer \textit{when} another suffers.\textsuperscript{208} Yet the two meanings do not represent a dichotomy; they are not mutually exclusive. I (merely) feel “sorrow” for another when I regret a person’s physical, mental, and spiritual anguish, but this represents only one “stopping point.”

I exercise true compassion when I agree to support the sufferer (“endure”) through it all—when I understand a person’s suffering in the role of “the other,” but journey with them because “the other” is another \textit{person}. Martha Nussbaum has

\begin{footnotes}
\footnote{207} It should be obvious that the truth here is something like: “Killing an innocent person, even if she suffers, is wrong.” This truth would be justified on other, anti-utilitarian grounds (e.g., philosophy of medicine, natural law, deontology, etc.). The point here is that whatever the over-arching theoretical justification, the justification for \textit{this particular act} must go beyond an emotional response. As Leon Kass has eloquently observed, without reference to antecedent principles or truths, both the Argument from Autonomy and the Argument from Compassion lead to absurd, indefensible conclusions, such as doctors having sex with patients. (See Kass, Leon, “Neither for love nor money: why doctors must not kill,” \textit{The Public Interest}, Vol. 94, 1989: 24-46, esp. 28-29.) [Henceforth Kass (1).]

\footnote{208} I may even suffer when another suffers without any true compassion. For example, if I share a hospital room with a patient who incessantly vomits and groans all night, I can be suffering when he suffers but feel no true compassion.
\end{footnotes}
noted that true pity or compassion involves not merely empathy (although this is a vital component), but a certain measure of rational distance:

…[E]ven then, in the temporary act of identification, one is always aware of one’s own *separateness* from the sufferer—it is another, and not oneself, that one feels; and one is aware both of the bad lot of the sufferer and of the fact that it is, right now, not one’s own…One must also be aware of one’s own qualitative difference from the sufferer…For these recognitions are crucial in getting the right estimation of the meaning of suffering.\(^{209}\)

EPAS is the opposite of an authentically compassionate response, for it rejects the journey with another, and prematurely and actively calls for the journey’s end. Only a compassion which embraces the word’s bifid etymological meaning—*to feel and to bear with another*—is a real expression of love for persons.

According to Scheler (and Wojtyla), love allows us to know the reality of the worth of persons; we recognize this worth through affective contact.\(^{210}\) It is prudent at this juncture to recall Wojtyla’s distinction between *actus humanus* and *actus hominis* (or, between *agere* and *pati*). The illustration of these concepts in Chapter I—Wojtyla’s distinction between mature love and sexual feelings—is analogous and applicable. It is only in mature love—where man acts with a sense of responsibility for his action—that freedom exists. Compassion (like sexual feelings) can be a

\(^{209}\) Nussbaum, cited above, 35.

\(^{210}\) Colosi (2), 18. This “affective contact” is compatible with the concept of empathy. Haney elaborates: “To the extent that her [the other’s] face presents the other and her ethical claims, empathy becomes a precondition for ethical responsibility and, itself, an ethical responsibility.”(61)
natural, even virtuous feeling, but if it is not tied to truth its use in ethics is misguided, even dangerous:

[Compassion is a virtue, not a moral principle. Morally weighty as it is, compassion can become maleficial if not constrained by principle. In the world’s history, too many injustices have been committed in the name of someone’s judgment about what was compassionate for his neighbor. Compassion too, must be subject to moral analysis, must have its reasons, and those reasons must be morally cogent.]

The Argument from Compassion offers the “flip-side” of the Argument from Autonomy—rather than a rational argument devoid of the emotional element of human action, it emphasizes emotion (as its “power”), and uses a form of utilitarianism to bring it into rational discourse.

Kohl and Bok, for example, neglect the philosophical anthropology behind the Argument from Compassion; EPAS primarily involves acting from an emotional source. Compassion, as powerful and virtuous a feeling as it is in experience, is (mis)used, and becomes a *principle* to be weighed. From an anthropological

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211 Pellegrino (4), 875. In addition to the historical evidence for the misuse of the “compassion argument,” I wish to draw the reader’s attention to another very powerful paper adding to the evidence that a “slippery slope” is not only possible here, but *probable*. See Amarasekara, Kumar, and Bagaric, Mirko, “Moving from Voluntary Euthanasia to Non-Voluntary Euthanasia: Equality and Compassion,” *Ratio Juris*, Vol. 17 (3); September 2004: 398-423. The authors point out, rightly, that if the Argument from Compassion applies to the terminally ill, competent patient, there is no rational, legal, or emotional reason why one could not extend the argument to the non-terminally ill and/or incompetent patient. “The compassion that is universally felt for those with a terminal illness which is accompanied by undignified symptoms or unbearable pain is experienced no less for minors and intellectually impaired patients who are in the same condition. Their helplessness in fact probably adds to their vulnerability and emotional appeal.” (405)

212 Reich, cited above, in his moral account of compassion, directly roots theories of compassion (e.g., Schopenhauer) in ethical theory as a response to an overly rationalistic Kantian ethic. (83)
viewpoint, the Argument from Compassion represents the danger of a phenomenology which neglects metaphysics: once the emotional experience of value passively directs you to act, you may act—even to take your own life or the life of another—if that experience is weighed decisively.\textsuperscript{213} This represents a kind of “degenerate Scheler”; it overstates the case for empathy and presumes that empathy is the \emph{only way} in which one person can apprehend the subjectivity of another. To put it another way, the story of the ethical justification for the Argument from Compassion effectively may end once you have placed yourself within the experience of another; in effect, this is exactly what Woodward has described as reducing the emotion of compassion to “intensities and sensations” in the post-modern culture.

But for Wojtyla and other personalists such as John F. Crosby, such a view is at odds with human experience, and ignores the fact that, while empathy is the prologue, conscience oriented toward the truth fills in the “rest of the story.” Crosby relates that there are (at least) two instances where one can know other persons

\textsuperscript{213} Of course, not \emph{all} people will do this. Thus, some terminally ill people, even in intractable pain, will choose to live. The Argument from Compassion does not say we ought to kill all people we have pity for, nor does it say all people will be moved by empathy and the powerful feeling to “act kindly.” But, if compassion is used as a principle rather than a virtue, there is no objective way to determine how heavily it ought to be weighed. Thus, some may use the Argument from Compassion to justify EPAS, and others may not. In addition, few attempt to rest the case for EPAS based on the compassion argument alone. Even Timothy Quill [see Quill (1), cited above] in his narrative of a patient whom he helped commit suicide, carefully weaves the Argument from Autonomy, the Argument from the Evil of Suffering, and the Argument from the Loss of Dignity with the Argument from Compassion throughout his prose.
where the “knowing” is not specifically empathetic.\textsuperscript{214} The first—and the only one crucial to the current discussion— involves one person who needs “fraternal correction” from another. Here he gives the biblical example of the good friend Nathan, seeking to break David’s denial of his adulterous and murderous ways and allow David to realize that the acts he has committed are morally wrong.\textsuperscript{215} Crosby explains:

Nathan is not interested in empathizing with David but in awakening his conscience…[David] is in a moral condition the very opposite of despair when Nathan comes to him, his conscience is asleep and he has not yet acknowledged doing any wrong. And yet Nathan takes David entirely as person; only persons can be guilty the way in which Nathan declares David to be guilty, only persons can repent in the way Nathan leads David to repent…Other persons can mediate self-knowledge to me by seeing me from their point of view; I overcome illusions about myself and gain self-knowledge by seeing myself with the eyes of others…If [another] does not look at me in this non-empathetic way, then he loses the capacity to challenge me to grow in self-knowledge. If the other only understands me empathetically, as I understand myself, then when I see myself with his eyes I will only find again in the other what I already know myself.\textsuperscript{216}

It is perhaps when a person is suffering and most vulnerable, when a person believes that her life is “meaningless” or “worthless,” that a type of “fraternal correction,”

\textsuperscript{214} Crosby (3), 41. The “second instance” of knowing a person in a non-empathetic way involves cases where one’s “sense of the otherness of the other person is strong,” that is, when the incommunicability of a person dominates one’s view of them. Then, empathy is not possible but knowledge of the person, albeit as “other,” is.

\textsuperscript{215} See 2 Samuel 12:1-20.

\textsuperscript{216} Crosby (3), 41.
from a non-empathetic point of view, is most needed. The “other”—a physician or family member—may in this way bring a terminal ill person contemplating EPAS toward the truth—the truth about killing, and the truth about her worth as a person.

Thus, the Argument from Compassion is also subject to Wojtyla’s critique of Scheler: this view lacks the normative element that organizes and presents values to the will. It “emotionalizes consciousness,” a view which Wojtyla rejects. For supporters of the argument, compassion (Quill), a feeling of mercy (Bok), or of kindness (Kohl) are *prima facie* reasons to act in favor of EPAS. The argument ignores the person as the efficient cause of his action, or the action as transformative of the person, and thus the action is likewise divorced from ethical experience. In Chapter I, I described the difference between a man-act (*actus humanus*), and an act-happening-in-man (*actus hominis*). It was only in the former that human efficacy is to be found, and only with human efficacy does a man truly change. A proponent of the Argument from Compassion does not *need* to concern herself with how the action of EPAS relates to responsibility or duty, or the how this effects (metaphysical) change in the person she acts with compassion toward. An *actus hominis*, like a strong emotion (compassion, sexual desire etc.) does not involve the presentation of values to the will. Of course, a person may feel “transformed” (later), but here we take “transformation” in a different sense. The type of transformation

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218 Take, for example, Timothy Quill’s account, after helping his patient Diane to obtain drugs to commit suicide: “Diane taught me about the range of help I can provide if I know people well and if I
I refer to and have defended above is intimately connected with truth. The person becomes better. The Argument from Compassion does not consider the actualization of the person, the subordination of action to the good. What they feel is another matter. Schmitz notes:

Feelings in themselves do not determine values or our knowledge of them—the reference is to the author’s on-going critique of Scheler—though they frequently accompany our relation to them: ‘The fusion of sensitivity with truthfulness is the necessary condition of the experience of values.’ [my emphasis](AP 233)

Conscience, as was alluded to above, is also a critical player here—both in illustrating the richness of Wojtyla’s theory of person, as well as showing what the Argument from Compassion lacks. We should recall that for Wojtyla, duty, which conscience allows us to experience, is the experience of truth itself. Yet, Scheler excludes the ethics of duty from his theory, to the neglect of conscience. Viewed through the emotional prism, truth is not a decisive factor in the Argument from Compassion: the weight of compassion is pre-rational, as in Scheler.  

allow them to say what they really want. She taught me about life, death, and honesty and about taking charge and facing tragedy when it strikes.” [Quill (1), 694]. Such an account shows a transformation (he “learned something”), but did he truly become better? Did it matter if he did, when he acted?

219 Schmitz, 81-82.

220 Wilfried Ver Eecke put it to me this way in conversation: “From a psychoanalytic point of view, feelings and emotions always express a truth, but the truth maybe one-sided. In psychoanalysis, after the patient (sometimes with the help of the therapist) has formulated the presumed truth of a feeling, the patient is in a position to take distance from the absolute claim to truth of the feeling and is free to formulate a more true evaluation of the reality. This is the great advantage of letting the patient put into words their hidden or repressed feelings. [Bertram P.] Karon explicitly makes such a two step approach with his patients, but goes even further. To deal with the emotions, he says that you have to justify them. Thus, he says something like: suppose you say that your step-mother is so bad that she
Of course, the objection I have raised, if it is to be an objection at all, assumes that in truth, an authentically formed conscience would show that EPAS is wrong. Let us suppose that “in reality” the proposition “EPAS—if done because you feel compassion and wish to relieve another’s suffering—is right” is a true proposition. The Argument from Compassion would still be suspect because, lacking a basis in conscience, it does not require the person to make an effort to deliberate or consider whether the emotion one feels ought to be acted on vis-à-vis other considerations. It is, at the very least, an irresponsible argument.

Hence, as Wojtyla would argue many years later in the papal encyclical *Evangelium Vitae*, killing for compassion’s sake “must be called a false mercy, and indeed a disturbing ‘perversion’ of mercy. True ‘compassion’ leads to sharing another’s pain; it does not kill the person whose suffering we cannot bear.”

Sharing in another’s affliction therefore requires an understanding of *vulnerability as a natural condition* of human persons—persons who live in dependent relationships with others. Properly understood, dependency represents an opportunity to share with another an intimacy that derives its significance from the

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221 EV, para. 66.
esse of the person himself, rather than the “event” (terminal illness). It is in presenting oneself to another, for another, that we offer to the sick a gift of immeasurable value that is recognized and valued by the sick patient. It is important to observe the phenomenological experience of compassion from the perspective of the sick person as well. When we—as family members, friends, or caregivers—are offering to “suffer with another,” we are also receiving the gift another’s vulnerable self. The suffering person draws us nearer to a place we instinctively resist but draws us nearer for a purpose. In her vulnerability she shows us that she is still a person and communicates this with her presence alone.

The “Good Death”?

One of the unstated assumptions of the Argument from Compassion is that death is a good for the individual who intends, chooses, and asks for it. Death relieves the person of suffering and pain; death is the liberator of the person from misery and as such constitutes a “good” for the person. There are many philosophical problems with this approach. The first is a variation on what Christopher Kaczor has...

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222 For further reading on the natural role of dependency see, for example, Carse, Alisa (cited above). Carse calls this “taking our vulnerability to heart.” (40). See also MacIntyre, Alasdair, Rational Dependent Animals: Why Human Beings Need the Virtues (Chicago: Hardcourt Press), 1999: 73-75.

223 Fuat Oduncu provides an interesting framing of this “giving” concept of compassion. The author utilizes the Aramaic term “Rahme,” to describe compassion as (1) “taking care of the sick,” i.e., the delivery of technical care; and (2) “caring about the sick person,” which involves a “virtue of devoting” or companionship till the end. See Oduncu, Fuat S., “Euthanasia: Killing As Due Care?” Wiener medizinische Wochenschrift (1946), Vol. 153 (17-18); 2003: 387-391.
called a “Cartesian” mistake: the human person is not a separate body and soul.\textsuperscript{224} Hence, what is perceived to be good for the “person” (in the case of EPAS, death) is inextricably linked to the good for the body and vice versa. Now, while colloquially one might say that the physiologic death of life sustaining cells, tissues, and organs constitutes a “good” for the physical body in the face of terminal illness, what is really meant is that such a death is a psychological good—perhaps for the terminally ill, and certainly for the other interested, supportive parties. The scientific fact, however, is the opposite. Leon Kass eloquently brings this notion to the forefront vividly:

‘Personhood’ is manifest on earth only in living bodies; our highest mental functions are upheld by, and are inseparable from, lowly metabolism, respiration, circulation, excretion. There may be blood without consciousness, but there is never consciousness without blood. The body is the living ground of all so-called higher functions. Thus one who calls for death in the service of personhood is like a tree seeking to cut its roots for the sake of growing its highest fruit. No physician, devoted to the benefit of the sick, can serve the patient as person by denying and thwarting his personal embodiment.\textsuperscript{225}

In short, the intentional killing of the physical body cannot, by definition, constitute an authentic good for a person who no longer exists (except, perhaps, in the afterlife)


\textsuperscript{225} Kass (1), 41. He calls this an argument against PAS from the point of view of human “wholeness.” See also, Kass, Leon, “Death with Dignity and the Sanctity of Human Life,” \textit{The Human Life Review}, Spring 1990: 19-40. [Henceforth Kass (2)]: “Individuals strive to stay alive, both consciously and unconsciously. The living body, quite on its own, bends every effort to maintain its living existence. The built-in impulses toward self-preservation and individual well-being that penetrate our consciousness, say, as in hunger or fear of death, are manifestations of a powerful and deep-seated will to live.” (23)
after death occurs. Suppose, however, one were to object that “losing a limb is not a
good. However, it does not follow that amputation is bad. Losing a limb is not a
good, but amputating a limb can be a good, if it is meant as a means to other goods.
Likewise, the defender of PAS can say that the death of the body is not a good, but
the killing of the body is good if it is a means to other goods.”

To understand the answer to this objection, it is prudent to reflect briefly on
what natural law theorists refer to as “basic human goods.” Natural law philosophers
(and many others) typically agree on a first principle: that one should pursue the
good and avoid evil. This has been called by Professor Gomez-Lobo “a general
principle of practical rationality,” which, if we do not accept, we cannot proceed in
moral discourse. If one is to pursue good and avoid evil, our principle task is to
determine whether what I pursue is really good for me or whether I merely think it is.
This is the classical distinction between real and apparent goods. One answer to
the objection posed would be that the pursuit of EPAS is an apparent good and not a
real good, and proponents are mistaken in thinking that it is fulfilling of the person.

This would be a simplistic and rather unfulfilling answer, but I believe the case has

226 Alexander Pruss, in correspondence, offered this objection as a devil’s advocate, which I
appreciate.

227 Gomez-Lobo, Alfonso, Morality and the Human Goods: An Introduction to Natural Law Ethics,

228 What is “the good?” is of course a crucial question, and a full discussion of it will never be
complete here or elsewhere. I simply take the good to mean what I have defended elsewhere in this
work—that which is fulfilling or perfective of the agent herself.

229 For an excellent, succinct discussion of this distinction, see McInerney, Ralph, Ethica Thomistica:
been made in Chapter I that man is fulfilled or perfected through free action in accordance with the truth. Thus real freedom (and perfection) comes in knowing one could end one’s (or another’s) life and choosing not to do so. There is more to the answer than this. In the example above, the loss of a limb is not a good, but an amputation can be a good, if it is done for the sake of other goods. What other goods are we talking about?

Here we distinguish between basic human goods and other, derivative goods. Life—that is to say, biological life—is a basic human good, and I would argue, as Gomez-Lobo has done:

> Life is not the sole good (we can possess many other goods beyond being merely alive), but it is surely the very first one. Without it we cannot partake in any other goods. In this sense, it is the grounding good.\(^2\)

When a limb is amputated, it is amputated for the sake of a basic human good—that is to say, it improves the chances of the *survival* for the human person.\(^3\) This shows a commitment or priority to the basic human good of life. Likewise, one cannot sacrifice this “grounding good” (as in EPAS) for a quality of life which is dependent on biological life in order to be extant. Again, I borrow from Gomez-Lobo to place the counter-argument in an analytic form:

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\(^2\) Gomez-Lobo, 11. See also McInerney, cited above, especially 12-34 for a more detailed discussion of basic human goods and their roots in Aquinas.

\(^3\) The Principle of Totality and the controversies surrounding it are relevant, but beyond the scope of this work. Some contemporary discussion can be found in Cowdin, DM and Tuohey, “Sterilization, Catholic health care, and the legitimate autonomy of culture,” *Christian Bioethics*, Vol. 4 (1); 1998: 14-44; See Janet E. Smith’s excellent response clarifying and defending the principle in “Sterilizations Reconsidered?” *Christian Bioethics*, Vol. 4 (1); 1998: 45-62.
P1: Any act whose goal is intentionally to attack, harm, destroy an instance of a basic human good is irrational and morally wrong (This is the guideline of respect for basic goods under the Formal Principle of practical reason…)

P2: Life is a basic human good (the first supplementary principle of practical rationality).

P3: Active euthanasia is an action whose goal is intentionally to take the life of a terminally ill patient to alleviate great pain…

P4: Active euthanasia is irrational and morally wrong.\textsuperscript{232}

The Argument from Compassion’s driving force is that it is better for that person to end his life intentionally than to continue his biological life, but this argument works only if distinctions are ignored between real and apparent goods and basic and derivative goods.

Furthermore, when viewed through the lens of natural law ethics, which Wojtyla endorses, we find a subtle objection with respect to how “the good” is defined. Some who argue that a “compassionate death” is “good” for the person are defining a “good” as the thing which the person desires and subsequently requests.\textsuperscript{233}

Dan W. Brock, in discussing a second “fundamental value” at stake in the euthanasia debate (apart from autonomy), says that the perception of an individual’s well-being is crucial:

\textsuperscript{232} Gomez-Lobo, 101.

\textsuperscript{233} Again, I refer here only to someone who \textit{consents} to active euthanasia or PAS Prior to requesting euthanasia, a person must, of course, \textit{desire} to end her life, either as an end in itself or as a means to another end (e.g., achieving the absence of pain). Not all people who are terminally ill, or desire death, or wish to stop pain, will request EPAS or consent to it. However, for those that do, a formal request (e.g., as in the Oregon statutes) should represent, according to proponents (ideally) a “codified desire.”
Life is no longer considered a benefit by the patient, but has now become a burden. The same judgment underlies a request for euthanasia...Especially in the often severely compromised and debilitated states of many critically ill or dying patients, there is no objective standard, but only the competent patient’s judgment of whether continued life is no longer a benefit. [my emphasis] 234

Therefore, simply asking for euthanasia (for whatever reason—pain, suffering and the like) makes euthanasia good, however, this does not follow. 235 Philosophers should instead argue that the thing is requested because it is good. The antecedent objective is to determine the good that inheres in the thing desired, if any. Whether this is done by speculative or practical intellect, the object grasped as good and then willed is one which also must be compleitive for the person. 236

From the perspective of Wojtyla’s phenomenological personalism, the person deprived of life, either by their own hand (PAS) or another’s (euthanasia) is a person who is also deprived of the experience of responsibility for his action—by his own hand. It is a person who does not experience a “good” act, and chooses not to do so, because his conscious self no longer exists when the act is finished. This is the core of the moral act. An act which deliberately prevents one from the possibility of transformation through action can never be licit; it is the highest affront to morality

234 Brock, cited above, 11.

235 Gomez-Lobo has called this the Subjectivist Thesis: “If X seems to A to be good, then X is good for (beneficial to) A.” He also spends time refuting it. (7-9).

itself. I am not claiming that one has to necessarily experience the completion of an act for an act to be good or to transform the person. Alexander Pruss has offered two examples: first, a person who throws himself on a grenade to save the life of another commits a good act but does not expect to survive the act. Second, a person who takes a sleeping pill achieves a good (sleep) but is not conscious of the completion of the act. The difference between these acts and EPAS can be understood in terms of the Principle of the Double Effect, in its classical formulation: An act which has two effects, one good and one bad, can be performed if these criteria are met:

1. The action itself is morally indifferent or morally good.
2. The bad effect must not be the means by which the good effect is achieved.
3. The person must not intend the bad effect (but it can be foreseen, predicted, or tolerated—just not willed)
4. There will be a favorable proportion or balance (prudentially judged) between the good and bad effects.

In the case of throwing oneself on a grenade, the end of one’s life is a predicted consequence of saving another’s (3), but not intended. Likewise, in taking a sleeping pill for good reason (sleep), one does not intend to avert responsibility or avoid awareness of the completion of the act. What if we modify the sleeping pill example: let us say the person chronically takes sleeping pill as an “escape” from the “burdens

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237 I am aware of the controversies surrounding the Principle of the Double Effect, but addressing these controversies here is beyond the scope of this work.

238 Adapted from Gomez-Lobo, 80.
and tragedies of life” because he does not wish to introspect on mistakes made, or deal with bills, or talk to his wife at night. In this case, the action may be wrong [violating (3) and (2)], because the person is deliberately choosing not to be aware of the act’s completion. Turning to EPAS, if freedom is experienced in the movement from potency to act (Chapter I), and a person deliberately chooses to end one’s existence (and/or other’s help him), he certainly violates conditions (1), (2), and (3) above [and possibly (4)].

What proponents of the compassion argument probably want to claim (but are understandably reluctant to do so) is that the act of EPAS is a good for them. This is at least a more plausible claim. The mistake which they make here lies in an exaggerated or misguided sense of empathy, as stated above. Alisa Carse warns:

[W]e must guard against the peril of inappropriate involvement—the danger that we might be intrusive in our presence, or, on the other hand, ourselves compromised—‘vicariously possessed’—by the state of the other as we might imagine it…A properly bounded caregiver must, on the one hand, be sufficiently respectful of and open to another in need while, on the other hand, sustaining self-possession, emotional equanimity, and critical distance required to avoid unhealthy self-effacement.\(^\text{239}\)

In failing to maintain critical distance, a caregiver is susceptible to the sort of “natural revulsion” humans feel when confronting the sick and dying. We wish to avoid them because we wish to avoid “it.” When confronted with both the reality of sickness as well as the sick person, one who supports the Argument from Compassion places himself with the sick, without actually giving himself to the sick

\(^{239}\) Carse, cited above, 43.
(here we recall the bifid etymology of compassion—a call to be with and endure with another). The mutuality of true compassion and vulnerability is lost; the caregiver becomes the principal actor. Causal efficacy then, falls on this “second actor”—either the physician who prescribes the lethal drug, or the person who actively euthanizes the patient. In order for EPAS to be a real (completive) good for this second actor, the act would have to transform the person into a person who is better (from a moral point of view) than he was before. It must go beyond merely “feeling good,” or “feeling like a good act.” To do this, it must be tied to the truth.

Both the Argument from Autonomy and the Argument from Compassion fail on a significant level for the same reason that Kant’s and Scheler’s ethical theories prove to be inadequate: both separate the ethical act from experience. In addition, the Argument from Autonomy distorts the notion of human freedom, making freedom subject to consciousness alone, without an accurate vision of self-determination that allows the person to realize himself as the author of his action and thus be perfected by it. On the other hand, the Argument from Compassion does not require objectivity of even the kind Scheler had hoped for (an objectivity of values). The normative element to ethical action is overwhelmed by the emotional, and without even a reference to truth, this argument is grossly inadequate as a justification for active killing.
When this body is gravely ill, totally incapacitated, and the person is almost incapable of living and acting, all the more do interior maturity and spiritual greatness become evident, constituting a touching lesson to those who are healthy and normal.


Chapter III: Suffering and Its Meaning

The Argument from the Evil of Suffering

In my review of the literature, there is, as of yet, no published article or monograph which lays out an argument from suffering in the precise form I am about to. What I construct below is an argument which is often entwined with the Argument from Compassion to a great degree, and is implicit in many of the arguments which support EPAS, but not brought to high relief by the authors who support it. Daniel Callahan, writing against PAS, summarizes his opponents’ argument in this way:

240 See Figure 2: Wojtyla’s “World of Suffering” which follows this chapter.

241 I have chosen this phrase to characterize the argument that terminal, extreme, or intractable pain and suffering is useless and, in that sense, is “evil.” In addition, some proponents of euthanasia (e.g., Peter Singer, Jack Kevorkian and other utilitarians) use the “weight of suffering” as the content of the utilitarian calculus, which they balance against the happiness or unhappiness of alternatives. I will elaborate more on this below. I use this phrase, then, not because supporters of EPAS are the only ones who see suffering as an evil; rather, I do so for the sake of clarity and ease of language. (For example, a more accurate, but linguistically cumbersome alternative might be “The Argument from the Pointlessness or Valuelessness of Suffering” etc.)
The [physician-assisted suicide] movement’s deepest point might be simply understood as this: If we cannot trust disease to take our lives quickly or peacefully, and we cannot rely on doctors to know with great precision how or when to stop treatment to allow that to happen, then we have a right to turn to more direct means. In the name of mercy, physicians should be allowed to end our lives at our voluntary request, or alternatively, be permitted to put into our hands those means that will allow us to commit suicide.  

The Argument from the Evil of Suffering can therefore be said to be something like this:

1. There is a distinction between pain and suffering. Pain can cause suffering and suffering can cause pain; they may or may not coexist. Both pain and suffering are subjective phenomena.

2. Adequate pain control is not often present, particularly at the end of life. Even if it were the case that most pain can be controlled with palliative care, there are still a significant minority of patients who will have “intractable pain.”

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243 See, for example, Cassell, Eric, “Recognizing Suffering,” Hastings Center Report, May-June 1991: 24-31. [Henceforth, Cassell (1)]

244 This argument is made repeatedly in the monograph, Quill, Timothy, and Battin, Margaret, ed., Physician-Assisted Dying: The Case for Palliative Care and Patient Choice, (Baltimore: Johns Hopkins University Press) 2004 [Henceforth, Quill (3)]. See in particular Angell, Marcia, “The Quality of Mercy,” 15-23; see also Quill, Timothy and Battin, Margaret, “Excellent Palliative Care as the Standard, Physician-Assisted Dying as a Last Resort,” 323-333.
3. Even in the absence of physical pain, a patient’s suffering can be mental, spiritual, or existential, and can be severe. Since suffering is a complicated individualized phenomenon, no one except the sufferer can precisely know how and with what intensity a person suffers.²⁴⁵

4. Intractable pain and/or unbearable suffering that cannot be relieved are therefore present in (some) patients at the end of life.²⁴⁶

5. Since one of the crucial goals of medicine is to relieve suffering of the competent patient who requests it,²⁴⁷ pain or suffering that does not lead to a greater good in the eyes of the patient serves no point and, therefore, must be eliminated.²⁴⁸

6. If terminal pain or suffering is not able to be relieved through palliation and counseling, the physician has a duty to honor a patient’s request to actively end her life and thereby relieve her suffering.²⁴⁹

²⁴⁵ See Cassell, Eric, “When Suffering Patients Seek Death,” in Quill (3), 75-87, esp. 82-87.

²⁴⁶ This follows from the arguments above, but is also emphasized in other papers. See for example, Quill, Timothy, “How much suffering is enough?” Lahey Clinic Medical Ethics, Spring 2006: 10-12. [Henceforth, Quill (4)]

²⁴⁷ Here I am narrowing the argument to include cases of voluntary, active euthanasia or PAS in adults. Of course, a “stronger version” might argue for some instances of non-voluntary euthanasia, or cases of pediatric euthanasia. My counterarguments would apply in these cases also.

²⁴⁸ See, for example, Brock, Dan W., “Physician-Assisted Suicide as a Last-Resort Option at the End of Life,” in Quill (3), 130-149.

²⁴⁹ Quill frames his argument in terms of what he calls the “principle of nonabandonment.” (See Quill, Timothy, “Nonabandonment: A Central Obligation for Physicians,” in Quill (3), 24-38.) Briefly, he argues that physicians enter into a special “continuous caring partnership” with patients; the dimensions of this covenant include “virtues of caring, fidelity, altruism and devotion.”(24) The covenant has limitations—including the ability of physicians to refuse certain requests if this conflicts with their personal moral values. However, the principle is described as a “central obligation,” even
One of the most emotionally-charged arguments for EPAS rests in the claim that EPAS is justified because, at the end of life, if people suffer or are in intractable pain, it is a physician’s duty to relieve them of that pain and suffering. Of course, one cannot help but recall the Argument from Compassion (a duty to kindness) as related to this line of reasoning. However, there is something deeper. Why do suffering and pain place such a duty on physicians in the first place? Why should a person who suffers unbearably not be given relief of that suffering, if he requests it? It must be acknowledged that there is a definite “negativity” associated with terminal pain and suffering—the very words themselves are unpleasant—for both proponents and opponents of EPAS. One author describes the phenomenon of suffering in this way:

Suffering leaves us no doubt that it is decisively against us. Its purpose, if it can be said to have a purpose, appears to be fundamentally opposed to our humanity. It works to obliterate all the pleasure and hope we have in life. Suffering destroys our bodies, ruins our minds, and smashes our ‘spirit.’

“paramount.” Quill wants to use the principle as a permissive principle—that is, for those who wish to, it “may allow clinicians to take some risks on behalf of patients who have no good options.” (34-35). It should be noted that not all who support EPAS would agree with the principle. Derek Humphry, for example, argues that “the help of a physician [in PAS] is imperative, because loved ones and family members untrained in the medical profession are rarely able to help a loved one to die…A physician is not emotionally bound to the patient. There are no enduring intimate connections. Doctors are body technicians, and most of them are caring, loving human beings as well.” [my emphasis] (Humphry, Derek, “Active Voluntary Euthanasia,” Free Inquiry; Winter 1988/89: 7-10, quoted from 8.)

250 Wilkinson, Iain, Suffering: A Sociological Introduction, (Cambridge: Polity Press) 2005: 1. I am not agreeing with this negative characterization. A person suffering remorse from a terrible crime, for example, might not have a “smashing of the spirit,” but rather, a restoration of it. This is a view supported by Wojtyla’s notion of the transformative act—in this case, an act of conscience.
If that is so, what are the “positives” of *not* relieving a person’s suffering or pain through EPAS?

The answer from many proponents will be that there are no positives—or, if there are they certainly do not outweigh the benefits of EPAS. Implicit (and sometimes explicit) in this assertion is that the patient’s suffering is “pointless.” Take for example, the now famous, anonymous description of a resident’s decision to euthanize her patient:

The room seemed filled with the patient’s desperate effort to survive…It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, “Let’s get this over with.” I retreated with my thoughts to the nurse’s station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 milligrams of morphine sulfate into a syringe. Enough, I thought, to do the job. I took the syringe into the room and told the two women I was going to give Debbie something that would let her rest and to say good-bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world…With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved. It’s over, Debbie.251

The narrative makes a subtle point: the patient’s suffering (and the failure of medicine to restore health) was, at this stage without purpose; euthanasia is the acceptable solution. Marcia Angell, a physician and proponent of PAS notes more directly:

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Symptoms of terminal illness other than pain are often hard to manage. That is particularly true of existential suffering—the sense of the *utter pointlessness* of a protracted death. If tomorrow will be worse than today, one day after another until the end, why not die today? Why continue to disintegrate, to lose bodily functions, to grow ever more helpless and dependent? [my emphasis]252

Some go further. Charles Baron, in a provocative essay called, “Hastening Death: The Seven Deadly Sins of the Status Quo,” argues that “Inhumanity,” in denying PAS, is one of these sins by “enforcing suffering” on the terminally ill who request it and are denied. Something enforced on another unjustly is something unnecessary. He goes on to argue that a second “sin” is “Paternalism”—and that denying PAS is forcing people to accept that suffering “may serve some important goal for the dying person.” Since Baron claims this view is grounded in religion (a claim not substantiated), it cannot be justly continued in a pluralistic society.253

Proponents of EPAS likely mean that only *some* types of suffering (e.g., that do not improve the health of a patient, that are intractable in the terminal state) are pointless or serve no purpose for the patient, rather than all types of suffering.254

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252 Angell, in Quill (3): 19.


254 There are conceptual problems with the claim that suffering is entirely pointless (without qualification) as Stanley Hauerwas has pointed out: “For if suffering to be recognized, i.e., named, involves an interpretive context, then the very interpretation seems to carry a ‘point.’ The interpretation at least places the suffering in a narrative context even if the narrative is thought to be absurdist.” (See Hauerwas, Stanley, *Suffering Presence*, (Notre Dame: University of Notre Dame Press) 1986: 31.)
Furthermore, in cases of voluntary EPAS it must be seen as pointless from the perception of the patient alone:

Whatever may be the origin of suffering…the loss of the person’s intactness—the hallmark of suffering—is related to the specific nature of that person. Whatever may be the origin of suffering, once suffering has started, it is the suffering that is the main problem, not the pain or other symptoms, as awful as they may be. The suffering of some patients cannot be relieved because its sources within the patient are inaccessible.²⁵⁵

_The Meaning of Suffering_

Stanley Hauerwas claimed in 1986 that “after trying to read all I could get my hands on concerning the meaning of suffering, I am convinced that never has there been a word used with such uncritical assumption that everyone knows what they are talking about.”²⁵⁶ A full conceptual analysis of the meaning of suffering would be beyond the scope of this work. I will try only to narrow the discussion to the points of controversy, as they relate to EPAS. Proponents such as Quill, Angell, Baron and others would likely agree with the summation that intractable pain or suffering at the end of life serves no moral purpose or lacks moral value; whether or not others gain something from another’s suffering is irrelevant.²⁵⁷ Hauerwas, in probing the idea of

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²⁵⁵ Cassell, in “When Suffering Patients Seek Death,” in Quill (3), 79.

²⁵⁶ Hauerwas, cited above, 29.

²⁵⁷ Baron argues, as another “deadly sin of the status quo,” that what he terms “Utilitarianism” (taking into account the benefit that others—like the family or community—may gain from personal suffering is not only irrelevant but essentially immoral. (Baron, in Quill (3), 312-314.)
suffering as “having no point,” suggests that when people use that expression, what they likely mean is that suffering “serves no purpose in our moral project.” What matters, the argument goes, is the patient’s own perception of the value that suffering has for them. In a complex study of the meaning of suffering Adrian C. Moulyn notes that “whatever the answers, the question why we suffer always starts with the premise that it is against the natural state of affairs, which is happiness. This premise is grounded on the belief that suffering is a sign of evil…One concludes that suffering is valueless because it destroys happiness.”

I agree with Pellegrino’s analysis that one primary reason for these arguments lie in the modern philosophical anthropology of bioethics, which he describes as the “positivist-empirical view”:

Extrapolations of science’s materialist premises produces a bioethics measured by the good of the body or the species, for that is all there is. Mind, soul, emotion, spirit—all are simply epiphenomena of mater…There is no reality beyond what we can touch, see, feel, or smell. Suffering is pointless. When the machinery of the body is irreversibly damaged, death can, and should be chosen. 

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258 Hauerwas, 32-33. Suffering, however, can be said to have existential value, as Hauerwas himself has astutely observed: “Suffering is not morally significant only because things happen to us that we cannot avoid, but because the demands of morality cannot be satisfied without asking the self to submit to limits imposed by morality itself. In this sense, without allowing ourselves and others to suffer we could not be human or humane.” (25)


260 Pellegrino, in Taylor and Dell’Oro, cited above, 255. There are certainly cultural influences as well, as S. Kay Toombs notes, “In a culture that views health and happiness as a personal right, suffering is seen as an affront.” (Toombs, in Taylor and Dell’Oro, cited above, 134-135.)
If one accepts that all a person is is what her biological makeup dictates, then to suffer without a cure seems to lack a point. Hauerwas describes how the nature of modern medicine has continued to reinforce this idea:

…[M]edicine can be interpreted as the attempt to have us view our suffering as pointless, this making it subject to therapeutic intervention. In other words, medicine tends to break the moral link between our suffering and our projects by suggesting that our suffering is pointless. Medicine thus schools us to think of our suffering in a mechanical model.  

Thus, the Argument from the Evil of Suffering first requires further definition. Peter Colosi asserts that three fundamental questions concerning suffering can be posed:

“(1) What is the origin of suffering?; (2) What is the metaphysical status of suffering?; and (3) Given the reality of suffering, what is its inner meaning, how does it relate to the other aspects of our lives, and what should our response to it be?” The origin of human suffering is a vast topic and far beyond the scope of this work. Thus, our discussion in the context of the EPAS debate will primarily focus on (3), and, I will touch on (2) as well.

Let us look more closely at (3). If one were to begin an inquiry with the question, “does suffering have meaning?” one would need to understand the precise goal of the inquiry. Do we mean by this question, “what does suffering mean?” and thereby, “is there a definition of suffering?” Some authors, such as Cassell, have

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261 Hauerwas, 33.

262 Colosi, Peter, “John Paul II and Max Scheler on the Meaning of Suffering,” publication forthcoming, Logos, 2008: 2. [Henceforth, Colosi (3)]
offered a concise one.\textsuperscript{263} Others write extensively about the conceptual problems and elusiveness of a single definition of suffering,\textsuperscript{264} and still others make the case that no definition of suffering is possible at all.\textsuperscript{265} Definitions, then, are only marginally helpful. Most of us know intuitively to recognize suffering in another, and all have experienced suffering of some kind. “Suffering is common to us all, yet can only be known uniquely as our own…the very fact that suffering is such a deeply personal experience may well be part of the explanation for why it remains so difficult for commentators to agree on a definition of what ‘it’ is.”\textsuperscript{266}

\textit{The Different Types of Suffering}

Distinctions, however, unlike definitions, can be very instructive when discussing suffering. Lynn A. Jansen and Daniel P. Sulmasy have written an important paper on the distinction between \textit{neuro-cognitive suffering} and \textit{agent-}

\textsuperscript{263} See for example, Cassell, Eric, “Diagnosing Suffering: A Perspective,” \textit{Annals of Internal Medicine}, Vol. 131 (7); October 5, 1999:531-534. [Henceforth, Cassell (2)] Cassell defines suffering as “a specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted.” (534).

\textsuperscript{264} See Wilkinson, cited above, especially Chapter 2, 16-45.

\textsuperscript{265} Frank, A.W., “Can we research suffering?” \textit{Qualitative Health Research}, Vol. 11 (3); 2001: 353-362. “Suffering is the unspeakable, as opposed to what can be spoken; it is what remains concealed, impossible to reveal; it remains in darkness, eluding illumination; and it is dread, beyond what is tangible even if hurtful.” (355)

\textsuperscript{266} Wilkinson, 16.
narrative suffering. The authors first note that some supporters of EPAS have argued that a “principle of proportionality” should be used to determine when a physician’s interest in ending his patient’s suffering should override the duty to do no harm. Jansen and Sulmasy summarize this principle as follows:

[T]he greater the patient’s suffering, the greater the risk the physician can take of potentially contributing to the patient’s death, so long as the patient understands and accepts the risk.

The principle of proportionality in this context, as laid out by EPAS advocates, requires the physician to estimate the total amount and intensity of suffering and determine whether this is proportionate to the risk of harming the patient (i.e., hastening death).

However, such a definition either ignores the distinction between types of suffering, or assumes (incorrectly) that the distinction is irrelevant. Neuro-cognitive suffering is “suffering that has a direct causal relationship to the patient’s underlying medical condition” and would cause suffering in a person “regardless of her beliefs”; examples include anxiety disorder, depression, bone pain, phantom limb pain, etc. Agent-narrative suffering is “suffering that has an indirect causal relationship to the patient’s underlying medical condition” and is dependent on factors “(largely)

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269 Jansen and Sulmasy (1), 323.
particular to the person experiencing the suffering”; examples include fear, loneliness, disgust, worthlessness, loss of independence, etc.\textsuperscript{270}

There are two crucial points arising from these distinctions, as Jansen and Sulmasy make clear through clinical examples.\textsuperscript{271} The first is that no competent clinician, in recognizing the distinction between these types of sufferings, would treat them in the same way. While neuro-cognitive suffering may be amenable to pharmacological intervention, agent-narrative suffering may require a more holistic approach, including pastoral care and counseling, for example. The proportionality principle, as formulated by Quill et. al., “lumps all suffering together,” making the physician’s estimation of the intensity of suffering more difficult (if not impossible), and clouding appropriate treatment options. Second, Jansen and Sulmasy note that the purpose of medicine is not simply to “end suffering,” but rather, to restore the patient to a state of health. “Serving this restorative goal requires physicians to attend to the psychosocial well-being as well as the physical well-being of their patients.”\textsuperscript{272}

This should not automatically exclude the terminally ill. Such an error is commonly made and assumes that terminally ill suffering patients do not have a restorative interest in health, or that such patients are not capable of restoration. Although they cannot be restored to “perfect health,” “patients retain an interest in their

\textsuperscript{270} Jansen and Sulmasy (1), 324-325.

\textsuperscript{271} Jansen and Sulmasy (1), 326-335.

\textsuperscript{272} Jansen and Sulmasy (1), 326.
psychosocial well-being right up until their death…Since patients have an important
interest in responding to these [important] questions in a manner that is consistent
with their character and considered values, they have an important interest in being
in a psychosocial condition that makes this possible.”

Thus, Jansen and Sulmasy reformulate the “principle of proportionality” into
“the principle of therapeutic responsiveness”:

A physician’s therapeutic response to terminal suffering is justified, even if it imposes a high
risk of hastening the patient’s death if and only if (i) the measures implemented are directly
proportionate to the intensity of the patient’s suffering; (ii) the measures implemented are
appropriate for the type of suffering the patient is experiencing and therefore, are properly
responsive to the patient’s restorative interests; and (iii) the patient or the patient’s legal
surrogate understands and accepts the risks associated with the measures.

This principle is critically important for several reasons. First, it takes into account
the tremendous amount of empirical evidence suggesting that agent-narrative
suffering is present at the end of life, and calls for a specific response to it in keeping
with the patient’s interest in restoration. Second, it requires physicians to be more
discriminating about types of suffering, which improves the care of both types and
“rehumanizes” the terminally ill patient by affirming the goal of restoration for the
remainder of his existence. Third, it places limits on the physician’s medical

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[274] “Appropriate” should be understood to be in the “restorative interests” of the terminally ill patient. (Jansen and Sulmasy (1), 330)

authority—they could not, for example, treat agent-narrative suffering with barbiturates or opioids.\textsuperscript{276} Finally, no physician, under the principle of therapeutic responsiveness, would have to provide any treatment for a patient that was not medically appropriate—that is, taking into account the different approaches to the different types of suffering as outlined.\textsuperscript{277}

\textit{The Purpose of Suffering}

What I wish to explore, which is at the root of the Argument from the Evil of Suffering, is the claim that suffering appears (for some) to have no \textit{purpose}, or perhaps more precisely, no \textit{value}, and therefore, “it is an unmitigated evil that justifies relief, even if it means accelerating death.”\textsuperscript{278} Thus, we will embark on an exploration of the question “does suffering have meaning?” as “does suffering have a purpose?”\textsuperscript{279} Of course, these two questions can be seen as conceptually different. If

\textsuperscript{276} Jansen and Sulmasy deal extensively with an objection (“the hard case”) where existential suffering, it is argued, requires pharmacologic intervention because all other ways of relieving suffering have failed (331-335). The authors counter that such “terminal sedation” with the purpose of hastening death or making the patient unconscious is an assumption that the patient has no restorative interests worth preserving and that while making the patient unaware of his agent-narrative suffering, it would not serve his restorative needs. Furthermore, they point out, rightly, that patients who are suffering but not terminally ill would then have more of a claim to sedation till death, since such patients “would have more time to experience intense agent-narrative suffering than those who are closer to death.” (333)

\textsuperscript{277} Jansen and Sulmasy, 329-331.

\textsuperscript{278} Pellegrino (1), 245.

\textsuperscript{279} I am aware of the complicated nature of the philosophical discussion around “meaning” itself, some of which can be found in Cassell, Eric, “When Suffering Patients Seek Death,” in Quill (3), 75-87, esp. 82-84. See also Moulyn, cited above, 289-313. For our purposes here, I follow Moulyn’s linguistic analogy: I will use the terms \textit{empty} and \textit{full}, as opposites in every day language, to help to
I ask “does a chair have a purpose?” I will get a different answer than if I ask “does a chair have a meaning?” Yet, as I will show below, understanding suffering’s purpose (the “what’s it for?” question) leads us directly to understand suffering’s meaning and significance.

In order to begin to elucidate the purpose of suffering, then, we must ask the teleological or “what’s it for?” question—does suffering have a purpose, and if it does, how can it be considered an evil? The first distinction to be made is that there are some things which are goods which we actively seek because of their usefulness. If I ask, “what’s a chair for?” the answer is likely to be an expression of a good—namely, a chair is for sitting; sitting can aid man in terms of utility and comfort. To pursue the acquisition or use of a chair would not be considered abnormal; quite the contrary—it might even be embraced. Now, no rational person actively seeks suffering. Some may actively seek pain, perhaps (the fitness fanatic—“no pain, no gain!”), but suffering as we have articulated—an attack on the integrity of a person—is not something we actively seek. On the contrary, it can be seen as a valid goal of medicine to ameliorate suffering when it is able to do so.

However, by way of preview, as I will argue below, suffering also has a purpose (or, more accurately, several points). Some of these include “the unleashing
of love” in the world, and the “rebuilding of goodness” in the subject. Yet we do not embrace suffering or seek it. Why? The Thomistic view is that suffering is an evil precisely because the person who suffers lacks something (a good) he feels he ought to have; evil is therefore “a certain lack, limitation, or distortion of good. We could say that man suffers because of a good that he does not share, which in a certain sense he is cut off from, or which he has deprived himself.” Thus, although suffering represents a lack of a good, it points back, always, to a good. Here we come to discover that the despair that can come with suffering, a “loss of hope in the good,” as Adrian J. Reimers puts it, can lead to two fundamental errors:

The first is the denial that there is anything higher, a _sumnum bonum_ in terms of which pain or suffering might be redeemed. As a practical matter, each person lives as though some _sumnum bonum_ exists, even though this may be as crude as his own momentary pleasure…If this be denied, then life and activity become pointless…once life becomes sufficiently unpleasant and unmanageable, it can no longer be lived…The second form of despair acknowledges the reality of the _sumnum bonum_ but denies the possibility of

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280 Pope John Paul II, _Salvifici Doloris_, (Bombay: St. Paul Books), 1984: para. 28. [Henceforth as (SD)].

281 SD, para. 12.

282 SD, para. 7. It should also be noted that various religious traditions also view suffering as an evil—but the human response to suffering differs markedly. For example, in Buddhism, suffering is an evil which is seen as alien to the human condition; man’s appropriate response is to detach from worldly desires in order to escape it. Hinduism has a similar view, although suffering’s origin is closely tied to the concept of _karma_. Unfortunately, these differing views—including whether evil has content—are beyond the scope of this work; however, an interesting analysis of the differences between the Christian and Buddhist conceptions of suffering can be found in Max Scheler’s writings. See Scheler, Max, “The Meaning of Suffering,” in _On Feeling, Knowing, and Valuing: Selected Writings_, edited by Harold J. Bershady, (Chicago: The University of Chicago Press), 1992: 82-115 (esp. 97-110).
attaining it…it is closed to him…Conscious that the authentic good is inaccessible to him, he experiences profound isolation and alienation.\textsuperscript{283}

It is clear that arguments supporting EPAS from the Argument from the Evil of Suffering assume one, or another, of these points of view. Wojtyła, many years later, in his papal encyclical on the nature of suffering, eloquently summarizes the core of this argument:

\begin{quote}
[In Christian anthropology] A source of joy is found in the overcoming of the sense of \textit{uselessness of suffering}, a feeling that is sometimes very strongly rooted in human suffering. This feeling not only consumes the person interiorly, but seems to make him a burden to others. The person feels condemned to receive help and assistance from others, and at the same time seems useless to himself.\textsuperscript{284}
\end{quote}

However, although a person finds herself suffering an evil, this does not exclude the possibility that another good may come from this evil, and that in some mysterious, transcendent way, this may be why the suffering had to be. Suffering reveals to a person \textit{the summmum bonum}, for the idea of a “mysterious” dimension to suffering has theological implications:

\begin{quote}
Human suffering evokes \textit{compassion}; it also evokes \textit{respect}, and in its own way it \textit{intimidates}. For suffering is contained in the greatness of a specific mystery. This special respect for every form of human suffering must be set at the beginning of what will be
\end{quote}

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\textsuperscript{284} SD, para. 27.
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expressed here later by the deepest need of the heart, and also by the deep imperative of faith.  

It is in uniting one’s suffering with the suffering of Christ that a person comes to understand why we suffer. Because of this component of mystery, Wojtyla’s account, and perhaps no account of suffering, can ever be truly “complete” with philosophical exegesis alone. Yet, the critical point is that suffering can be used to teach a person something about himself, and in turn, teach a community about how they ought to view another person. Therefore, the role of the community will ultimately be to reach back to the sufferer and to help her to experience the good (love) as something accessible and really present.

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285 SD, para. 4.

286 Against this, some might argue that persons who suffer may be reduced to a means to bring about a greater end or good (the flourishing of love in society, or an increase in personal virtue, for example.) This argument has been addressed very well by Peter Colosi in Colosi, Peter J., “John Paul II and Christian Personalism vs. Peter Singer and Utilitarianism: Two Radically Opposed Conceptions of the Nature and Meaning of Suffering,” published online in 2004 from an address at St. Catherine’s College, Oxford, UK. Accessed at http://www.inter-disciplinary.net/msc/hid3/Colosi%20paper.pdf on March 1, 2008. [Henceforth, Colosi (4)]. It is perhaps proper to think of the good that comes from suffering as a “side effect” of suffering, rather than suffering’s intent.

287 This would include individuals without the intellectual capacity to “grasp” love. Children and the severely retarded can, I believe, experience the love of another through touch, gesture, sound, and even smell. Recent neonatal research has shown, for example, that infants exposed to familiar smells (such as an article of the mother’s clothing) have reduced pain responses during procedures, compared with infants exposed to unfamiliar scents. (See Goubet, N., et. al., “Familiarity breeds content? Soothing effect of a familiar odor on full-term newborns,” Journal of Developmental and Behavioral Pediatrics, Vol. 28(3); June 2007: 189-94.) Some children’s hospitals in the U.S. have kept a small towel, used by the mother, in the transport bassinets of babies being admitted to the neonatal intensive care unit. Thus, even the physical proximity of another can bring physical comfort, and even transmit love, to another. There remains much controversy (and mystery) regarding what persons of limited intellectual abilities can (or cannot) experience.
Another crucial goal is to understand the real distinction between pain and suffering. This distinction has been elucidated extensively elsewhere and is a relatively recent phenomenon. Bioethicists such as Cassell have argued, I believe legitimately, that medicine’s historic focus on pain as equivalent to suffering and thus a purely bodily or physical phenomenon has caused attention to be diverted from relieving suffering, or perhaps more accurately, from the suffering person taken as a whole.

Historically, medical conceptions of pain have progressed from being seen as a punishment for sins; to a mysterious element which enters the body from without; to a series of independent, internal pathways (a theory which Descartes proposed). With the advent of the Scientific Revolution and introduction of analgesics (cocaine) and anesthetics (ether), pain began to be seen as a physical phenomenon that could be treated. In the 20th century, the involvement of the field of psychology and the development of gate control theory (1965) greatly advanced the understanding of pain as a complex phenomenon, involving the interplay between biology, psychology, and the social environment. Authors of a recent textbook on pain management summarize the significance of these developments:


289 See Cassell (2), 533: “Medicine has tried throughout the past two centuries (most successfully in the last generation) to see diseases and the body as part of directly observable, objectively existing, and purely material state of affairs, in the way that biological science generally sees nature.”

290 “Pain” is derived etymologically from the Latin, poena, or “punishment.”

This biopsychosocial approach to the pain experience encourages the realization that pain is a complex perceptual experience modulated by a wide range of biopsychosocial factors, including emotions, social and environmental contexts, and cultural backgrounds, as well as beliefs, attitudes, and expectations. As the acute painful experience transitions into a chronic phenomenon, these biopsychosocial abnormalities develop permanency. Thus, chronic pain affects all facets of a person’s functional universe, at great expense to the individual and society. Consequently, logic dictates that this multimodal etiology of pain requires a multimodal therapeutic strategy for optimal and cost-effective treatment outcomes.\textsuperscript{292}

Such a view reflects the great progress medicine has made in the field of pain, even since Cassell’s criticisms. The International Association for the Study of Pain (IASP) defined pain in 1979 as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage,”\textsuperscript{293} a definition still in wide use today. The definition reflects the role of the sensory and emotional element in the pain experience, and yet the definition’s annotations also indicate that pain “most often has a proximate physical cause.”\textsuperscript{294}

Pain is therefore a dynamic biopsychosocial phenomenon, with sensations relayed to discrete pain centers in the brain. It can be further classified as nociceptive pain (activated by specific pain receptors), and neuropathic pain (damage to neural
Pain can cause suffering, or it may not—depending on the severity of the pain, and a person’s own “pain tolerance.” What is certain is that pain is a subjective experience, one which is difficult to study with objective criteria. Pain assessments are always based on self-report, making precise quantification impossible and introducing—to use Wojtyla’s language—the complex dynamisms of human action and interaction into decisions about medical treatment. These will be critical to its role in EPAS.

Suffering, on the other hand, “encompasses all the psychological, social, and personal responses of individual persons to the predicament of a serious illness, whether the pain is severe or not.”

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296 For example, Wilfried Ver Eecke’s analysis of Sigmund Freud’s paper “Beyond the Pleasure Principle,” (Ver Eecke, Wilfried, “Myth and Reality in Psychoanalysis,” *Proceedings of the American Catholic Philosophical Association*, Vol. 45; 1971: 158-166) is instructive as to the complexities of the notion of pain itself. Freud examines instances where people may seek pain (sado-masochism, self-punishment, the need for repetition). Repetition of painful events—both physically and psychologically—seems to contradict the basic idea that humans wish to avoid pain and seek pleasure. “Freud analyzes at length the fact that a little child with whom he was familiar played a game imitating the absence of the mother…Freud wondered why the child should repeat constantly the painful moment of the disappearance of the mother rather than its more joyful moment of reappearance…There are finally a number of every day phenomena or pathological events which point to the need for repetition even if it has no relation to the pleasure principle….Because of these various phenomena of repetition and the impossibility of relating them to the pleasure principle, Freud concludes that the basic law governing the forces of human life is the need for repetition.” (162)

297 Pellegrino (2). 245. Nathan Cherny in “The Problem of Suffering,” (in Doyle, Derek, et. al, ed., *Oxford Textbook of Palliative Medicine*, 3rd edition, (Oxford: Oxford University Press) 2004:7-14) notes that “the defining characteristics of suffering include: (a) the presence of perceptual capacity (sentence), (b) the fact that the factors undermining quality of life are appraised as distressing, and (c) the fact that the experience is aversive. According to this definition, suffering is a phenomenon of conscious human existence, the intensity of which is determined by the number and severity of the factors diminishing from quality of life, the processes of appraisal, and perception. Each of these variables is amenable to therapeutic interventions.” (7)
Salvifici Doloris. Here he uses the terminology of “physical suffering” and “moral suffering,” which may roughly correlate to Jansen’s and Sulmasy’s “neuro-cognitive” and “agent-narrative” suffering:

This distinction is based upon the double dimension of the human being and indicates the bodily and spiritual element as the immediate or direct subject of suffering. Insofar as the words ‘suffering’ and ‘pain,’ can, up to a certain degree, be used as synonyms, physical suffering is present when the ‘body is hurting’ in some way, whereas moral suffering is ‘pain of the soul.’

John Paul II also astutely notes that while medicine has principally focused on physical pain, since it rightly can provide appropriate therapy for it, “The field of human suffering is much wider, more varied, and multi-dimensional. Man suffers in different ways, ways not always considered by medicine, not even in its most advanced specializations.” Since pain and suffering are two distinct entities, their relief calls for two distinct approaches.

The reduction of pain, particularly at the end of life, has clearly been historically recognized as a legitimate goal of medicine, even if not explicitly articulated in medicine’s most famous oaths; in practice, it is often assumed that pain

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298 SD, para. 5.
299 SD, para. 5. Cicely Saunders, the founder of St. Christopher’s Hospice in the UK, describes the various kinds of pain that patients experience during terminal illness, including mental, social, and spiritual. See Saunders, Cicely, et. al., Living and Dying: A Guide to Palliative Care, (Oxford: Oxford University Press) 1995. There are further distinctions regarding pain that could be made, of course, particularly within the field of psychology. One author, for example, following Freud, makes the distinction between “mental pain” and “psychic pain.” Mental pain refers to pain that the patient cannot describe in words, and psychic suffering can be referred to and described by the patient. See Fleming, Manuela, “Distinction between mental pain and psychic suffering as separate entities in the patient’s experience,” International Forum of Psychoanalysis, Vol. 15; 2006: 195-200.
relief ought to be an aspiration of good medical care. In 1995, the SUPPORT study indicated that about 50% of conscious patients who died in the hospital experienced significant pain at the time of death. The Institute of Medicine’s (IOM’s) massive 1997 report, Approaching Death: Improving Care at the End of Life, reviewed the literature to date on pain prevalence; the report pointed out that, although most research was done on cancer patients, unrelieved pain occurred in patients with advanced disease at levels ranging from of 40-75%. Another study noted that pain prevalence in patients with terminal cancer was 54% at four weeks prior to death, and 34% one week prior to death. Unfortunately, pain prevalence is higher with the terminal elderly, minorities, and women. Reports such as these underscore claims by proponents of EPAS that there is a certain urgency to the legalization of EPAS; they also reinforce the fears of the general public that death may be a painful one.

300 For example, the Hippocratic Oath, the 1948 Declaration of Geneva, and the AMA’s Principles of Medical Ethics do not explicitly mention the relief of pain and suffering as a goal of medicine. The Oath of Maimonides does. See Murphy, Thomas, “The Ethics of Pain and Suffering,” Cancer Research and Treatment, Vol. 140; 2008: 117-135. The author provides an excellent review of the historical and contemporary debates regarding pain and suffering.


302 Institute of Medicine, Approaching Death: Improving Care at the End of Life (Washington, DC: National Academy Press); 1997: 126-135.


However, the fact that people have died in pain, or continue to die in pain, does not mean that significant pain relief is impossible, that improvements to access and research in palliation are hopeless, or that a terminally ill person will always die in excruciating pain. In fact, one recent paper\textsuperscript{305} identified several (rectifiable) reasons why patients have unrelieved symptoms (including pain) at the end of life. These included (1) a lack of training on the part of health care professionals to identify and treat pain; (2) a general lack of evidence-based research on methods to alleviate pain and other physical suffering in the terminally ill; and (3) an inability to translate what is known from the literature into actual practice. Other papers indicate the physician’s or the patient’s own worries about addiction and tolerance to narcotic medicines pose a significant barrier. Another significant and interesting problem is that many patients desire to be a “good patient,” or not to be a “bother” to the health care staff, and therefore often underreport their own pain.\textsuperscript{306} Such barriers—empirically identified—constitute areas for improvement that warrant a more conservative and comprehensive approach than EPAS.

Expectations of pain relief are an important factor to consider. Is the goal of medicine—both in the eyes of patients and physicians—to eliminate pain altogether, or to alleviate it as much as possible, within ethical standards? The IOM’s

\textsuperscript{305} Von Gunten, Charles F., “Interventions to Manage Symptoms at the End of Life,” \textit{Journal of Palliative Medicine}, Vol. 8 (S1); September 1, 2005: S-88-S-94.

recommendations explicitly stop short of promising complete pain elimination; instead, the authors argue that the goals of medicine ought to focus on improving palliative care research and access, and on the education of medical professionals in recognizing and treating pain promptly. Experts in the field of palliative medicine generally agree that in most cases, physicians can significantly alleviate the physical symptoms of terminal illness. “With a multidisciplinary and holistic approach palliative care can also address emotional, psychological, spiritual, and existential distress. In the last days of life, with the appropriate use of sedatives and strong pain killers, there is no reason why anyone should experience uncontrolled physical symptoms.” Other studies suggest that the pain of terminal illness can be alleviated in 95% of cases, with the other 5% of patients being partially relieved of their symptoms—although access to the highest levels of palliative care is lacking in many places. One recent review suggests that 80% of pain can be brought under control with a basic algorithmic approach; the remaining 20% will require a pain management expert.

307 IOM, 1-13; also 127. The report goes on to recount promising research in the field of pain relief, now more than 10 years old at the time of this writing. However, more recent research has been cited in several sources below. Generally optimistic, they do not promise pain elimination but provide strong evidence for improvement in pain symptoms at the end of life.


309 Amarasekara, cited above: 404.

Still, one should acknowledge that there are certain types of pain—for example, idiopathic pain or chronic pain—that cannot be traced to a specific source, and thus persons must live with a certain degree of “permanent pain.” There are others who may choose to live with a certain degree of pain—for example, those who wish to retain sharper mental faculties for the sake of interaction with family members.

In sum, we can conclude: (1) a large number of patients experience pain at the end of life; (2) most of these patients, however, if identified and treated with current palliative methods, could experience significant alleviation of these symptoms; and (3) there will be a small percentage of patients who will live with some degree of pain, which is either refractory to modern methods of palliative care or chosen in order to avoid the sedative effects of pain medicine.

The fact that some terminal pain is untreatable could be used to justify EPAS in a select number of individuals. Marcia Angell has made this argument, for example. However, as empirical evidence has mounted that most pain can be

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311 Murphy, 119.

312 One paper suggests that if the family believes that better pain management is possible, they will advocate for their sick family member’s pain relief—and he or she will actually receive higher quality palliative care. See Berry, Patricia H., “The pain of residents living with terminal cancer in USA nursing homes: family members perspectives,” International Journal of Palliative Nursing, Vol. 13 (1); 2007: 20-27.

313 Angell, cited above in Quill (3): “I have no doubt that if excellent palliative care were available to everyone who needed it, there would be few requests for assisted suicide. I also have no doubt that even under the best of circumstances, there will always be a few patients whose suffering simply cannot be adequately alleviated; and there will be some who prefer suicide to other measures to deal with unremitting suffering...”(21-22)
controlled with multi-disciplinary palliation, more emphasis has recently been placed on the idea that suffering which goes beyond pain is the critical element to consider. Timothy Quill, for example, a proponent of PAS, claims that one of the “myths” about human suffering espoused by many doctors is that all suffering can be relieved with pain control or hospice care. However, this is not so much a “myth” as a “straw man” used by EPAS proponents, for I have yet to find in the philosophical or medical literature the claim that all suffering, or even all pain, can be relieved by current palliative methods. The deeper questions revolve around whether the residual pain which is untreated (and may cause suffering) justifies deliberate killing and whether society has an inherent duty to provide a right to EPAS based on unrelieved pain in terminal illness.

While the American public’s support for EPAS is highest for hypothetical cases of “unremitting pain,” the empirical literature suggests that, paradoxically, for the terminally ill, pain is “not a major determinant of interest in or use of euthanasia or PAS.” Another smaller study of terminally ill cancer patients demonstrated that their primary motivation for a hypothetical use of EPAS was driven by a fear of future pain or prior pain experiences, rather than actual pain; furthermore, the

314 Quill, Timothy, “Exploring Human Suffering: Why the Reluctance?” Bioethics Forum, Spring 1994: 3-6 [Henceforth, Quill (2)]: “Myth 2: If doctors use hospice care more effectively, particularly when treating physical pain and depression, intolerable suffering prior to death can always be avoided.” (4)

315 Emanuel (2), 143, 150; See also Pearlman et. al., 238.

316 Johansen et. al., cited above.
perception of meaning and quality of life was heavily influenced by whether or not these patients felt (future) pain would be a factor. When patients in this study were given comprehensive information about advanced techniques in pain control on admission to the palliative care unit, hopelessness decreased.\textsuperscript{317} What these facts suggest is that a commitment to excellent palliative medicine, as well as patient education about these choices and possibilities, would undercut the major reason for public support of EPAS; it would also go a long way to alleviating those fears of the terminally ill that suppress hope for a meaningful life.

\textit{Suffering and Vulnerability}

We ought now to direct our philosophical gaze toward the arguably more complicated issue—the suffering of the patient. It is clear from the medical literature that—a high percentage of terminal patients suffer from a variety of other significant physical symptoms at the end of life, which we have called, following Jansen and Sulmasy, “neuro-cognitive suffering.” These include dyspnea or shortness of breath, incontinence, fatigue, nausea and vomiting, constipation, and depression—to name a few of the more common ailments.\textsuperscript{318} The critical importance of such symptoms in the decision to request euthanasia has been empirically documented in the Netherlands; they are key factors in contributing to the

\textsuperscript{317} “Fear of uncontrollable pain and a corresponding wish for euthanasia/PAS could thus be partly rooted in insufficient patient information.” (Johansen, 458)

\textsuperscript{318} Von Gunten, S-89.
“unbearable suffering” needed to meet that country’s legal criteria for euthanasia.\textsuperscript{319} Of course, even without true physical symptoms, persons can (and do) suffer when faced with the possibility of death or disability. Thus, persons may suffer existentially—that is, they may suffer even without terminal illness. The Netherlands allows EPAS based on “unbearable suffering,” which does not require a terminal diagnosis. The complexities of such requests, which “come mostly from elderly people who suffer from age-related physical ailments and have lost the appetite for living because they experience life as meaningless and empty,” is evident from the uncertainty with which even staunch proponents of EPAS analyze them.\textsuperscript{320} Empirical evidence indicates that euthanasia is practiced in Holland for reasons of “intolerable suffering” (for the patient), and, in 20\% of cases, when other medical treatments were still available but refused.\textsuperscript{321}

Whether it is from emotional trauma or from terminal illness, suffering is an \textit{outward} sign as well as an interior state that is recognized by the sufferer and another. Severe illness which exposes vulnerability has thus been characterized in

\textsuperscript{319} Georges, Jean-Jacques et. al., “Differences between terminally ill cancer patients who died after euthanasia had been performed and terminally ill cancer patients who did not request euthanasia,” \textit{Palliative Medicine}, Vol. 19; 2006: 578-586.

\textsuperscript{320} Kimsma, G.K., “Euthanasia for existential reasons,” \textit{Lahey Clinic Medical Ethics}, Vol. 13 (1); Winter 2006: 1-2, 12; See Timothy Quill’s response in Quill (4) cited above. Quill draws the line \textit{personally} at euthanasia for existential reasons, but does not rule it out for others, if it is done in the boundaries of a stable physician-patient relationship, relying on “good clinical judgment.” Kimsma, while justifying existential euthanasia “philosophically,” argues that physicians can only competently make clinical judgments, and therefore existential reasons fall outside their expertise.

terms of the experience of “threats”—threats from one’s own body (acute or chronic), threats from one’s environment or “world,” threats to one’s personal integrity.\(^{322}\) Suffering, as I will argue below, is not meant to be a solitary experience. The presence of the suffering person for others can evoke a variety of responses: revulsion, pity, sympathy, empathy, or authentic compassion in the form of action.

For many who experience the harsh conditions of terminal illness, suffering shatters what Alisa Carse has called “the myth of the in-control agent,”\(^{323}\) and in doing so, exposes a natural vulnerability. Empirical evidence with the terminally ill indicates that many at the end of life perceive themselves as burdens to others. This “self-perceived burden” was viewed as a serious problem by 19-65% of terminally ill patients in one study, for example, and directly correlated with patients’ perceptions of a “loss of dignity, suffering, and a ‘bad death.’”\(^{324}\) It is in this exposure of one’s vulnerability that we see suffering’s link to agency and autonomy. According to

\(^{322}\) Toombs, S. Kay, “Vulnerability and the Meaning of Illness,” in Taylor and Dell’Oro, cited above: 119-137. Toombs’ chapter also provides an excellent analysis of vulnerability within a Christian context: “As Christians, we are called to live our lives in relationship: relationship with God and with each other...Indeed, in imitating the example of Jesus, the suffering servant, we are called to continually lay down our lives for one another: ‘Greater love has no one than this, that one lay down one’s life for one’s friends.’ Because love is the cardinal value, caregiving (care of and for another) is not considered a negative form of self-sacrifice, but rather, it is the foundation of Christian community.” (131)

\(^{323}\) Carse, Alisa, “Vulnerability, Agency and Human Agency,” in Taylor and Dell’Oro, cited above: 35.

\(^{324}\) McPherson, Christine J., et. al., “Feeling like a burden to others: a systematic review focusing on the end of life,” Palliative Medicine, Vol. 21; 2007: 115-128. McPherson’s work, as well as another recent study, showed that a self-perceived burden was directly related to desires to commit suicide or hasten death. See also Wilson, Keith G., et. al., “A Burden to Others: A Common Source of Distress Among the Terminally Ill,” Cognitive Behaviour Therapy, Vol. 34 (2); 2005: 115-123.
Carse, Western philosophical thought has underplayed our vulnerability in favor of “self-sufficiency, independence, a capacity for deliberation and rational transcendence of emotion”—with drastic moral consequences. On this view, when we suffer, we may realize our dependence but believe that this dependence is somehow new and alien to us; thus, our sense of identity and autonomy may become eroded. Over time our imputed dignity may become progressively tied to our vulnerability. When vulnerability is seen as something unnatural—serving no purpose but to alienate us from our agency—its exposure through suffering is likewise seen as meaningless. In a culture which does not value vulnerability, dependency on others becomes a true evil, the “demon to be exorcised.” Therefore it is not surprising, as Toombs notes, that 63% of persons who committed suicide in 2000 under the Oregon Death With Dignity Act did so, in part, because they felt they were a “burden” to their own families and friends.

While dependency in terminal illness and the exposure of a person’s natural vulnerability may be a fact of lived experience, the human response to this fact—both for the ill person and the community—is at the very heart of the EPAS debate. If we could but make the bold claim (and hold fast to it) that dependency is not alien, that a person who is vulnerable is a person who exposes his very inner self (and thus

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325 Carse, in Taylor and Dell’Oro, cited above: 34.

his inestimable value) to us—we would be a long way on the road to ending the EPAS debate altogether. Would people clamor for absolute autonomy and independence in decision making if it was acceptable to be dependent and to allow others in?\footnote{Even the fear of future pain, prominent in motivations for EPAS, would likely be lessened or ameliorated if we had confidence in dependency; that is, if we first accepted dependency as a natural condition and then understood what commitments that would entail for others. With respect to pain, it would entail that others had an obligation to relieve your pain as much as was medically, and ethically, possible.} Would we not view the Argument from Compassion in a different light if true love (“suffering with another”) was made clear to us through the vulnerability of another?\footnote{Indeed, it is clear that suffering and compassion are philosophically linked, prompting Reich to comment that “[I]t is necessary to explain suffering if we are to have an intelligible and convincing account of compassion, for neither the nature nor the requirements of compassion can be clear unless we first turn to the experience of the suffering person…This approach requires an experiential interpretation of suffering.” (84)} If we grasped, rather than indignity, the immutable dignity of a man in his suffering,\footnote{See SV, para. 23, where Wojtyla claims, counter-intuitively, that in suffering, “the great dignity of man is strikingly confirmed.”} could we argue that we should hasten his death to preserve his value?

*The Argument from the Evil of Suffering as a Utilitarian Argument*

In the first section of this chapter I outlined what I perceive to be the basic claims of the Argument from the Evil of Suffering. I would now like to draw attention to claim (5): “Since one of the crucial goals of medicine is to relieve suffering of the competent patient who requests it, pain or suffering that does not
lead to a greater good in the eyes of the patient, serves no point, and therefore must be eliminated.”[my emphasis]

I have thus phrased (5) as a consequentialist or utilitarian argument. The idea is that, on balance, the negative consequences of continued living with severe pain or suffering in the last stages of one’s life outweigh any alternative or benefit.

Proponents of EPAS will often frame the Argument from the Evil of Suffering in terms of the suffering of the patient alone. Peter Singer, for example, in

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330 See for example, Anonymous, “Its Over Debbie,” cited above, as well as Quill (1) and Quill (2). This preserves the illusion of consistency with the patient-centered approach to the practice of medicine. I believe, however, that other factors apart from the patient’s suffering alone play a role. The perception, for example, of the terminally ill that their suffering is a burden to family or health care staff—empirically well-demonstrated, as I have shown above—indicates that negative consequences of continued care are felt by others as well. These “negative consequences” are then transmitted back to the patient herself to be utilized in the decision-making process. The question arises, then, whether the “power” of the Argument from the Evil of Suffering is wholly contained in, and limited to, the terminally ill person alone. For the dying person at the bedside, the suffering is obvious, but is it also not true that the family watching the person also suffers, as do the health care providers? At least one recent study has shown that both physicians in the US and the Netherlands would provide euthanasia (7% and 14%, respectively) or PAS (22% and 18%, respectively) for patients who saw their lives as “meaningless”; for patients who saw their lives as a “burden,” the response of physicians in the US and the Netherlands was 7% and 4%, respectively, for euthanasia, and 24% and 9%, respectively, for PAS. Responses were lower for “pain” and “debility.” (See Wilems, Dick L., et. al., “Attitudes and Practices Concerning the End of Life: A Comparison Between Physicians from the United States and from the Netherlands,” *Archives of Internal Medicine*, Vol. 160; Jan. 10, 2000: 63-68.) A more recent, rather startling study indicated that in cases of involuntary euthanasia in Europe, the act was performed by physicians and not discussed with the patient because the “act was clearly in the best interest of the patient” in 10%, 26%, and 36% of cases in Belgium, Denmark, and Switzerland, respectively. Euthanasia was not discussed at all with the patient because the “discussion would have done more harm than good” in 5% of Belgian cases and 23% of Danish cases of involuntary euthanasia. Thus, utilitarian calculations are being made by others besides the patient alone. (See Reitjens et. al., cited above, 205-221.) Some advocates of euthanasia have explicitly advocated taking into account other considerations apart from the patient’s own wishes. George Robertson, for example, has argued that in considering euthanasia for the senile elderly, one should consider (1) the patient’s own wishes; (2) the distress caused to the family (and other patients) by the patient’s senile behavior; (3) financial considerations for the family and society at large; (4) a desire to promote the patient’s dignity. (See Robertson, George S, “Dealing with the brain-damaged old—dignity before sanctity,” *Journal of Medical Ethics*, Vol. 8; 1982: 173-179.) Therefore when EPAS is performed, we must ask critically whose suffering is intended to be relieved.
“Voluntary Euthanasia: A Utilitarian Perspective,” describes a Dutch case of euthanasia in which Dr. Boudewijn Chabot euthanized a 50-year old woman suffering from depression that was purportedly “unresponsive to treatment.” He was ultimately convicted, but not because he euthanized a patient with no terminal illness; rather, he was convicted because he had failed to follow Dutch guidelines in having a second physician examine the patient. Singer argues:

> The Supreme Court of the Netherlands accepted the more important claim that unbearable mental suffering could, if it was impossible to relieve by any other means, constitute a ground for acceptable voluntary euthanasia…From a utilitarian perspective, Chabot and the Dutch courts were correct. For the hedonistic utilitarian, what matters is not whether the suffering is physical or psychological, but how bad it is, whether it can be relieved and—so that others will not be fearful of being killed when they want to love—whether the patient has clearly expressed a desire to die. Whether preference utilitarians would reach the same conclusion would depend on whether they are concerned with satisfaction of actual preferences, or with the satisfaction of those preferences that people would have if they were thinking rationally and in a psychologically normal state of mind.

Dan W. Brock makes a similar appeal in his classic defense of voluntary euthanasia:

> A [third] good consequence of the legalization of euthanasia concerns patients whose dying is filled with severe and unrelievable pain and suffering…euthanasia may be the only release

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331 Singer, Peter, “Voluntary Euthanasia: A Utilitarian Perspective,” Bioethics, Vol. 17 (5-6); 2003: 526-541. [Henceforth, Singer (2)]

332 Singer (2), 534. Hedonistic or classical utilitarians count only pleasure or pain in the consequentialist calculation; preference utilitarianism says that “the right act is one that will, in the long run, satisfy more preferences than it will thwart, when we weigh the preferences according to their importance for the person holding them.” Singer describes himself as a preference utilitarian. (527)
from their otherwise prolonged suffering and agony. The argument from mercy has always
been the strongest argument for euthanasia in those cases to which it applies. 333

These arguments set everyone’s “suffering” as a quantifiable entity, which is
weighed negatively against the “positives” of the person living—a sharp contrast to
Christian philosophy, which views suffering in a non-additive, personal context. 334

Thus far we have explicated Wojtyła’s philosophical anthropology as it
relates to EPAS. We have alluded to, but not directly examined, Wojtyła’s theology
as it relates to human suffering in the context of the EPAS debate. Such a direct
examination has been provided elsewhere and is beyond the scope of this work. 335

Yet it should be clear from the outset that the Argument from the Evil of Suffering is
contrary to the Christian notion of suffering, which sees in the suffering of Christ
both meaning and mystery. Although in The Acting Person, Wojtyła does not
directly address the concept of human suffering, as pope, he demonstrates in Salvifici
Doloris how much his philosophical anthropology permeates and complements his

333 Brock, cited above, 15. Note again how the Argument from Compassion, or mercy, is tied in with
suffering.

334 See Colosi (4): 3. Later, Colosi notes that “The utilitarian view of suffering, then, can be
understood to split suffering off from the individual who suffers in order to obtain an entity which can
be measured.” (6)

335 Wojtyła’s theological encyclical as pope which dealt with the issue of EPAS directly was
Evangelium Vitae (1995), cited above. In addition, many other commentators have analyzed
theological aspects of Salvifici Doloris. See for example, Jeffreys, Derek S., cited above; Colosi (3)
and Colosi (4), also cited above.
We will therefore examine the philosophical underpinnings of this document in some detail.

**Wojtyla on the Value and Meaning of Personal Suffering**

From the very beginning of *Salvifici Doloris*, Wojtyla strikes a philosophical note, preparing the reader for his bold claim that *suffering is an encounter with truth*. For those not familiar with Wojtyla’s philosophy of action, the quotation below may seem merely a part of a poetic Introduction; however, within the context of a rich philosophical anthropology, suffering is seen as a transformative event:

> Suffering seems to belong to man’s transcendence: it is one of those points in which man is in a certain sense ‘destined’ to go beyond himself, and he is called to this in a mysterious way.  

He continues a few paragraphs later:

> Even though in its subjective dimension, as a personal fact contained within man’s concrete and unrepeatable interior, suffering seems almost inexpressible and not transferable, perhaps at the same time nothing else requires as much as does suffering, in its *objective reality,* to

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336 This is not to say, of course, that Wojtyla does not understand the limits and boundaries of both philosophy and theology. Quite the contrary: his encyclical *Fides et Ratio* (*Faith and Reason*) 1998, (cited above) is devoted entirely to explicating the intellectual areas of exclusivity and complementarity between these disciplines. He notes, almost poetically, in describing the mystery of the Resurrection: “*[The Resurrection] is the reef upon which the link between faith and philosophy can break up, but it is also the reef beyond which the two can set forth upon the boundless ocean of truth. Here we see not only the border between reason and faith, but also the space where the two may meet.*” (FR, para. 21)

337 **SD**, para. 2.
be dealt with, meditated upon, and conceived as an explicit problem; and that therefore basic
questions must be asked about it and the answers sought.\footnote{SD, para. 5.}
The philosophical discussion begins both with a reference to Wojtyla’s anthropology
(the “transformative” nature of suffering), and his personalism (a person has both an
incommunicable interior and an external, objective reality which can be probed).

Wojtyla’s view of the “world of suffering,” as he calls it, can be summarized
in this way: First, there is a personal, subjective element to suffering, a world known
to the subject alone. Wojtyla describes what I will call suffering in man—the
existential experience of suffering of the person which “consolidates itself and
becomes deeply rooted in him.”\footnote{SD, para. 8.} There is also another part to human suffering, and
that is the awareness of suffering brought to man by another person—where man
himself is the cause of suffering. Thus a person may suffer, but a person may also
cause suffering.\footnote{Of course, Wojtyla does not claim that man is the cause of all suffering (e.g., natural disasters,
disease etc.), only that where he is the cause he recognize it as such.} Both experiences will transform, and both help to articulate the
“context” of a person’s suffering. We all suffer, and the world of suffering is thus a
world which exists “in dispersion”—a realm of unrepeable experiences in every
subject.\footnote{SD, para. 8.}
In the ancient biblical story of Job, the Pope saw a personal dimension to suffering that is transformative. Suffering as punishment for sin, for example, while a reality, is viewed as an inadequate explanation for its meaning. Job, after all, was a just man who suffered. The story points, then, to a meaning beyond punishment—suffering allows for the possibility for the act of repentance and the building of virtue:

Thus the personal nature of suffering is affirmed…This is an extremely important aspect of suffering. It is profoundly rooted in the entire Revelation of the Old and above all the New Covenant. Suffering must serve for conversion, that is, for the rebuilding of goodness in the subject, who can recognize the divine mercy in this call to repentance.  

Again, we realize Wojtyla is not speaking metaphorically when he says “the rebuilding of goodness in the subject”; rather, he is speaking metaphysically. A person’s authentically virtuous response to suffering—as Job’s response in the famous story demonstrates—is an act which changes a person. Such suffering can show us, as the quotation which began this section noted, that when “the person is almost incapable of living and acting, all the more do interior maturity and spiritual greatness become evident, constituting a touching lesson to those who are healthy and normal.”  

Wojtyla elaborates on the impact of building virtue through suffering:

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342 SD, para. 12.

343 SD, para. 26.
Suffering as it were contains a special call to virtue which man must exercise on his own part. And this is the virtue of perseverance in bearing whatever disturbs and causes him harm. In doing this, the individual unleashes hope, which maintains in him the conviction that suffering will not get the better of him, that it will not deprive him of his dignity as a human being, a dignity linked to awareness of the meaning of life.\(^{344}\)

Later, he will also argue that suffering is a call to the virtues of courage and fortitude. Such a revealing of the person is consistent with at least one sociologist’s examination of the nature of suffering across disciplines:

Yet in suffering we come across one of the greatest enigmas in human existence. This wholly violating and destructive experience has repeatedly been looked upon as that which may reveal the most basic truths about our humanity (Bowker 1970). The phenomenon which seems most fundamentally opposed to us is also conceived to disclose an essential part of the truth about what we are fundamentally for. Whilst with one voice we emphatically denounce this experience as a desecration of our humanity, with another we declare it to have the potential to reveal us in our most sanctified form.\(^{345}\)

As I will elaborate on below, suffering is “a vocation” to Christ himself.\(^{346}\) Wojtyla is realistic about the process involved in turning the sufferer from despair to hope. He sees this as a difficult, but not intractable, problem. Still, he acknowledges that even the starting point for the transformation of the person is elusive\(^{347}\); we must,

\(^{344}\) SD, para. 23.

\(^{345}\) Wilkinson, 2.

\(^{346}\) SD, para. 26.

\(^{347}\) SD, para. 26.
however, go beyond the subjective element alone to understand suffering’s true meaning.

**Wojtyla on the Value and Meaning of Social Suffering: Participation vs. Alienation**

“Suffering,” Wojtyla argues, “…is also present to unleash love in the human person, that unselfish gift of one’s ‘I’ on behalf of other people, especially those who suffer.” Beyond the subjective element, Wojtyla describes a parallel “collective” dimension to human suffering. While each person suffers in a way no one else can experience, what binds us together is our understanding that others suffer with us—this is the *social* dimension to human suffering. If we recognize that human beings are sufferers by (our fallen) nature, we find that the experience of suffering (however unique from the point of view of the subject) contains a certain solidarity for all persons—a solidarity which calls us to act out of love for the sake of another.

As I shall touch on below, Wojtyla’s final call is to participate in the suffering of Christ himself. Yet, not only are we called to “offer up” our suffering to God, but we are also called as persons to *participate* in all human action—including (or perhaps especially) suffering—with others in community. To understand this, we should pause at this juncture to analyze the meaning of “participation” in the context of a person.

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SD, para. 29.
Wojtyla has two very specific meanings of participation. The first, as a property of the person, is “the ability of human beings to endow their existence and activity with a personal (personalistic) dimension when they exist and act together with others.” In this sense of participation, we have a notion of an elevated person, a subject who is not obscured by the community but, along with other unique wholes, comprises it. A person acts, and when he does, he ought to act with others by his very nature. One may feel alone, and even physically or psychologically isolate oneself, but ontologically the actor is never truly alone. Hence, EPAS—which argues for a radically autonomous death in the face of increasing personal and social isolation—represents the deliberate alienation of the person from the community and, therefore, from his very nature. Thus, participation in the act of EPAS is one, from a personalistic point of view, which affects both the patient and the caregiver (family member, physician etc.).

In a second, critical sense, Wojtyla views participation as relational:

...as a positive relation to the humanity of others, understanding humanity here not as the abstract idea of the human being, but...as the personal self, in each instance unique and unrepeatable. Humanity is not an abstraction or a generality, but has in each human being the particular ‘specific gravity’ of a personal being...To participate in the humanity of another human being means to be vitally related to the other as a particular human being, and not just

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related to what makes the other (in abstracto) a human being. This is ultimately the whole distinctive character of the evangelical concept of neighbor.\textsuperscript{350}

As Peter Colosi has pointed out, the utilitarian argument for the negativity of suffering (and the logical extension to euthanasia) is based in large part on the assumption that there is a philosophical mutual exclusivity between acting out of love based on individual suffering (e.g., the love Mother Theresa has for persons), and acting out of love based on non-individual suffering (e.g., Peter Singer’s view).\textsuperscript{351} Acting upon the suffering of humanity taken as a whole is considered by Singer and other utilitarians to be the only rational way to act morally. Thus, although in theory one could say that a utilitarian should support acting out of love for an individual would be right if it improved the well-being of the most number of people, the utilitarian argument for euthanasia claims the opposite is true.\textsuperscript{352} Against this, however, is the idea that participating with another involves a love that is tied to the particular person as an absolutely unrepeatable entity. A person suffers in a way only she can experience, but that suffering, when absorbed by the love of another,

\textsuperscript{350}PC, 237.

\textsuperscript{351}John Stuart Mill made this argument in Utilitarianism. See Ryan, Alan, ed., \textit{John Stuart Mill and Jeremy Bentham: Utilitarianism and Other Essays}, (London: Penguin Books) 1987: 272-338, esp. 288: “…the happiness which forms the utilitarian standard of what is right in conduct, is not the agent’s own happiness, but that of all concerned…utilitarianism requires him to be…a benevolent spectator.” Singer, a preference utilitarian, argues that preferences should “count anything people desire as in their interests,” but that preferences which do not increase the overall welfare of the greatest number of people should not be adopted, in favor of those that do: “This requires me to weigh up all these interests and adopt the course of action most likely to maximize the interests of all those affected…[my emphasis]” [Singer (1), 13]

\textsuperscript{352}Colosi (4), 5.
brings to the forefront her dignity and invaluable worth. I do not accept the view that “if we could stick a thermometer into the world, which could measure the amount of suffering, then a right action is one which makes the needle go down.”

The relief of suffering, which medicine has been historically committed to, is certainly not alien to love—quite the contrary. The relief of suffering, provided it respects the person as incommunicable, can demonstrate the depths of love, by encouraging participation in both its personalistic and relational senses. Thus, participation means replacing self (interest) with the neighbor’s true good, an interior transformation through action.

I have briefly described Wojtyła’s two meanings of participation above. The first implies that the person as a human subject has an “irrevocable primacy,” both metaphysically and “methodically,” in relation to the community. In a commentary on *The Acting Person*, “The Person: Subject and Community” (1976), Wojtyła’s explains his views on the concept of *alienation* in relation to the human subject:

Alienation has relevance not for the human as an individual of the human species but for the human being as a personal subject. The human being as an individual of the species is a human, being and remains a human being regardless of the system of interpersonal or social relations. The human being as a personal subject, on the other hand, can experience alienation, or a kind of ‘dehumanization’ in these relations… People tend toward participation, whereas they defend themselves against alienation, and…the basis for both

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353 Colosi (2), 10. Colosi, referencing Dietrich von Hildebrand, also notes that it is love of the person (grasping her individual value) as well as disvaluing her suffering, which motivates man to alleviate the suffering of another.
participation and alienation is not people’s essence as members of the human species but their personal subjectivity. [my emphasis]  

Alienation is a concept rooted in phenomenology: a person experiences (because of the personal subjectivity of consciousness) alienation or “dehumanization.” Even such an unreachable human experience does not remove the person’s dignity or value. It is not belittling of the claim of the suffering person to suggest that his metaphysical value as a subject in the community remains intact, even if he feels alienation. For the proper response to alienation—participation—which is rooted in love, will bring him back to the realization of his value.

Examining the attitudes towards death and the end of life among the homeless population are instructive in the context of alienation and participation. Perhaps no group in the United States is more acutely aware of the phenomenon of absolute alienation than the homeless person, particularly when contemplating the end of life. The homeless person has already experienced a kind of physical isolation from the community. Although research is scarce, empirical studies suggest that the homeless—who have dramatically higher mortality rates than domiciled people—experience fear and uncertainty about the disposition of their body after death; a desire to be with any compassionate person when they die (not necessarily family); a general wish to be “treated with respect”; and a desire to have health care providers

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354 PC, 237-238. See also The Acting Person, Chapter 7.
and other strangers take their concerns seriously. Many feel they are a burden to others:

Relationships were described as complex, fractured, or nonexistent. Many were estranged from their family of origin. Some homeless persons viewed dying as an opportunity for reconciliation, though they where uncertain whether this would happen…A majority of participants did not want contact with their families while dying or after their deaths, There were several reasons for this preference, including the assertion that their families, ‘abandoning’ them in life, had no right to claim a relationship or authority in death…

All of these concerns are telling and cry out for a community response. They demonstrate that what the human heart desires when alienated is another human heart. The alienated person looks beyond herself toward another for help. The example of the homeless person dying challenges us to ponder the experience of a person who suffers alone. In some ways, to suffer alone is worse than to die alone. Why is solitary suffering such a terrible (and terrifying) thought? Although many people indeed “suffer alone” every day, what strikes us as wrong, even “unnatural,” about this situation is not the “suffering” part so much as the “alone” part. We instinctively perceive in the solitary sufferer a “loose end,” so to speak, a hand held out without a person to grasp it. The incompleteness directs us to the meaning found in suffering through participation in a loving relationship with others.


356 Song, 439.
Alienation, like participation, can thus take both social \( (we) \) and personal \( (I-Thou) \) forms within a community. In the former, “the multiplicity of human subjects, each of whom is a particular \( I \), is unable to develop appropriately in the direction of an authentic \( we \).” Participation is denied when a society adopts what Wojtyla calls totalism:

The dominant trait of totalism may be characterized as the need to find protection from the individual, who is seen as the enemy of society and of the common good. A society which condones EPAS is headed toward just this type of alienation.

Herbert Hendin provides a fascinating, yet disturbing analysis of several individual “high profile” cases (in television and print media) meant to “make the case” for EPAS. A detailed analysis reveals how much of the physician’s and family’s own interests are weighed in the final decision—to the point of masking the patient’s own autonomy. The vision of the common good is lost—the person is sacrificed (or sacrifices herself) because she is too heavy a burden, too expensive, too hard to look at or to treat. The sense of community is destroyed because the perception that the

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357 PC, 256.

358 AP, 274.


360 See the empirical data referenced above, regarding the perceived self-burden of patients at the end of life (McPherson et. al., and Wilson, et. al, cited above. These studies showed a strong correlation between a self-perceived burden and a loss of dignity, suffering, and a “bad death,” as well as an increased desire to hasten death.). See also the empirical data on physician attitudes toward EPAS in the US and the Netherlands (Wilems, et. al., cited above). See also the Reitjens et. al. study which indicated that in cases of involuntary euthanasia in Europe, physicians chose to euthanize patients without consent for reasons of lack of consciousness, but also dementia; mental retardation; euthanasia “was in the best interests of the patient” [in the estimation of the physician]; and “the
Assisted suicide and euthanasia foster all these attitudes, which lead only to the ruin of community, not its strengthening.\textsuperscript{361}

Participation is also hindered on a personal basis when one adopts the attitude of (radical) \textit{individualism}, which “isolates the person from others by conceiving him solely as an individual who concentrates on himself and his own good; this later is also regarded in isolation from the good of others and the community.”\textsuperscript{362} This describes the Argument from Autonomy, as outlined in Chapter I. The radicalization of autonomy has created and justified “acting alone,” a deliberate separation of the person from others. EPAS, then, should be looked at comprehensively from the viewpoint of the person’s place in community. What ought to be our response to a person’s suffering? A move toward participation with another, and a move away

discussion would have done more harm than good.” Furthermore, in 2-17\% of cases, the reason for involuntary euthanasia was “unknown” in the four countries studied (Holland, Belgium, Denmark, and Switzerland), a troubling empirical fact.

\textsuperscript{361} An analogy may be made here to the treatment of a stray dog (in Western culture). Suppose a stray dog is placed in the pound. In captivity, he plays happily and is well fed; his quality of life is likely better than that on the street, but if the dog is not claimed within a certain period of time, he is euthanized. It is argued that this is the most compassionate course of action. Why? First, because he ceases to have \textit{value} to society—his value is dependent upon his “wantedness.” Second, we worry (since dogs themselves cannot worry) about future suffering—for he is clearly not suffering in the pound. The case for EPAS alienates the sufferer from the community of persons in just the same way, tying his value to his wantedness and to concerns about future anguish.

\textsuperscript{362} AP, 273-274.
from isolation, is contained in the act of love\textsuperscript{363} and rooted in the nature of the person herself.

Suppose one offers the following challenge:\textsuperscript{364} “The physician who assists in the patient’s suicide is participating in the patient’s suffering. The burden of suicide is a heavy one to bear alone. The physician not only gives technical help, but ensures the action is not one in which the patient is alone, and allows the patient to be a participating part of the community that supports his decision to die.” Such a challenge bears a striking resonance with Timothy Quill’s proposal of the “principle of nonabandonment”:

A commitment not to abandon supplements a caring relationship because it requires that the clinician and patient work together over time, even when the path is unclear. Clinical and moral challenges must be met and engaged with the patients, not shied away from by recourse to falsely bright lines or unbending rules. There is a world of difference between facing an uncertain future alone and having a medically skilled, caring partner who will be present no matter what happens.\textsuperscript{365}

There are several responses. First, true caring, love, and nonabandonment, I would argue, must hold that there are qualifications attached to such nonabandonment, that

\textsuperscript{363} I want to be very clear: in arguing as I have that true participation is an act of love, I am not implying that those who desire EPAS (and here I am speaking of patients, families and caring physicians) do not love themselves or those involved. In fact, I believe that they are almost always motivated by profound caring for the terminally ill person. What I am arguing is that love which values the person as person (a unique unrepeatable person) would elevate the person in community with others, rather than validate a desire to die in alienation.

\textsuperscript{364} I thank Alexander Pruss for bringing this objection to my attention.

\textsuperscript{365} Quill, cited above, in Quill (4), 35.
(first and foremost) involve not allowing the person you love to denigrate (let alone, destroy) herself. This is the reason behind, for example, the notion of “tough love” for a person who is a drug addict. We do not, in this instance, continue to care for her by allowing her (much less aiding her) to acquire drugs. Rather, love may involve not cooperating with what the person desires and encouraging the opposite. Here I am also reminded of the 1995 film “Leaving Las Vegas” in this second counterexample. One plot synopsis is as follows:

Mike Figgis’ grim drama documents a romantic triangle of sorts involving prostitute Sera (Elisabeth Shue), failed Hollywood screenwriter Ben (Oscar-winner Nicolas Cage), and the constant flow of booze which he loves more dearly than life itself. Arriving in Las Vegas with the intention of drinking himself to death, Ben meets Sera, and they gradually begin falling for one another. From the outset, however, Ben warns Sera that no matter what, she can never ask him to quit drinking, a condition to which she grudgingly agrees.\[366\] Ben, in addition, agrees to never question Sera about the wisdom (or morality) of her occupation—prostitution. The movie progresses as each person accepts what is obvious to all watching—mutually destructive behavior that demeans the human person. On the one hand, the two do care for one another on some level. On the other, what is utterly disturbing to anyone who has seen the film is the notion that in agreeing to this pact of “nonabandonment,” the couple ultimately fails each other—even to the point of death.

Second, a physician who assists in EPAS allows the person to continue to make an irrevocable mistake about the value of suffering and her own value—

namely, that suffering (at this particular stage) serves no purpose, and, critically, that a person’s value is lost or degraded with suffering. If instead, what I have argued is correct, then one’s suffering has meaning because the person herself has meaning. No torment or anguish removes this fact. Instead, the suffering person reveals her true self and allows us to grasp her uniqueness when she is most vulnerable. The response of the compassionate physician ought to be to assure the patient that he will do all he can to keep you in a close community with us, rather than to send the signal that you are ever more permanently alienated from it because of illness.

Third, we must remember the distinction between personalistic and relational participation discussed above. EPAS thwarts the personal dimension of participation by validating the notion that the suffering sick is permitted to believe (falsely) that her worth (and her actions) are to be estimated and evaluated in isolation from others. One never truly acts alone, and hence, a person should know that even her suffering is valued by “another I.” The person has (metaphysical and methodical) primacy, but there is more. The relational aspect of participation is not merely that other people in society can “relate” to what a suffering person goes through, nor that they happen to agree with a person’s choice for EPAS. Relational participation means realizing that a person is related to another as unique and unrepeatable (incommunicable), discovered only in affective contact.\(^{367}\)

\(^{367}\) PC 237: “To participate in the humanity of another human being means to be vitally related to the other as a particular human being, and not just related to what makes the other (in abstracto) a human being. This is ultimately the whole distinctive character of the evangelical concept of neighbor.”
Participation with another in community therefore involves the realization that this person has a value “all their own” and that value is the same as mine. Utilitarian calculations about the preferences or pleasures to be fulfilled for oneself and others, when weighed against life’s sufferings, are incompatible with true participation. A society which condones EPAS and claims, as some have, to “treat the patient as person,” does so with autonomy as the dominant factor for consideration.\(^{368}\) However, as we have seen, not only is the Argument from Autonomy anthropologically flawed, but the idea of such a radical individualism (to the point of death) pulls the person ever more away from the understanding of her (central) valued place in community.

It is at the end of *The Acting Person*, in response to the problem of alienation, Wojtyla offers perhaps his most poignant reflection: that the commandment “Thou shalt love” is the key to the fullness of participation.\(^{369}\) In obeying this commandment one juxtaposes neighbor with self, and the “relation to the neighbor is then the ultimate point of reference resulting from the membership in a community,” a community that is “truly human.”\(^{370}\)

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\(^{369}\) AP, 295-299.

\(^{370}\) AP, 296. Wojtyla continues in a long line of Catholic thinkers who view a harm to self as a harm to the community (one’s neighbors). St. Thomas Aquinas argues against suicide, for example, on the assumption that the community is a good and that destroying oneself harms the community. He does not argue in such intimate or personalistic terms as Wojtyla, but the underlying value of the person in the context of his community is upheld. See Eberl, Jason T., “Aquinas on Euthanasia, Suffering, and Palliative Care,” *National Catholic Bioethics Quarterly*, Vol. 3 (2); Summer 2003: 332-333.
Years later in *Salvifici Doloris*, Wojtyla returns to this theme again, as he asks the reader to reflect on the parable of the Good Samaritan, a story told in response to the question “who is my neighbor?” The philosopher-pope argues that, like the Good Samaritan, the nature of the suffering person demands that we not pass by, nor merely stop out of curiosity; rather, suffering requires another to fully engage the person suffering from the inside—to make oneself *available* to another:

> [Availability] is like the opening of a certain interior disposition of the heart, which also has an emotional expression of its own…Therefore one must cultivate a sensitivity of heart, which bears witness to *compassion* towards a suffering person. Sometimes this compassion remains the only or principal expression of our love for and solidarity with the sufferer.

Through the call to “cultivate a sensitivity of the heart,” Wojtyla is directing the reader toward a process of change through action; the language is again revealing of a metaphysical reality that accompanies all who come into contact with the suffering, terminally ill patient.

My remarks regarding availability seek to drive home a fundamental message: suffering does have a purpose and meaning, namely, “to unleash love in the human person.” Realization of that meaning is entirely dependent on the actions of the caregivers (including health care providers) in loving another as they love themselves; it is also dependent on the actions of the sufferer, who opens her heart to

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372 SD, para. 8.

373 SD, para. 29.
receive the love of others and build virtue in herself. With the principle of therapeutic restoration as a clinical tool, the physician and patient work together in a relationship of trust that seeks to restore the patient to his (biopsychosocial-spiritual) health.

**Wojtyla on the Definitive Value and Meaning of Suffering**

Finally, human suffering has its “fundamental and definitive meaning” through participation in the suffering of Christ. The theological conception, for Wojtyla, is the universal context for all suffering. The example of Jesus, Wojtyla argues, shows a man that knew suffering as something profound and progressively isolating and hostile; yet, His response was one which clung to the love of the Father, and the experience of that love; the internalization of the reality of this love is where the ultimate meaning of suffering lies, and the primacy of the human person is made even greater by this participation:

The Redeemer suffered in place of man and for man...Each one is *called to share in that suffering* through which the Redemption was accomplished...In bringing about the Redemption through suffering, Christ has also raised human suffering to the level of the Redemption.\(^{376}\)

\(^{374}\) SD, para. 14. Again, much more could be said here, but the theological argument is beyond the scope of this work. I include this brief summary here only for completeness.

\(^{375}\) SD, para. 16, 20.

\(^{376}\) SD, para. 19.
Christ, as man, in turn “opened his suffering to man, because he himself in his redemptive suffering has become, in a certain sense, a sharer on all human sufferings.”

Wojtyla notes in *Salvifici Doloris* that the saints and other Christians down through the ages have found an interior closeness to Christ through their suffering. It is not simply a unidirectional stream of grace, but rather a “wonderful interchange” between God and man, the ultimate fulfillment of being. Therefore we might argue that since suffering itself can be perfective through man’s appropriate response to it, suffering has meaning; it derives a greater meaning still when united to the suffering of Christ. Wojtyla argues that the sufferings of Jesus have a “creative character,” in that they “created the good of the world’s redemption.” In doing so, the meaning of suffering is both profound and eternal.

Of course, those that believe the Argument from the Evil of Suffering, or reject the Christian foundational view will not be convinced by the latter point; nevertheless, such skepticism would not be enough to justify EPAS on this reason alone, as I have shown in the preceding sections. Now, one may argue that it is not right to impose “the definitive” (religious) view upon another. Suppose the patient thinks her suffering is meaningless, no matter what one might say? The response is straightforward: the religious meaning, while connected to the philosophical, is independently justified. One may not have access (through faith) to the religious

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377 SD, para. 20.

378 SD, para. 24.
meaning, but one has reason and experience, which grant access to the philosophical value of suffering. Furthermore, the medical professional himself exercises independent judgment about the good of the patient; simply because the patient thinks A is good for her does not require the physician to provide the patient with A. Finally, we cannot say that because we have no consensus over suffering’s meaning, that it follows that there is no meaning at all. We might recall that if we do not know precisely why people suffer, this fact makes suffering a mystery, not meaningless.

FIGURE 2: WOJTYLA’S “WORLD OF SUFFERING”
Chapter IV: The Argument from the Loss of Dignity

The Argument from the Loss of Dignity Defined

The last argument prominently used to justify EPAS which we will consider in this paper is one that may seem quite familiar to modern culture because of the ubiquitous use of the phrase “death with dignity,” both in the scholarly literature and in everyday speech. Yet, in my review of the literature, as with the Argument from Compassion, the Argument from the Loss of Dignity is not precisely formulated. Rather, it exists in a variety of expressions, some more explicit than others, and therefore needs to be brought into better relief. Proponents of EPAS argue that terminal illness, with the loss of control, and pain and suffering it brings, remove human dignity, and that the deliberate, hastened death of the patient allows her to “die with dignity.” The patient feels alienated from herself, those whom she loves, and from the community at large. Ultimately, the perception of a loss of dignity rests on this isolation. Alisa Carse has called this phenomenon our “dignitary vulnerability”:

We are creatures who are susceptible to dignitary struggle: we can be shunned, mocked, dishonored, and subjected to contempt, aversion, and indifference in ways that deeply

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379 I am indebted to Peter J. Colosi for his time and effort in critiquing this chapter and making sure I am interpreting his thought accurately.

challenge our sense of value and respect-worthiness. Persistent devaluation or sustained mistreatment can concretize the degradation of our status. Our dignity is a fragile, vulnerable good.  

Timothy Quill, a proponent of PAS who helped his patient Diane commit suicide, writes of his decision in this way:

I wrote the prescription with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

Reflecting on his decision, Quill later wrote:

I firmly believe the possibility of a controlled death gave Diane the freedom to live those final months without being haunted by fear that she would linger in a dependent, debilitated state prior to death. In her eyes, such an existence would have been worse than death, and she would likely have found some way to avoid it even without my help….Diane took charge and made active decisions that helped to control her fate in a way that had meaning and purpose for her…At the end, Diane was less afraid of death than she was of dependence and progressive debility. Though she did not wish for death, for her it became the lesser of two unfortunate evils. Diane did not ask to become ill or to face these difficult choices, but she did ask to be allowed to control her destiny in a way she found dignified and acceptable.

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381 Carse, cited above, 34. In context, Carse is referring to our perception of dignity, not our intrinsic dignity.

382 Quill (1), cited above, 693.

Several important points need to be made. Quill suggests that PAS allows Diane to “maintain dignity,” indicating her condition was one in which dignity was being lost, and implying that dignity is important enough to allow one to kill oneself in order to preserve it. Indeed, Quill remarks that allowing a “hopelessly ill patient” to “die with dignity” is “one of medicine’s most important purposes.”

Second, the idea of a “death with dignity” in Quill’s narrative is tied to control and autonomy (“controlled death”; “Diane took charge and made active decisions”; “control her destiny”).

Third, patient choice is paramount: what made Diane’s decision “dignified” was that she herself made it, that it “had meaning and purpose for her.” Finally, unwanted dependence on others is seen as a serious threat to one’s dignity.

Another author puts the “death with dignity” argument in this way:

A person is a locus of meaning and value and has a center of activity. It matters, therefore, how he dies…To die with dignity, a person must achieve equanimity before the awful majesty of death. He may not allow events or other persons to take command of him, but should master himself and his situation. He should conduct himself according to his own standards, setting his goals and deciding how to achieve them. Dignity demands the fulfillment of his reasonable purposes through the exercise of his agency. And other people should respect him not only by feeling themselves into his experience, but by concerning themselves to preserve his integrity and his sense of identity to the last.

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384 Quill, Timothy, et. al., “Care for the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide,” *New England Journal of Medicine*, Vol. 327 (19); 1992: 1380-1384, [Henceforth, Quill (6)]: “The idea of a noble, dignified death, with a meaning that is deeply personal and unique, is exalted in great literature, poetry, art, and music.” (1380-1381)

This description of the dignity argument contains many of the same elements which Quill highlights: control, autonomy and choice. However, it also implies that dignity is lost when integrity and identity are threatened.

The Argument from the Loss of Dignity could therefore be described in this way:

1. Terminal illness often involves life conditions which involve severe, prolonged pain and suffering, and a loss of control over bodily and mental functions.

2. The experience or the prolongation of this suffering has negative, deleterious effects on a person’s perception of her integrity, identity, independence, and autonomy.

3. The negative effects progressively remove a person’s dignity, an important value worth preserving.\(^{386}\)

\(^{386}\) It seems to me that euthanasia advocates need for their argument a permanent removal of dignity. If the process were reversible, the inherency of making a decision about EPAS would be much less. For example, proponents would have to answer the question: “Why not wait out this ‘dip in dignity’ until someone or something brings it back?” However, there is now empirical evidence to suggest that certain non-pharmacological methods such as “dignity therapy” can improve a person’s sense of the loss of dignity. (Chochinov, Harvey, et. al., “Dignity Therapy: A Novel Psychotherapeutic Intervention for Patients Near the End of Life,” *Journal of Clinical Oncology*, Vol. 23(24); August 20, 2005: 5520-5525.) Dignity therapy is an intervention which addresses “psychological and existential distress” among the terminally ill through brief evocative interviews and recordings of patients’ feelings about their legacy, sense of self, pride, hopefulness, fears of the future, and current care. Transcripts are made and edited for the patients to keep and give to family members. In Chocinov’s study of elderly cancer patients, increases were seen in satisfaction [with life] (93%), hopefulness (91%), sense of dignity (76%), purpose [in life] (68%), and meaning [to life] (67%). (5524)
4. If a person chooses, they ought to be allowed to have assisted suicide or euthanasia. Such a free choice will preserve dignity by allowing a person to maintain control over the timing and manner of her death.

A person’s own perception of the loss of dignity is absolutely crucial. Ronald Dworkin, another proponent of EPAS, makes this clear:

It is, however, plausible, and to many people quite compelling, that total dependence is in itself a very bad thing, quite apart from the pain or discomfort it often but not invariably entails. Total or near dependence with nothing positive to redeem it may seem not only to add nothing to the overall quality of life but to take something important from it…Sunny von Bulow still lies wholly unconscious in a hospital room in Manhattan; every day she is turned and groomed by people willing and paid to do it…It would have been odd for her not to think, before she fell into her coma, that this kind of pointless solicitude was insulting, itself an affront to her dignity.\textsuperscript{387}

\textit{Basic and Personal Dignity}

The word “dignity” itself has historically had many confusing (and conflicting) meanings. Proponents and opponents of EPAS have used the term at cross purposes, as I will show below.\textsuperscript{388} These linguistic confusions have led


\textsuperscript{388} The idea that “dignity” has been used by opposing ideological forces is well documented. A very good explication of the confusion surrounding the word, its use, and its historical sources can be found in, Schulman, Alan, “Bioethics and the Question of Human Dignity,” Chapter 1, in the President’s Council on Bioethics, \textit{Human Dignity in Bioethics}, (Washington, DC: US Government Publication) March 2008: 3-18. Indeed, in Switzerland, the institution where patients from Europe may travel to for PAS is called “Dignitas.”
naturally to philosophical errors. Therefore, I wish to adopt, at the beginning of this chapter, a simple distinction made by Daryl Pullman.\footnote{Pullman, Daryl, “Human Dignity and the Ethics and Aesthetics of Pain and Suffering,” \textit{Theoretical Medicine}, Vol. 23; 2002: 75-94. [Henceforth, Pullman (1)]. I realize that, given the body of literature written on dignity, other distinctions and conceptualizations can be made. See, for example, Sulmasy, Daniel, P., “Dignity and the Human as a Natural Kind,” in Taylor and Dell’Oro, cited above, 71-87. [Henceforth, Sulmasy (1)]. This very rich and complex article cannot be fully elaborated on here, but the classifications noted should be read by anyone serious about cutting through the ambiguities of the term “dignity.”} There are two principal ways in which humans conceptualize dignity: dignity as “basic dignity,” and dignity as “personal dignity”:

[The inherent dignity of every human person] is a universal and inalienable moral quality. One does nothing to earn it, and nothing can take it away…Inasmuch as this sense of dignity applies to each and every human being irrespective of rank, station, or any other contingent quality, we refer to it as ‘basic dignity.’

There are, however, appeals to another sense of dignity that are more particular, individualistic, and transient in nature. This is the dignity that is tied to personal goals and social circumstances, to a sense of who one is as an individual in the social world. It is a dignity that can be enhanced or diminished depending on a variety of circumstances…A debilitating disease, for example, might rob one of dignity. It is this kind of dignity that is in view in the ‘death with dignity’ debate. We refer to this latter sense as ‘personal dignity.’\footnote{Pullman (1), 76.}

Basic dignity, then, is our intrinsic worth or our value. It can never be taken from us. However, how we \textit{perceive} that worth (whether or not we experience it) can be affected by our self-perceptions and our treatment from those around us. The argument which I will set forth below will root basic dignity in the notion of
Incommunicability as outlined in Chapters I and II. Incommunicability as Wojtyla, Crosby, and Colosi take it, is best described as the innate unrepeatability of a person that, when experienced, allows another to grasp her intrinsic value. Incommunicability itself is never the same in any individual. What makes up the real content of me—the qualities which my wife experiences and loves—can never be found in another. I will show that basic human dignity is independent of contingencies, and that “the communicable fact of incommunicability” constitutes a reason to prohibit EPAS.

Supporters of EPAS, then, consider dignity as “personal dignity,” or, in Dan Sulmasy’s terminology, “attributed dignity,” although it is not explicitly described in these terms in the literature. Hence, such dignity can be removed or degraded with sickness, pain, and suffering. Some use the notion of “suffering indignities” as identical to a loss of dignity. Here Dworkin, in describing a “right to dignity” for the demented patient, notes:

[People have a right not to suffer indignity, not to be treated in ways that in their culture or community are understood as showing disrespect…Why is indignity a special kind of harm, whether self-inflicted or inflicted by others…I have been arguing that we not only have, in common with all sensate creatures, experiential interests in the quality of our future experiences but also critical interests in the character and value of our lives as a whole. These

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critical interests are connected, as I said, to our convictions about the intrinsic value—the sanctity or inviolability—of our own lives.\textsuperscript{392}

Note again, that the “critical interests” determining the value of one’s life are the same as one’s own convictions about that value.

It is crucial at this stage to elaborate on another distinction which Pullman sets forth:

[T]he concept of dignity emerges at the interface of the moral and the aesthetic. Thus it carries both moral and aesthetic connotations…Think of the various connotations attached to the term ‘dignity’ as situated along a continuum. One end of the continuum represents the moral and the other the aesthetic. Basic dignity, as described above, falls clearly toward the moral end of this continuum. Thus the term carries connotations of something objective and absolute…they bear a certain objective quality that enables them to serve as a basis if social norms and policies…Personally referenced notions of dignity, on the other hand, tend more toward the aesthetical. As such they are more subjective and contingent in nature. Most appeals to human dignity convey something of both the moral and aesthetical.\textsuperscript{393}

One problem with the Argument from the Loss of Dignity is that it conflates the moral and aesthetical senses of dignity, justifying killing due to a loss of dignity in the “moral sense,” but based primarily on concerns about the aesthetic nature of dignity. In this way, Quill (and other proponents of PAS or euthanasia) interestingly use the term “dignified” to describe the kind of death they wish for all persons, a death which EPAS will purportedly give to those who choose it. Thus “the dignified

\textsuperscript{392} Dworkin (2), cited above 233, 235.

\textsuperscript{393} Pullman (1), 77.
death.” Quill implies, should be seen as one which is meant to be more expressive of basic dignity than a less dignified one. The problem is if one ascribes the intrinsic value of the person (basic dignity) to the perception of the person’s attributed dignity. If personal dignity possesses just the value I ascribe to it, and if having control over the timing and manner of my death are crucial to having dignity, then if I do feel as though I have permanently “lost control” of my life, I have an admittedly powerful argument for ending it.

The argument I wish to forward here is that intrinsic or basic dignity is a concept rich in history and meaning, and one which provides a prima facie reason for not killing another human being, particularly when that human being is vulnerable. Although difficult to articulate in common language, the concept of basic dignity is best thought of as the incalculable value of the person which is first grasped through a profound (and simple) experiential encounter with another; and then, we can discover through (the complex process of) reason that she, and all human persons, possess a dignity that cannot be taken away.

394 See Sulmasy (4) and Sulmasy, Daniel P., “Death, Dignity, and the Theory of Value,” Ethical Perspectives, 2003: 103-118. [Henceforth, Sulmasy (3)]. In both these essays, particularly (4), Sulmasy continues and expands his lucid work in differentiating between arguments in favor of EPAS, which are based in a person’s loss of attributed dignity, versus an argument against EPAS based in the notion of intrinsic Dignity. (Sulmasy uses dignity with a capital “D” to describe intrinsic dignity.) Specifically, Sulmasy shows how intrinsic Dignity and the (six) principles which follow from it create a substantial argument in favor of not killing a vulnerable terminally ill person: “Thus while one might, out of human sympathy, suggest that a duty to build up attributed dignity legitimizes euthanasia, the conception of dignity presented in this essay would argue that this cannot be permitted because it undermines the fundamental basis of morality itself—respect for intrinsic dignity.” [Sulmasy (4): 488]
Wojtyła’s Concept of Dignity: Discovering Value Through Experience

In *Person and Community*, Wojtyła’s essay, “On the Dignity of the Human Person,” elaborates on the underlying notions of human dignity found in *The Acting Person*. Wojtyla begins by stating simply that “the human being is a person,” and that everyone (in some way) agrees. He defines dignity simply as a “natural greatness,” discovered by *experiencing* a person; the experience of this value is evident both on an individual level and when one investigates the relationships between individuals in a community.

This community aspect of “discovering dignity” is worthy of elaboration. In Chapter II, we explored Wojtyla’s view of compassion, where we came to understand that one’s personal worth and value can be understood principally through “affective contact” with another. In Chapter V, we will investigate Wojtyla’s theory of community itself, a group of persons bound to one another for the common good. By way of previewing what will follow, I will outline that, *contra* Hobbes, and following Maritain, Wojtyla believes that the community actually arises out of human dignity itself. Therefore, the community functions both as the mechanism for discovering, and the product of, intrinsic human dignity. First, the community is the

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395 PC, 177-180.

396 PC, 178. The claim that “everyone in some way agrees” with the idea that every human being is a person is, of course, no longer true, as philosophers such as Peter Singer have made clear. (See Singer, Peter, *Practical Ethics* (Cambridge: Cambridge University Press); 1993: especially the classic example of the hemophiliac infant and the introduction of “replacement theory,” 185-186. [Henceforth, Singer (1)] See also, Singer, Peter. “Voluntary Euthanasia: A Utilitarian Perspective,” *Bioethics*, Vol. 17 (5-6); 2003: 526-541. [Singer (2)])

397 PC, 178.
vehicle by which we experience our own dignity and the dignity of others; second, the connectedness of “persons with dignity”—and the value of each person discovered through their interdependence—is what makes a community possible and gives the community a dignity all its own. However, if the intersubjective experience of dignity is ignored, then the opposite occurs, and the human person is at risk of isolation and rejection, and the community which binds one to another is shattered.

We acquire this “intersubjective experience” through basic, but uniquely human activities, recalling Wojtyla’s description of the interacting energies or dynamisms of life—in particular, the dynamism of the free act (actus humanus).\(^{398}\) Wojtyla wants to root dignity in the \textit{experience} of the person herself, the “lived experience of human dignity”\(^ {399}\):

\begin{quote}
Who the human being essentially is derives primarily from within that being. All externalizations—activity and creativity, works and products—have here their origin and their cause.\(^ {400}\)
\end{quote}

He acknowledges in this essay that man’s worth is, in fact, connected to his capacity for reason and free will, but he is also quick to tie this to truth and to the good.\(^ {401}\)

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\textbf{398} AP, 105. See also, Chapter I, “Self-possession, Self-governance, and Self-determination.”


\textbf{400} PC, 178.

\textbf{401} PC, 179.
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Dignity cannot be understood outside of man’s ability to act freely and in truth, but it can also not be fully understood outside of the spiritual dimension of man.\textsuperscript{402} In a later essay,\textsuperscript{403} Wojtyla would defend the traditional definition of person given by Boethius and Aquinas (\textit{persona est rationalis naturae individua substantia}).\textsuperscript{404}

This definition, of course, has two parts—it does not define the person by reason alone. If this were the case, we would revert to the Kantian notion of dignity, based in a person’s capacity for reason. Instead, the person is an \textit{individual substance} of a rational nature; an understanding of the significance of the individual substance of a person is therefore necessary and will be explored by revisiting the notion of incommunicability. Thus, as Peter J. Colosi has pointed out to me in correspondence, “If you make a new friend, you don’t rejoice that you met another being capable of rational thought; you rejoice that you met a unique person – this person expressed him/herself to you through some concepts, and you can’t have a person without this

\textsuperscript{402} PC 179-180. This obviously does not tie Wojtyla to a spiritual explanation of dignity alone, nor does it make Wojtyla’s argument susceptible to the “critique” that dignity is essentially meaningless outside of a religious context. For believers, the illumination that faith brings helps to articulate the person more accurately and definitively. Reason and emotional experience have their limits; however, Wojtyla explains that for “those who do not acknowledge a religious reality and do not find the fullest confirmation of the dignity of the human person in such a reality,” dignity can be confirmed from experience: “in relation to the visible world, in the economy, technology, and civilization.” (PC, 180)

\textsuperscript{403} “The Human Person and the Natural Law,” in PC, 181-185.

\textsuperscript{404} An excellent, modern defense of human dignity rooted in this definition can be found in Lee, Patrick, and George, Robert P., “The Nature and Basis of Human Dignity,” Chapter 16, in the President’s Council on Bioethics, \textit{Human Dignity in Bioethics}, (Washington, DC: US Government Publication) March 2008: 409-433. What make humans substantially different from other entities that demands respect is that “Human beings perform \textit{acts of understanding}, or conceptual thought…An act of understanding is the grasping of, or awareness of, a nature shared in common by many things. In Aristotle’s memorable phrase, to understand is not just to know water (by sensing or perceiving this water), but to know what it is to be water.” (420)
capability, but strictly speaking a person is not [merely] 'the capacity for rational thought.'” Therefore, it is important to realize that Wojtyla departs from the strictly Kantian notion of dignity which is located only in the powers of reason. How we discover our dignity cannot come solely from rational abstraction, but from living itself. Reason certainly plays a crucial element in dignity; Kant had this right. However, the experience of basic dignity is an experience not of a “being with a rational capacity”; rather, what makes us grasp another’s value is that encounter which conveys his utter irreplaceability and uniqueness. This discovery points us back to Wojtyla’s original characterization of human action, which I described in great detail in Chapter I: “a particular lived experience that goes by the name of ethical experience.”

Here we find shades of one of the great, but oft-overlooked, thinkers of the twentieth century, the French “concrete personalist” Gabriel Marcel. Edmund Pellegrino has elaborated on Marcel’s notions of “problem” and “mystery” in a

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*For a concise but informative biography of Marcel see Moran, Denis, *Gabriel Marcel: Existentialist Philosopher, Dramatist, Educator*, (Lanham: University Press of America); 1992: 1-30. It is clear that Wojtyła’s philosophical anthropology, taken as a whole, can be located within the tradition of Catholic personalists such as Marcel and Jacques Maritain. Wojtyła was heavily influenced by them in his philosophical work. Kenneth Schmitz even finds Marcel’s influence in Wojtyła’s dramatic efforts (See Schmitz, cited above, 35, and footnote 11.). Marcel himself thought one could not separate his own philosophical work from his dramatic work: “[M]y plays…might be compared to an underground stream whose overflow, often scarcely perceptible, irrigates, as it were, my speculative thought.” (Marcel, Gabriel, *The Existential Background of Human Dignity* (Cambridge: Harvard University Press); 1963: 5.)*
recent essay,\textsuperscript{407} highlighting the insight this distinction gives to thinking about dignity:

For Marcel a ‘problem’ is a question that can be examined objectively. It is susceptible to the scientific method of observation…He calls this method the examination of experience by primary deduction…A ‘mystery’ on the other hand, is a question not susceptible to purely objective analysis…The word ‘mystery’ does not mean an infused truth, a revelation in the religious sense, nor is it shorthand for the unknowable…A mystery is examined, as it were, from ‘within,’ as the concrete experience of a person as person. It is examined by secondary reflection…Secondary reflection uses the same instruments of thought as primary reflection. However it orients them in a different direction—toward transcending experience in a way that recognizes the mystery enmeshed in the concrete details of experience.\textsuperscript{408}

Dignity is thus both a problem and a mystery, in Marcel’s sense. In an objective sense we can think about it, know it as a concept and begin to understand its significance. The profundity of dignity must also be discovered in a process of a person living \textit{as a person}. Reflecting on the nature of the person herself in light of experience allows us to “recognize the bipolarity of human dignity between its concept and its lived experience and to respect the dynamic oscillation between the two.”\textsuperscript{409}

I have a friend whose father died in his fifties, some years ago, after a prolonged battle with stomach cancer. The father’s pain was severe; he lost a

\textsuperscript{407} Pellegrino (5), cited above.

\textsuperscript{408} Pellegrino (5), 519.

\textsuperscript{409} Pellegrino (5), 520.
tremendous amount of weight due to the malignancy and chemotherapy, and he rarely ate anything at all. In his last days, his daughter related this story to me: She and her family were visiting him in the hospital. He was now so ill he barely spoke. The family left one by one; visiting hours had ended. My friend remained in the room, the last to leave. As she looked at her emaciated, jaundiced father with tears in her eyes, she asked him if there was anything else she could do for him. He replied, with tears in his eyes, that he had lost control of his bladder and needed to be changed. It is easy to see how a proud, independent father and a dutiful, previously dependent daughter, could feel in this instance, the incredible anguish of the loss of personal dignity. It is an utterly “undignified” scene. Indeed, as difficult as it is to think about, we can imagine such a loss of attributed dignity. Yet, does such a loss mean the person has lost value? It is in real snapshots like this one we also come to appreciate the power of basic dignity and intrinsic value: looking in from the outside we might grasp, simultaneously, the loss of aesthetical beauty and the intrinsic value of the daughter and father as persons. Would EPAS add to the father’s basic dignity, even if he or his daughter asked for it? Does his condition detract from his worth? From “the inside,” for the daughter who changes her father’s bedclothes, and for the father who bears the indignity of being changed for the first time, this can be a moment of profound love and interdependence. In fact, we are moved by the loss of attributed dignity here precisely because we recognize the basic dignity. Attributed dignity only matters because of basic dignity. Basic dignity here is affirmed, not
principally by rational argument, but by living and experiencing the person as
person.

*Dignity as a “Call and a Demand”*

Wojtyla insists that the dignity of the person needs to be seen as the dignity
of each individual person, not as the dignity of man *en masse*. A personal encounter
with this utterly unique entity is what points us back to the realization of her intrinsic
dignity, a dignity which is not attributed or created. This has crucial implications for
euthanasia and assisted suicide. It is not a person’s intrinsic dignity that is degraded,
but what Pellegrino calls their *imputed dignity*:

> Imputed dignity lies in the eyes of the beholder, in the ways she reacts to the results of the
ravages of serious illness and dying...This is the human and natural response, often
exaggerated and even caused by how those around the dying behave—in the way they shun
him, are discomforted by his appearance and plight, and treat him like a child or an alien
being, sometimes only thinly and unsuccessfully veiling their unconscious wish for his
demise.\(^{410}\)

The reaction of others to the sick and suffering often contribute to this loss of
imputed dignity. Imagine one’s self-perception and self-esteem when they fall ill in a
society that condones their death! In the preceding chapter, we noted that empirical
studies suggest that a high percentage of patients at the end of life can perceive
themselves to be a burden on others, a perception that strongly influences desires for

\(^{410}\) Pellegrino (1), 246.
PAS.\textsuperscript{411} These same studies also show a strong link between perceptions of a loss of dignity, and feeling as though one was a burden on others. One paper summarizes a review of this literature:

In these studies, concern about burdening others has emerged routinely as a central theme related to quality of life and terminal illness (Cohen & Leis, 2002), optimal end-of-life care (Singer, Martin, & Kelner, 1999), the maintenance of dignity at the end of life (Chochinov, Hack, McClement, Kristjanson & Harlos, 2002), “fates worse than death” (Pearlman et. al., 1993), and the characteristics of “a bad death” (Vig & Pearlman, 2004)…

…[T]he fact that a loss of dignity was the single most important predictor in the regression analysis suggests that self-perceived burden may be part of a more general dimension of existential distress.\textsuperscript{412}

Another author of a qualitative study involving extensive interviews with ten terminally ill women concluded that “Whether they [the women] have a ‘good death’ or not is determined not only by the progression and management of their disease process but also by the way they are perceived by the people around them.”\textsuperscript{413}

Therefore, Wojtyla notes, “the matter of the dignity of the human person is always more of a \textit{call and a demand} than an already accomplished fact, or rather it is

\textsuperscript{411} Wilson et. al., cited above; McPherson et. al., cited above.

\textsuperscript{412} Wilson, et. al., 115-116, 120.

\textsuperscript{413} McKechnie, Roz, et. al., “Facing uncertainty: The lived experience of palliative care,” \textit{Palliative and Supportive Care}, Vol. 5; 2007: 367-376, quote from 373. To date, no data on the self-esteem or self-perceived burden of terminal patients has been collected in countries where PAS or euthanasia has been legalized, as a means of comparing it with other countries. This is an area that ought to be explored for future empirical research.
a fact worked out by human beings, both in the collective and the individual sense.” [my emphasis]  

If dignity is a “call and a demand,” then we must ask—for whom? The answer is straightforward: it is a call and a demand for each human person, for himself and for his neighbor; but it is also a call and demand for the community, which constitutes a group of persons bound by love. What then, are we to argue against a person who hails from a society in which such a “call and demand” is not acknowledged? For example, certain tribes of Eskimos were known to abandon both disabled babies and elderly non-productive members of the tribe on ice flows. As Wilfried Ver Eecke, who raised this challenge, put to me in correspondence, “What you present is your call and demand and your vision. Who must pay for your vision?...Legislation against euthanasia is, after all, an imposition by one view on others with another view.”

My answer to this objection is as follows: first, all humans (universally) have intrinsic dignity due to the natural kind of entity a human is—an unrepeatable being, whose value is experienced and grasped through contact with another. Dignity—and its demands—are therefore independent of culture. Perhaps more accurately, the truth of the dignity of persons places demands on all of us. However, this does not exclude the possibility that well-meaning persons—indeed entire societies—may be

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414 PC, 179.

415 Many thanks to Dr. Ver Eecke for this objection, in correspondence, May 13, 2008.
in error about what dignity calls for.\textsuperscript{416} The practice of \textit{sati} in Hindu India—in which a recently-widowed woman would burn herself to death on a funeral pyre—was once seen as a good both for the widow, her family, and her deceased husband. However, since the passage of prohibitory laws under colonial rule (1829) to the present day, the practice has been nearly wiped out.\textsuperscript{417} So, I would say that, as human history bears out, there is always someone who “pays the price” when an error in thought is rectified—but the payback is worth the cost. Why? It is because the experience of the nature of the person finds that her fulfillment and flourishing is found in true things.

Second, I would argue that it is better and more rational to value a thing for what it is (in reality) than to not do so. I may use a first edition copy of \textit{Les Miserables} as a doorstop. It may be a very effective doorstop indeed, but we would all find this troubling nonetheless, and would assume that either a) I know the book’s value, but I am insensitive to it or b) there is simply something I am not seeing that prevents me from grasping the book’s true value. It is this latter mistake that the vast majority of EPAS supporters, or Eskimos who abandon the infirm for that matter, make. Therefore, the job of the personalist is to educate, to reveal, to demonstrate how one’s own experience of life can corroborate the intuition of the dignity of the person.


\textsuperscript{417} Interestingly, the Indian government’s latest attempts to ban the practice held entire communities responsible with fines and imprisonments—including life in prison. See “India to toughen laws on burning of widows,” Reuters News, accessed on May 14, 2008: http://www.reuters.com/article/latestCrisis/idUSDEL55004
Third, since individuals who make moral mistakes can form societies that make moral mistakes, I would argue that there is a duty on all persons to not “leave well enough alone” and to attempt—even by legislation if needed—to amend those mistakes. The existence of slavery in the antebellum South was justified, in part, by the existence of slavery elsewhere and throughout history. Thus we see even today, people who cast an eye to the Netherlands and Belgium (where euthanasia is legal), as if the experience there constitutes a reason to consider the practice in the United States. Yet, if truth directs our conscience to act in ways which literally change us for the better, then we are bound to show ourselves and others (through reason, through experience) that upholding the dignity of the person is “worth the price” paid.

Finally, the characterization of dignity as a “call and a demand” is especially poignant when we remind ourselves of the nature of the physician-patient relationship. Here, there is a “confrontation, a face-to-face encounter between someone who professes to heal and someone in need of healing.”

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418 For example, the pro-slavery politician John C. Calhoun of South Carolina is noted to have said that “I hold then, that there never has yet existed a wealthy and civilized society in which one portion of the community did not, in point of fact, live on the labor of the other. Broad and general as is this assertion, it is fully borne out by history...it would not be difficult to trace the various devices by which the wealth of all civilized communities has been so unequally divided, and to show by what means so small a share has been allotted to those by whose labor it was produced, and so large a share given to the non-producing classes.” (Speech delivered February 13, 1837.)

419 See Singer (2), for example.

420 Pellegrino (5), 522. Pellegrino explores the various ways in which imputed dignity is assaulted in the experience of the sick person. These include admission of vulnerability (physical and cognitive), guilt, shame, “routine humiliations” by hospital staff etc. (522-526) Ultimately, and especially in the context of chronic illness, death, and dying, such assaults and personal indignities affect the way
terminally ill patient seeking medical care is, in reality, demanding recognition of her intrinsic dignity; she is calling for a restoration of the toll which pain and suffering have inflicted on her imputed dignity. The authentic healing relationship of the healthcare giver and the suffering sick is therefore an opportunity to uphold the value of both physician and patient. If, on the other hand, the vulnerable patient is allowed—even supported by family, friends, or the physician—to choose death through EPAS, the parties involved have surrendered the battle for restoration of the person’s personal dignity and have acknowledged a falsehood: that basic human dignity can be lost.

The error that supporters of EPAS make begins with the use of language. A person may feel “undignified” without losing her basic dignity. A person may have indignities thrust upon them by pain, suffering, and loss of control,421 but her value—if located within her nature as a person—is still intact. Just as one cannot subtract dignity, one cannot “add dignity” to oneself. The isolation of illness that alters our perception of human value in the face of illness cannot stand, if only we people see their future, and ultimately their own worth. This is a subtle, but important, point. Violations of extrinsic dignity, if left unchecked, begin to erode a person’s perception of her intrinsic dignity, making it easier for the patient and provider alike to conflate the two.

421 Alan Radley makes this argument, confusing intrinsic dignity with being or feeling “dignified,” in Radley, A., “Pity, Modernity, and the Spectacle of Suffering,” Journal of Palliative Care, Vol. 20 (3); Autumn 2004: 179-184: “The particulars of any one person’s feeling dignified will depend upon a host of things peculiar to their situation, including whether they are disabled, the course of their disease, and the pain they might suffer as a consequence.” (180) Ruth Macklin [see below, Macklin (1)], simply accepts this mistake. Of course, as I have stated, such an argument also confuses basic and personal dignity: “[D]ignity can be thought of as something that is recognized in a person as a consequence of handling adversity…For this to happen, another person—the observer of witness—must see something of the suffering the individual must endure.” (Radley, 179)
accept that, as persons, we are called to act in truth and love with one another. 
Through action, our dignity is confirmed in freedom; through the mystery of the ineffable person, we are brought to appreciate her incalculable value. It is this value alone which stands between the embracing of vulnerable life and the isolation and death of the unwanted person.

Ruth Macklin’s Argument Against Dignity: Implications for the EPAS debate

There is another, important argument left to consider which is distinct from the Argument from the Loss of Dignity: namely, that the concept of “dignity” is not a helpful or useful concept at all. It cannot be legitimately proffered (although it regularly is) by either side in the EPAS debate. Rather, “dignity” is a vague concept which ought to be folded into other, broader conceptions—most notably respect for autonomy. This is the argument which bioethicist Ruth Macklin famously made in her 2003 paper “Dignity is a Useless Concept.”

Macklin begins by outlining the extensive use of the term “dignity” in politics, law, and bioethics, citing everything from the UN Declaration on Human Rights to the 1983 President’s Commission Report on forgoing life sustaining treatment. She points out that the term (particularly in bioethics) has never been clearly defined, which the 1983 Commission itself admitted: “Phrases like…’death with dignity’…have been used in such conflicting way that their meanings, if ever

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422 Macklin, Ruth, “Dignity is a Useless Concept,” British Medical Journal, Vol. 327; December 20-27, 2003: 1419-1420. [Henceforth Macklin (1)]. As Dan Sulmasy has pointed out, others prior to Macklin, such as Ronald Dworkin, have questioned dignity’s meaning in ethics (See Sulmasy (1): 71-72); it was Macklin’s paper which has arguably caused the greatest stir.
they were clear, have become hopelessly blurred.” She also claims that a more recent President’s Commission report had not even defined “dignity” before including it as a factor in weighing bioethical matters. Macklin’s ultimate conclusion is that dignity adds nothing to debates in bioethics that cannot be found outside the principle of respect for autonomy, and as such, ought to be eliminated as a factor altogether. Later, she would refine the argument, stating that dignity is not a “useless concept”—since everyone uses it in one way or another—but it is perhaps better characterized as “an infinitely elastic” concept, making it just as meaningless. Macklin posits “a possible explanation” for the appeal to dignity on the influence of religious thought, specifically mentioning Roman Catholicism. She does not, however, give evidence to support this claim, nor does she offer a more comprehensive study of the history of the term “dignity” and its various religious origins and connotations. She also admits that religion could not entirely explain


426 Macklin (1), 1420. Macklin’s claim is that references to dignity in ethics mainly emerged in the 1970s; making dignity appear as a rather recent phenomenon is something which clearly serves Macklin’s purpose of more easily discarding the concept. However, it is clear that the history of
“how and why dignity has ‘crept’ into the secular literature in medical ethics.” She clearly views dignity as an “invasion” of the secular space.

The argument has important implications for the debate over EPAS, for both sides use dignity as an argument for justifying their position. The pro-euthanasia side will say that prolonged suffering and loss of autonomy erode human dignity; the pro-life movement will claim that human dignity exists as a *prima facie* reason not to kill, because it can never be taken away by illness. If dignity is meaningless, and folds into the concept of autonomy, then those opposed to euthanasia lose an important protection of the person which has been deeply imbedded in medicine since its founding.

*A Response to Macklin: Incommunicability Revisited*

Ruth Macklin’s paper, which caused an incredible stir in the bioethics community since its publication, has been challenged in many ways. Perhaps the definitive rebuke came in March 2008 with the release of the President’s Council on dignity is much richer than this, and the philosophy of dignity has ancient roots. See, for example, John Crosby in “The Two-fold Source of the Dignity of Persons,” *Faith and Philosophy*, Vol. 18 (3); 2001: 292-306. [Henceforth, Crosby (1)]. In this very impressive and, in my view, revolutionary paper, Crosby traces the origins of dignity to the Greek philosophers and outlines its evolution to modern thought rooted in rationality. Daniel Sulmasy (in Sulmasy (2): 15-18), cited above, traces the philosophical and theological roots of the concept of dignity from the ancient Hebrews to our modern notion, and includes an interesting theory linking the Catholic view of dignity to Kant through early personalism. However, Sulmasy argues in a later work [Sulmasy (4), cited above: 471] that the term “dignity” has its origins not in religious thought, but rather in the Roman Stoics. Alan Schulman in “Bioethics and the Question of Human Dignity” (in Chapter 1 of the President’s Council on Bioethics, 2008, cited above: 6-15) explores the historical uses of dignity from the Hellenic period, to the biblical era, through Kant, and finally in political documents such as the UN Declaration on Human Rights. Schulman also indicates various philosophical problems with each approach, highlighting the challenges to defining the meaning of “dignity.”

427 Macklin (1), 1420.
Bioethics’ *Human Dignity in Bioethics*, a 543-page discussion of the concept of dignity, its history, and its importance in medical ethics.\(^{428}\) A summary of the twenty scholarly chapters contained within it is obviously beyond the scope of any single study; the full impact of the undertaking will be realized only with the passage of time. The authors of this work approach the subject of human dignity and its defense from various backgrounds—Edmund Pellegrino from the “lived experience of human dignity,” Patrick Lee and Robert George from a natural law approach, Martha Nussbaum from her Aristotelian background, for example. The manifold ways in which dignity is defended speak to its undeniable universality in varied traditions of reason.\(^{429}\) Of course, one might argue that everyone is just plain wrong, and these various perspectives all suffer from one or another fatal errors. Yet, the rational evidence is weighty, and the burden of proof becomes far greater for opponents of dignity, a burden which I believe will certainly be too encumbering for any to bear.

To these scholarly arguments from far more learned authors, I would like to add another. Having outlined Macklin’s dismissal of dignity, I would like to take the reader back to the challenge I posed at the very beginning of this study. If we come to an impasse in the debate over EPAS—specifically the notion of dignity in this case—we ought to reflect on whether or not we are beginning at the correct starting

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\(^{429}\) Of course, one might argue that these “varying conceptions” seem to support Macklin’s view, as Steven Pinker has done. See my exposition and critique of Pinker’s argument below.
point. Therefore, to see where Macklin has gone astray, we need to begin with a look through the lens of philosophical anthropology—where the human person is the core around which everything else orbits.

Again let us explore our *experiential encounter* with the human person to arrive at a notion of dignity. If someone poses the question of which event is more horrifying in its totality—the history of American slavery, the genocide in Rwanda, or the Holocaust—we might find it difficult to answer the question, or even to articulate a method for deciding the question. Is it just the *number* of people killed that makes one historical event worse than another? Is there a quantifiable amount of suffering we could use to measure which event is the most terrible? Is there a scale we could create to help us judge? Our sorrow and shock over all of these events lies more with the intuition that a *person* has somehow been degraded or destroyed—even a person we never knew. The numbers do not crucially matter in comparing one form of genocide to another. The different levels of rationality of the victims are irrelevant to what we intuit. The desolate experience of this loss is often indescribable by common language.  

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430 Genocide is seen by most as “worse than” the killing of a single person. Yet, this is precisely because in genocide you have the killing of many persons—the value intuited is multiplied to a degree which may make the senses numb.

431 One need only think of Dwight D. Eisenhower’s remarks on entering a German concentration camp near Gotha: “The things I saw beggar description…the visual evidence and the verbal testimony of starvation, cruelty, and bestiality were so overpowering as to leave me…sick.” (Letter from Eisenhower to General George Marshall, April 14, 1945, accessed at: http://www.eisenhower.archives.gov/dl/holocaust/DDEtoGenMarshall15April45pg1-3.pdf on April 1, 2008.)
My contention is that dignity (and its violation) is a concept which we both know and feel (a “problem” and a “mystery”); it is difficult to adequately describe it in common parlance, but not difficult to experience it. The linguistic difficulty arises because dignity rests in an ineffable source—the human person. Kant’s view, grounded in his philosophical anthropology, held that humans had an unquantifiable dignity not because of their humanity per se, but rather because of the rational capacity which lay at the core of their humanity. Reason was the center of morality, and it was morality that gave humans value.\footnote{Kant, \textit{Groundwork of the Metaphysics of Morals}, cited above, 4:435; See also Gunderson, 279-280. See also Pullman, Daryl, “Death, dignity, and moral nonsense,” \textit{Journal of Palliative Care}, Vol. 20 (3); 2004: 171-178. [Henceforth, Pullman (2)]. Pullman makes an argument in this paper for the usefulness of the concept of dignity in this “basic sense,” but, as I have shown, an authentic anthropology as the one Wojtyla offers cannot ignore the real experience of the “encounter with another.” More recent analyses of Kant’s conception of human dignity, and the problems and promise for bioethics and political systems can be found in Shell, Susan M., “Kant’s Concept of Human Dignity as a Resource for Bioethics,” Chapter 13 in the President’s Council on Bioethics, 2008: 333-349; and Nussbaum, Martha, “Human Dignity and Political Entitlements,” in the President’s Council on Bioethics, 2008: 351-380.} We must admire Kant’s conclusion: that human beings are worthy of unconditional respect and protection. Kant himself, for example, opposed suicide precisely because it destroyed the rational being whose value was beyond measure.\footnote{See Kant, Immanuel, \textit{Lectures in Ethics}, trans. Louis Infield, (Indianapolis: Hackett, 1963: 148-159.} However, Kant’s argument, if taken as the sole source of dignity, has serious problems and is at the root of both the Argument from Autonomy and the Argument from the Loss of Dignity. One author, for example, has justified suicide (in cases of pain or progressive dementia) using Kantian conceptions of dignity and autonomy; as rational capacity deteriorates, dignity deteriorates, and
therefore the person committing suicide sacrifices himself to (paradoxically) "preserve" the value of his life which remains.\textsuperscript{434}

Furthermore, from an anthropological perspective, it is clear that Macklin has made the "Kantian mistake," which I have critiqued in Chapter I. Autonomy for her is the ultimate guiding principle in ethical decisions and the singular factor in determining what the person is. It is no small wonder, then, that Macklin feels perplexed by the dizzying array of definitions and uses of "dignity," finding the word to be "an infinitely elastic one." If one accepts the Kantian anthropological mistake, then a person acts in freedom when his own consciousness permits him to do so. Thus, everything valuable about the person is centered around autonomy and value framed around anything else but autonomy is superfluous.\textsuperscript{435} As we have seen, Macklin’s view neglects the reality of emotional experience, an ethical experience which—in the context of an encounter with another—provides invaluable insight into what dignity truly is.

I am alluding here to a third problem with the Kantian (rational) basis for dignity, if taken as the human being’s only source for intrinsic worth. Namely, as Wojtyla indicates in criticizing the “schizophrenia” of Kantian ethics, a purely


\textsuperscript{435} Perhaps an even simpler and effective response can be found in Sulmasy (4), where Daniel Sulmasy responds to Macklin’s attempt to fold dignity into the concept of “respect for autonomy”: “This hasty conclusion [the rejection of dignity]…can be justified only by begging the question. If one defines a word [dignity] completely in terms of another concept more to one’s liking [respect for autonomy], it will always follow that the word in question adds nothing to the concept one already endorses.” (469-470)
abstract notion of dignity would ignore the very things that bring humanity to human life—relationships with others. This was the core of Scheler’s (and Wojtyła’s) critique of Kant. Leon Kass recently argued:

[The Kantian notion of dignity] is in an important respect, inhuman… Precisely because ‘personhood’ is distinct from our lives as embodied, rooted, connected, and aspiring beings, the dignity of rational choice pays no respect at all to the dignity we have through our loves and longings—central aspects of human life understood as a grown-togetherness of body and soul.  

John F. Crosby’s seminal paper, “The Two-fold Source of the Dignity of Persons,” explores the neglected source of dignity—the source rooted in man’s “immanent makeup”—in comprehensive and convincing detail. We will spend some time elaborating on his idea that the dignity of the person arises both from her rational nature and also her mysterious, indescribable nature—her incommunicability. Crosby asserts, at the very beginning, his belief that dignity cannot be removed. When we ponder the fact that someone is treated in an “unworthy way,” for example, our revulsion at this treatment presupposes an unshakable dignity. I would argue that such revulsion need not relate to autonomy at all, as Macklin suggests—or, at least, the relation to autonomy is not what occurs in our actual experience. Rather, the maltreatment of a child, or a person in a coma—

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436 Kass, Leon in “Defending Human Dignity,” Chapter 12 in the President’s Council on Bioethics, 2008: 313. [Henceforth Kass (3)]

437 Crosby (1), cited above.

438 Crosby (1), 293.
people we tend to think of as not actively utilizing rational powers—repulses us because of something different. We sense that the value that is owed them as a person is not given; but we do not connect that value to their actual capacity or actual use of reason. Now, this does not mean that such a connection is not present unconsciously. The point here is that our experience leads us to believe there is something else too—something discovered only in the encounter with a person—which is connected with reason just in the sense that whenever there is a person there is necessarily also reason.\textsuperscript{439}

Crosby explores this “something else” in great detail. Dignity does not rest solely in things all human beings have in common—their reason, for example. Dignity rests in the uniqueness, or incommunicability, of the person. In our discussion of self-determination in Chapter I, we introduced incommunicability in the context of Wojtyla’s theory of action; it was in this context that Wojtyla tied incommunicability to inviolability. A person’s absolute unrepeatability is revealed through free action, through the encounter with another. It is discovered through love, which reveals and confirms the value of a person who cannot be replaced.

\textsuperscript{439} Alexander Pruss, playing “devil’s advocate,” posed this objection: “The maltreatment of someone not actively utilizing rational powers repulses us in a derivative way—if the person were exercising rational powers, the person would oppose the maltreatment. Also, we are repelled by the maltreatment of beings that do not have dignity. We are very much repelled, for instance, by wanton cruelty to animals.” My response is as follows: First, it may be that the rational capacity of a person is another reason—a very important one—that we are repulsed by his maltreatment. However, our actual experience suggests this is not what we actually feel or think of when we are confronted with, for example, child abuse. Rather, it is a grasp of the unrepeatability of the person that is at the root of revulsion (this is something we “grasp,” not necessarily articulate or make an argument for). Second, with respect to animals without dignity, I would suggest that here we have a derivative repulsion—we don’t like cruelty to animals principally because we don’t like cruelty to persons. (There may be other reasons too, but this is the most important.) For example, people are less inclined to feel repulsion at cruelty to bugs and fish, as they are to dogs and chimpanzees.
Now, one might object that “lots of things have uniqueness. Worms (or snowflakes?) are unique, unrepeatable, and are individual substances. Do they have dignity also?”

One way to answer this is through use of the phenomenological method. Although worms and snowflakes are, in fact, unique, we need only compare the personal experience of the unrepeatable uniqueness of a real person whom we love with the experience of a worm or snowflake to realize the difference. That difference is profound. Another key factor is the element of love, which plays a critical role in understanding incommunicability. While we may love our favorite dog, the love between two persons is different in quality and profundity. “Love is what makes you aware of the incommunicability of others, but love is not what creates incommunicability. Love makes a person grow in or into their uniqueness—but the uniqueness is still there from the beginning, from conception, and love is needed (like water for a plant) to make incommunicability blossom.”

As a pediatrician, I have personally encountered the death of children in the hospital—some in the Neonatal Intensive Care Unit (NICU). Here, children may have been born prematurely and died four months before their due date, but if you were to ask the parents whether having another child replaces the child lost, they would find the question absurd and offensive. Why? Those parents have had a very

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440 Peter Colosi, in correspondence, March 4, 2008. I thank him for the insight into answering this objection. Thus, incommunicability is present even in those who are incapable of exercising a capacity to love (e.g., anencephalic infants, persons in a coma, etc.). The inability to exercise the ability to love (or any ability, for that matter) is not a reason to think the person is not present.
short temporal relationship with the child, and their encounters may have been brief, likely behind the physical barrier of an incubator. Yet, family and health care providers alike recognize that the 24-week premature child is a person with dignity, and, more than that, that the loss of such a child is a profound, irreplaceable loss for their “universe.” Such experiences run counter to the so-called “replacement theory” of Peter Singer. 441

Thus, through of the mystery of love for the barely-born premature infant, her incommunicability reveals itself as “something ineffable, something too concrete for the general concepts of human language; something knowable through love but not utterable in concepts.” 442 This revelation of intrinsic value comes about not through rational abstraction alone, 443 but rather, through a process of discovery of this unrepeatable person. A person cannot be understood in isolation. This must be what Marcel means by an authentic “encounter” with another:

Encounter can only be accomplished at the level of presence. If it is an authentic encounter it cannot be limited to coexistence at a particular moment. Such coexistence is only a matter of ‘being there.’ There is a true encounter only if there is ‘being with.’ 444

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441 See Singer (1), cited above, 186-187. See also the response to replacement theory from two contemporary personalists in Colosi (2) and Colosi (4), and Crosby (1), cited above.

442 Crosby (1), 298.

443 Although, as Lee and George allude to, the grasping of commonalities—the understanding of the nature of a thing through our reason—is certainly possible and provides further evidence of our dignity. (Lee and George in the President’s Council on Bioethics, 2008: 420.) Yet, Lee and George’s account is incomplete without an explanation of the phenomenon of incommunicability.

444 Marcel, Gabriel, in “Reply to Gene Reeves,” in Schlipp, cited above, 274. Marcel’s highlighting of the reality of the authentic, mysterious encounter with another person gives further articulation to the
For the physician, another person’s dignity is discovered through his compassionate encounter with the patient; it is repeated with every thought and contact with her, confirming her dignity again and again. Importantly, the patient, when cared for and loved, and thereby pulled from the isolation which assaults her perception of dignity, will recognize her own worth in the process.

Crosby goes on to answer six objections to his theory of incommunicability, the details of which are beyond the scope of this work. However, one interesting objection is worth recapitulation. One may object that to base dignity (worth) on uniqueness may actually jeopardize equality among all persons; if each person is unique, then the dignity derived from this unrepeatability also differs between persons. Hence, some people, one could argue, might have more dignity than others. Crosby responds by first pointing out that arguments basing dignity in “sameness” alone (e.g., we are all rational creatures) theoretically (and historically) imperil equality more. After all, as Aristotle argued, although all humans have a rational nature, men and Greeks seem to “realize it more perfectly” than others. He goes on to elucidate that anchoring dignity in both a common nature and an incommunicable one safeguards the equality of persons:

445 Crosby (1), 299-302.

446 This point is also effectively made by Kass (3): 311-313.

447 Crosby (1), 302.
For you cannot say that one incommunicable person has more dignity and another has less, since you would be positing some dignity-grounding quality possessed to different degrees by the two persons…*The fact is that by being incommunicable and unrepeatable, persons are incommensurable with each other, and cannot be compared with each other, and because of this a certain equality is established among them*.448

It is important to address here, in light of the incomparable value of the mystery of the person, Macklin’s contention that dignity can be folded into the concept of autonomy. Both dignity and autonomy matter in the first place because the *suppositum* of both is the same, and that *suppositum* is the human person. Macklin does not examine the “source” of dignity and her value in an attempt to understand what the property of dignity is. One could say that the *experience* of dignity, as part of the inherent nature of the person, *manifests itself* in one way through autonomy—through a person who acts in authentic freedom.449 However, it is not the autonomous act that has value—rather, value is found in the person who acts; a free action is “dignified” precisely because the source has a dignity all its own. There are other ways we come to realize the dignity of ourselves and others—through love, or through perseverance in suffering, for example. These encounters are not accounted for in Macklin’s critique. Therefore, the conclusion we reach is finally this: Macklin has it exactly backwards. It is not dignity that is obscured and devoured by

448 Crosby (1), 302.

449 The fact that this sentence can be constructed demonstrates that “dignity” and “autonomy” can be separated both linguistically and conceptually.
autonomy; rather, it is a person’s fundamental dignity that gives rational choice its content, meaning, and beauty.

Ruth Macklin seems to have a certain discomfort with the inability to “quantify” dignity—to know precisely how we are to “weigh it” in our ethical decision making. What she fails to understand is that the incommunicable nature of persons defies a readily quantifiable conception of dignity. It is the violation of the whole person that is intolerable—the violation of that mystery who has a dignity all her own. To understand this is to accept that there are some things that cannot be weighed because there is no scale great enough to weigh them; the destruction of a person—inseparable from her dignity—is therefore an act that “just cannot be done.”

*Steven Pinker’s Challenge: Is Dignity “Harmful?”*

The President’s Council on Bioethics’ Report on human dignity has not been without its challenges. Steven Pinker, in a recent essay, “The Stupidity of Dignity,”\(^{450}\) attempts a rebuttal of the report and a rebuke of the concept of dignity—going so far as to call dignity “harmful.” The essay is worthy of a response.

Pinker begins by calling dignity a “squishy, subjective notion,” a theme he will return to throughout the essay. He briefly describes, and then reaffirms, Macklin’s claims (without argumentation), asserting that it is disrespect for autonomy, not dignity, that has led to the historical abuses of the human person (e.g.,

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Nazi Germany, Tuskegee). The next few pages, under the rubric “Understanding the Source” (of the Report) amount to a series of *ad hominem* attacks on the President’s Council’s founder (Leon Kass) the Council’s current President (Edmund Pellegrino), evangelical Protestantism, and Roman Catholicism. These attacks essentially amount to one long diatribe that succumbs to the informal fallacy of logic—the “genetic fallacy”—where an argument is discarded based on its origin, rather than the merits of its premises and conclusions. Thus we find no substantive argument against dignity until more than half way through Pinker’s piece.

Then, Pinker argues that “almost every essayist [of the Report] concedes that the concept [of dignity] remains slippery and ambiguous” and goes on to cite the plethora of ways in which the authors approach dignity as evidence of a contradiction in the very definition of the word itself. The implication is that Macklin was right: we have so many approaches to dignity that it is impossible to know precisely what it is. However, it is not a contradiction to suggest that many people...

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451 Of Kass, he writes that he has a “fixation with dignity” that “takes him right off the deep end.” (2) “And, in 2001, this man, whose pro-death, anti-freedom views put him well outside the American mainstream, became the President’s advisor on bioethics…”(3). He describes Pellegrino as “an 85-year old medical ethicist and former president of the Catholic University of America.” (How Pellegrino’s age is relevant is not explained, nor does Pinker mention that Pellegrino is also a physician, a past president of Yale University-New Haven Medical Center, and has held leadership positions in several other secular universities throughout his distinguished career; he is also the author of two dozen books and many more published articles.) Of the Catholic Church, Pinker says: “The Catholic Church, with its long tradition of scholarship and its rock-solid moral precepts, became the natural home for this [dignity] movement…Catholicism now provides the intellectual muscle behind a movement that embraces socially conservative Jewish and Protestant intellectuals as well…And the Church’s franchise to guide people in the most profound events in their lives—birth, death, and reproduction—is in danger of being undermined when biomedicine scrambles the rules.”(3) Here Pinker cleverly attempts to present the (false) dichotomy between religion and science.

452 Pinker, 4.
have different approaches to defining dignity, or even that the term is “slippery and ambiguous.” That much is obvious: it surely is an ambiguous term for some, as we have seen. It does not follow, however, that this entails that the correct meaning of dignity cannot be ascertained by reason, revelation, or a number of different approaches. Nor does it suggest that there is no objectively true characterization of dignity. If I give a group of third graders a fifth grade math problem, they too, might find the problem (and even mathematics) “slippery and ambiguous,” but it does not follow that there is no answer to the puzzle at hand.

Furthermore, recall that Macklin’s argument, to which Pinker adheres, asserts that dignity is a “useless concept” because no one can agree on quite how to use it. But I know of no author on either side of the debate that claims that a precise, unwavering definition of dignity has been found. Rather, the approach of the Council’s Report, and my defense of the incommunicability argument, is that, however one approaches the concept of dignity—whatever rational method one chooses—all paths lead to the same conclusions. What are those conclusions? Dignity is not a useless concept and has an important personal and social role; basic human dignity is inalienable and immutable; and, dignity cannot simply be “rolled into autonomy,” for it is distinct in its significance and utility.

Pinker next offers three reasons why he feels that dignity could not be used as a foundation for bioethics. “First, dignity is relative. One doesn’t have to be a scientific or moral relativist to notice that ascriptions of dignity vary radically with
the time, place, and beholder.” Of course, one could take any meaningful word in bioethics—even ones Pinker cherishes—and suggest it could not be foundational simply because people have different perceptions of it. People, for example, have different ascriptions for the meaning of “freedom” (which Pinker himself notes in his own essay), or for “autonomy,” or for “justice,” etc. His entire essay, in fact, seeks to convince the reader of a particular meaning for the word “dignity”—namely, that it has none. Unless he wishes us to disregard his essay as nothing but “mere opinion,” like all relativists, he faces the charge of self-referential incoherence. In short, one purpose of ethical discourse is to use reason to reconcile differences in points of view, but the very existence of these differences in no way undermines that moral project. In addition, Pinker fallaciously moves from the idea that “ascriptions of dignity vary radically,” to “dignity varies radically.” During the time of slavery in the United States, ascriptions of the moral status of the African slave “varied radically,” but his actual moral status did not.

“Second,” Pinker claims, “dignity is fungible. The Council and the Vatican treat dignity as a sacred value, never to be compromised. In fact, every one of us voluntarily and repeatedly relinquishes dignity for other goods in life. Getting out of a small car is undignified. Having sex is undignified.”

The response here begins

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453 Pinker, 4.

454 I thank Alexander Pruss for helping me clarify this point.

455 Pinker, 4.
with a reiteration of the distinctions we have already established—namely, between attributed and inherent dignity. Pinker mistakes “being dignified” with “having dignity.” The examples he cites may remove or decrease personal dignity—the respect which others, or the person involved, ascribes to himself. However, it would be absurd to suggest that one’s inherent value (whatever his perception) is removed by suffering indignities such “getting out of a small car.” In the case of suffering in the face of terminal illness (the real “test case”) we have seen that a response to the patient’s perceived loss of dignity should be a re-affirmation of his intrinsic dignity, as experienced in the person’s incommunicable (unrepeatable and ineffable) nature.

“Third,” Pinker goes on, “dignity can be harmful…Every sashed and be-medaled despot reviewing his troops from a lofty platform seeks to command respect through ostentatious displays of dignity. Political and religious repressions are often rationalized as a defense of the dignity of a state, leader or creed…Indeed, totalitarianism is often the imposition of a leader’s conception of dignity on a population…” As it is clear that a person’s attributed dignity can underestimated and degraded, so too can a person’s attributed dignity be overestimated and inflated. Thus we see that despots abuse others because they believe that their value is greater than another’s. Pinker’s assertion does not touch the claim (buttressed by Crosby’s

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456 I would also take issue with the examples Pinker cites. I am not sure that “getting out of a small car” or “having sex” is undignified, even for most people.

457 Pinker, 4.
argument outlined above—that one type of incommunicable dignity cannot be “ranked” over another) that inherent or basic dignity is the same for every person and is immutable. Furthermore, I would argue that historical abuses of the human person, such as totalitarianism, occur not because of the “imposition…of dignity” on a population, but precisely the opposite: the complete disregard for human dignity. This was a point well made and articulated by Jacques Maritain in *The Person and the Common Good* (1946), written in the aftermath of Nazism and the Communist conquest of Eastern Europe. What gives totalitarianism the quality of an intolerable “imposition” is that the government’s notion (or lack of a notion) of dignity (or freedom, or purity, or “the good”) is decidedly wrong. The fact that totalitarian governments differ in their view about what constitutes dignity or freedom or the good, vis-à-vis democracies, does not mean that any of these terms is useless.

Pinker’s concluding argument is that dignity is not entirely useless, for it is a “phenomenon of human perception”:

…certain features in another human being trigger ascriptions of worth. These features include signs of composure, cleanliness, maturity, attractiveness, and control of the body…This explains why dignity is morally significant: We should not ignore a phenomenon that causes one person to respect the rights and interests of another. But it also explains why

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458 See Maritain, cited above.
dignity is relative, fungible, and often harmful. Dignity is skin deep: it’s the sizzle, not the steak; the cover, not the book.\(^ {459}\)

Here again, Pinker confuses attributed and inherent dignity, as well as moral and aesthetic dignity. Surely none of the authors in the Report, nor my argument above, makes the claim that people have value because of things such as “cleanliness” or, perhaps more pertinently, “control of the body.” Rather, in spite of the perceptions of self or others, one’s value remains intact because one is a human person, who cannot be replaced.

Pinker, apart from a return to the invective that captures the general tone of the essay,\(^ {460}\) offers one last argument to support his case:

There is a second reason to give dignity a measure of cautious respect. Reductions in dignity may harden the perceiver’s heart and loosen his inhibitions against mistreating the person. When people are degraded and humiliated, such as Jews in Nazi Germany being forced to wear yellow armbands…onlookers find it easier to despise them…Note, though, that all these cases involve coercion, so once again they are ruled out by autonomy and respect for persons that gives us the grounds for condemning it.\(^ {461}\)

The example of Jews wearing armbands in Nazi Germany is an appropriate place to begin. When a person is deliberately treated in such an undignified way (an affront to attributed or personal dignity), it suggests something deeper: namely, a lack of

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\(^ {459}\) Pinker, 5.

\(^ {460}\) For example, “The sickness in theocon bioethics goes beyond imposing a Catholic agenda on a secular democracy and using ‘dignity’ to condemn anything that gives someone the creeps.” (Pinker, 5)

\(^ {461}\) Pinker, 5.
respect for the person’s value (inherent or basic dignity), which is not merely “skin deep.” It is also not, I would argue, a lack of respect for the person’s “rational nature” only—as Kant might say. Rather, it is also a disregard for the person as a unique and irreplaceable entity. Even the idea of armbands can be seen as an attempt to demystify the person and therefore to make every “non-person” seem like every other: replaceable (if desired). Such an example underscores why the incommunicability of persons is so crucial to understanding our own inherent value.
You matter because you are you. You matter to the last moment of your life, and we will do all we can do to help you not only to die peacefully, but also to live until you die.

--Dame Cicely Saunders, founder of St. Christopher’s hospice

Chapter V: The Community Solution

Toward a Phenomenology of Medicine

It would be helpful in this final stage to briefly propose other possible positive solutions to the euthanasia impasse. As a precursor to this discussion, we will start out, as Pellegrino has done previously, with a broad phenomenological reflection on medicine in practice.\(^\text{462}\) We first acknowledge that the physician-patient relationship is a profound experience of two persons, the clinical encounter where two “life-worlds” meet. Here we see an intrinsically dependent person (the sick or terminally ill patient) who reaches out of himself for the help of another. “The patient, for his part, is forced to trust the physician even if he wishes not to do so. At least he must submit even if he does not trust—if he wishes to be healed by this doctor.”\(^\text{463}\) The physician responds with a promise to strive to heal.\(^\text{464}\) This promise


\(^{463}\) Pellegrino (3), 196-197. There are, naturally, cases where the doctor-patient relationship does not fit this model—e.g., the fetus, the child, the comatose patient found at the side of the road and brought into the ER, etc—but in all of these cases, the physician ought to operate on the idealized model I have described, and, at the very least, the surrogate for the patient assumes that he does. One way to think of it is this: a distressed infant crawls to his mother, who holds him in her arms. Although there
is transparent—even public—but the trust between physician and patient is nevertheless intimate and critical to the relationship between the two persons. Everything that happens thereafter is dependent upon an assumed fidelity to that covenant.

Some supporters of EPAS have argued differently. Derek Humphry, for example, claimed this:

The help of a physician [in PAS] is imperative, because loved ones and family members untrained in the medical profession are rarely able to help a loved one to die... *A physician is not emotionally bound to the patient. There are no enduring intimate connections. Doctors are body technicians* and most of them are caring, loving human beings as well. [my emphasis]  

Such a view ignores the real (clinical) experience of physicians, who foster a bond to the patient through trust and the experience of her vulnerability; likewise, even in many of the personal narratives—often proffered by supporters of EPAS—which describe patients’ wretched conditions at the end of life, a plea for PAS or euthanasia is made through the medium of a close relationship with a physician.  

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464 This characterization excludes some acts which physicians perform—e.g., cosmetic surgery. In that case, the physician acts more as a technician or artist—seeking to beautify, rather than heal. As such, I would argue that although he still is a physician, he operates as something else. Physicians also perform other acts strictly outside their role as physician. For example, they often act as social workers, or, in my case as a pediatrician, a babysitter.  

465 Humphry, cited above, 8.  

466 See Quill (1), Anonymous, “Its Over Debbie,” cited above, and the Dax Cowart case, described above, for example.
Thus, other EPAS proponents would disagree with Humphry’s assessment of the physician-patient relationship. Quill’s “principle of nonabandonment,” for example, is founded on the notion of an abiding “covenant” between the physician and patient. Quill believes that such a relationship must exist if PAS is to be performed justly. He notes only two significant restrictions on this principle. First, a physician has the right to refuse to perform any act which violates his or her “fundamental values”; second, since the principle of nonabandonment requires additional time and energy commitments for physicians, physicians should make sure that they take care of themselves and their own need to “lead balanced, healthy lives.” The fundamental difference between supporters and opponents of EPAS with respect to the view of the physician-patient relationship is that (1) supporters consider the obligation of “nonabandonment” to include all of a patient’s wishes, including EPAS (provided they do not also violate physician conscience), while many opponents believe that true nonabandonment requires a fidelity to higher

467 See Quill (3), 24-36: “The obligation of nonabandonment emphasizes the longitudinal nature of a caring and problem-solving commitment between physician and patient. Principle-based ethical analyses of clinical actions sometimes focus on one moment in time and seek generalizable rules or answers. Patients and their families and physicians, however, do not have the luxury of existing in such isolation.” (29)

468 Quill (6): “[PAS] should be carried out only in the context of a meaningful doctor-patient relationship…Rather than create a new subspeciality focused on death, assistance in suicide should be given by the same physician who has been struggling with the patient to provide comfort care, and who will stand by the patient and provide care until the time of death, no matter what path is taken.” (1382). Interestingly, Quill says in the same paragraph that a physician need not have a “pre-existing relationship” with the patient who requests PAS, but must simply “get to know the patient personally” in order to understand her reasons for requesting it.

469 Quill (3), 34-35.
obligations such as beneficence and nonmaleficence, which would exclude EPAS; (2) supporters and opponents of EPAS differ over whether the “duty to heal” carries with it qualifications and limitations\textsuperscript{470}; if so, such limitations would reflect how we conceptualize the doctor-patient relationship itself.

A full explication of the fundamental nature of the doctor-patient relationship is beyond the scope of this work. However, it is worth briefly exploring, from the experience of healing within the context of this crucial dyad. The wounds which chronic or terminal illness can have on a patient can extend beyond the physical to encompass the psychological, emotional, and spiritual. We have discussed this profound sense of alienation in some detail in the preceding chapters. Pellegrino has called this an “ontological assault on the unity” of the person.\textsuperscript{471} The role of the physician as healer arises, phenomenologically, out of this experience of illness. As a physician, one is called to respond, to heal, but not simply to heal the physical body; rather, “to heal is ‘to make whole again’ and that entails confronting and ameliorating the ways illness wounds the humanity of the one who is ill.” [my emphasis]\textsuperscript{472} Quill believes that medicine “has its limits” and that when we have reached that limit of being able to alleviate suffering, the principle of nonabandonment requires physicians to go one step further and help patients actively

\textsuperscript{470} Supporters of EPAS would consider “killing” or a “duty to kill” as part of the “duty to heal.”


\textsuperscript{472} Pellegrino (5), 75.
take their life if they wish. What is confusing about this notion is the idea that (1) there is a limit to what “medicine” can do; but then, (2) as a part of the very profession which has these limitations to healing, physicians have a duty to then exceed those limitations.

What Quill is really calling for is an expansion of the doctor-patient relationship to include PAS, an expansion of what constitutes “good” medicine. However, such a view of the relationship between doctor and patient does not do justice to the phenomenological roots of the healing profession. For Quill, when one has done all one can “medically” do for the patient, and suffering continues, the continued “suffering with” is hopeless. What can we then do for the patient?

According to Quill and other EPAS supporters, we must help them fulfill their choice to die. Such a view describes an “act and react phenomenon,” where one agent “reacts” to another’s suffering, rather than responding in a way that is consistent with the very nature of the relationship. Take this simple example: suppose we imagine a marital relationship where the husband knows what is “required of him.” He appreciates the special bond of marriage, and the obligations and limitations marriage imposes. The marriage (like most) has its “ups and downs.” One day (during a long “down” period), his wife comes to him in tears, unhappy with her life, and expresses her desire to have a romantic relationship with another man, believing it will make her happier and improve their own marriage. Recognizing his oath to stay with her “for better or for worse,” the man consents. He
believes that the limitations of what can be done in the context of the marital relationship have been reached. He wants his wife to be happy and end her (existential) suffering. Yet, to consent to such a course of action is a mere reaction to the wife’s suffering, not a response; he has not pondered the reasons why she might be upset or what factors might prompt her to desire an extramarital affair. It is because she asked that he feels the duty to oblige. By reacting rather than responding, he cannot anticipate a truly loving response that takes into account her whole person and well-being. Looking at this scenario from the outside, there is also something else that strikes us as ironic: some actions which “expand marriage,” even if motivated from caring, might end up actually destroying marriage and being inconsistent with what we understand marriage to mean in the first place.

Let us take this example one step further. Suppose there are two communities. In one, fidelity is promised in marriage, but, if at some point an “unbearable limit” is reached, either partner may, with consent, have a romantic relationship outside the marriage (“extending the limits” of marriage). In the other community, couples are expected to be faithful to one another for life, and, if problems arise, they must “stick it out” with one another out of mutual respect for the covenant they have entered into. Others in the community (marriage counselors, clergy, etc.) are there to help. Which one of these communities really sees marriage in terms of “nonabandonment” of the whole person? If a rational person desired marriage, and wanted confidence in the faithfulness of the relationship, which
community are they likely to choose to live in? Finally, which community’s rules would engender trust from its citizens—a belief that others were really looking out for them?

In just the same way, a physician-patient relationship which rejects EPAS as an option offers the greater promise of nonabandonment, precisely because the patient knows that the physician is committed to him and to his (physical, psychological, emotional, existential, spiritual) suffering until death takes him naturally. The relationship with the patient includes a promise to strive to heal the whole person “even when cure is not possible.”

This bears out in practice. One qualitative study in a country where EPAS is legal (Holland) suggests that physicians who participate in the practice suffer a deep stress and ambivalence over their role. One physician interviewed noted:

*When euthanasia was not performed I found the deathbed a special aspect of the profession. It was an honour to be allowed to guide someone to his or her final moment. With euthanasia, I always feel: ‘was that necessary’? I hate it. The patient is no longer granted the time for a natural dying process. He’s saddled with the question ‘when do I want euthanasia’? To have to decide about the moment of death has created enormous unrest around the deathbed. (V, male)*

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473 Pellegrino (5), 75.

Thus, despite what a patient might choose to do, or desire to do, physicians ought to act in the best interest of the person (acknowledging medical limitations to relieve suffering, but recognizing that healing occurs in other ways). Pellegrino describes how autonomous decision making within the doctor-patient relationship, while crucial, has its limits:

The physician must strike the right balance for this patient between freedom that might be self-injurious and coercion that would impair a human decision. The physician must reflect on the existential and ontological nature of illness and his own healing acts if he is to sense when and to what degree persuasion is morally defensible…To stand idly by when the patient makes a patently bad choice without some effort at persuasion is a form of abandonment.\(^{475}\)

The trust and fidelity required of the physician-patient relationship is our starting point for examining more carefully a solution in the context of community.

_Toward A Community of Persons_

If we push our phenomenological reflection further, we place the terminally ill person in the context of the larger community. Whatever the solution is to the pain and suffering of the terminally ill, we know it is not something that can be accomplished by a single individual. Both euthanasia and assisted suicide necessarily involve at least one other person (apart from the terminal patient) directly (the

\(^{475}\) Pellegrino (5), 76-77.
physician or caregiver); and those persons are themselves imbedded in a human community.

Empirical evidence suggests that physicians and caregivers involved with EPAS decisions have serious negative emotional and psychological consequences, consequences which affect the doctor-patient relationship and the community itself. Such studies underscore the significance of the theoretical reflection we have just made on the covenant between physician and patient. A recent study in Oregon, where PAS is legal, demonstrated that many physicians feel “intimidated” to participate in the patient’s (and family’s) forceful requests for PAS and that countertransference plays a negative role in the doctor-patient relationship.476 Another qualitative study in the Netherlands showed that many physicians who participated in EPAS reported feelings of loneliness, tension, conflict with the family (including feeling “pressure” to participate), and a sense of “untoward pressure from society” to perform euthanasia. One physician in the study put it this way:

In the USA, there are people who execute the death penalty on authority of the judge. In Holland, we (as PCPs [primary care physicians], HvM) are appointed as such, to take someone’s life (A, female).477

It has been shown that among the terminally ill “the extent of caregiving needs was associated with interest in euthanasia and PAS.”478 As we have seen, terminally ill

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477 van Marwijk, et. al., cited above, 612.
patients often perceive themselves to be burdens on others, a factor that weighs heavily in their decision to pursue PAS. Thus, dependency, vulnerability, and suffering go beyond the dyad of physician and patient and extend to relationships between persons in a family, and that family’s relationship with the community.

Thus far I have shown how a reflection on Karol Wojtyla’s philosophical anthropology can be demonstrative of how one ought to view the human person at the end of life: a person who chooses the good in freedom; a physician and family who make a commitment to “suffer with” another, and thereby convey to the terminally ill that what she endures has meaning and value; and finally, that this person who suffers is unrepeatable and has a basic dignity which can therefore never be removed by affliction.

Finding an alternative to EPAS should reflect the kind of community we wish to build—a community where the person is central and has confidence in his value and worth, even at the end of life. It is prudent to return at this juncture to The Acting Person and examine Wojtyla’s role for the person in community. If requests for the EPAS are due in part to alienation from the community, following the commandment to love our neighbor, as Wojtyla suggests in the last pages of The Acting Person, is critical:

...the necessity of so coordinating acting and being ‘together with others”...will afford us the best protection from the dangers of alienation; in order to avoid this latter [danger] our

478 Emanuel (2), 150.

479 Wilson et. al., cited above; McPherson et. al., cited above.
concern must be to make the system of reference to the neighbor the ultimate criterion in the
development of the coexistence and cooperation of men in the communities.\footnote{AP, 298.}

Wojtyla also places all free acts (\textit{actus humanus}) of the person within the
context of a community of persons. All free acts are self-giving to oneself and to
another. He does not see the community as a “multiplicity of subjects,” a random
collection of individuals that happen to live together and are related accidentally: this
he calls a \textit{society}. He distinguishes society from \textit{community}, where community has
an integral \textit{unity} to its character.\footnote{PC, 239.} To further clarify, let us examine the difference
between Wojtyla’s distinction of community and society, and that of H. Tristam

Engelhardt defines community as a “body of men and women bound
together by common moral traditions and/or practices around a shared vision of the
good life, which allows them to collaborate as moral friends.” He goes on to define
society as “an association that encompasses individuals that find themselves in
diverse moral communities”—moral communities are a sort of “subset” of society.
Engelhardt is content with this state of affairs; humans fundamentally act from
within their own moral communities and interface with diverse moral points of view
in a society.
Immanuel Kant’s view of society and the social life of human beings can be even more sharply contrasted with Wojtyla’s. Kant’s lectures in *Anthropology* give us insight, for he sees the social life as a “life of discord and discontent,” a competition with one’s neighbor, a struggle against self-esteem and self-interest that leads to virtue:

[The human being] finds himself in the unsociable characteristic of wishing to have everything go according to his own wish. Thus he expects opposition on all sides because, in knowing himself, he knows that he, for his own part, is inclined to oppose others. Yet it is this resistance which awakens all the powers of the human being, making him overcome his propensity to laziness; and it drives him, by means of the mania for honor, domination, or property, to seek status among his fellows, whom he cannot *stand*, but also cannot stand to *leave alone* (*AK* 8: 21).\(^{483}\)

Wojtyla’s view of community is broader, more optimistic, and ultimately tethered to a teleological view of the person. What is a man called to do? To love another—and to love necessarily involves community. Thus, Wojtyla is not content with the implied separation of different “communities” interacting in “society,” as Engelhardt proposes. Rather, a person is by nature called to live in community with *all* other persons. The integral unity of the community is found both in shared lived experience, and also in the individual experience of each personal subject within the community. Because the human act involves *relational* participation, the lived experience of each subject and the whole are both distinctive aspects of this unity.

\(^{483}\) Wood, A., cited above, in *Essays on Kant’s Anthropology*, 54-55.
Thus, the suffering of the terminally ill person, and her ethical acts, necessarily impact the community at large; the actions of the community, in turn, crucially effect participation of the person:

Community, therefore, seems to be the more essential reality, at least from the point of view of the personal subjectivity of all the members of a given society or social group. From this it becomes clear that the social relations in a given (one and the same) society can become a source of alienation in proportion to the disappearance of community, that is, in proportion to the disappearance of relation, bonds, and social unity perceived and experienced by the individual subjects.\textsuperscript{484}

The community is essential for human existence and is necessary both as something in principle (it has an “ideal meaning”), and something practical (it has a “real meaning”). Its meaning, as “real and ideal,” is therefore “ontological as well as axiological, and hence also normative.”\textsuperscript{485} Years later John Paul II would argue that a lack of community is seen as a pathological consequence of a false view of freedom:

This view of freedom [in euthanasia] leads to a serious distortion of life in society. If the promotion of the self is understood in terms of absolute autonomy, people inevitably reach the point of rejecting one another. Everyone else is considered an enemy from whom one has to defend oneself. Thus society becomes a mass of individuals placed side by side, but without any mutual bonds.\textsuperscript{486}

\textsuperscript{484} PC, 239.

\textsuperscript{485} PC, 239.

\textsuperscript{486} EV, I para. 20.
Not only is this a rebuke of Kant’s anthropological view of society, but it is also the beginning of a positive case for “mutual bonds”—for love—as the fundamental building block of a community. Persons reach out to each other not to serve their own interests, nor to resist the temptation to do so; rather, persons reach out to one another because that is their purpose—to love. In love, the person and her dignity is revealed. Anything short of this is a society in need of healing.

I-Thou and the Common Good

The common good of the community is derived directly from its axiological meaning, from the objectification of its value. What is the common good? We must begin with the we dimension of community, which, according to Wojtyla, signifies a set of persons, each of whom as individuals act “together with another.” The actions of each person in the community, however, are related to a single value, and this is the common good. The common good is the social dimension of the community; but it is critical to realize that the persons that comprise the social dimension never stop being persons—they remain “I’s” and retain their infinite value, despite the fact that they orient themselves toward the we.

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487 PC, 247.

488 Wojtyla cites marriage as the best example of the we dimension, for here the couple retains an I-Thou interpersonal relationship despite orientation toward the social (common) good of the family. “In fact,” he notes quite powerfully, “their I-Thou relationship in its own way draws upon the we relationship and is enriched by it.” (PC, 247-248)
A lesson for the EPAS dilemma can be drawn from this compelling view of
community and the common good. Despite the sickness and suffering of a person,
and despite the possible social or economic utility of ending his or her life, the
person is still a transcendent being of inestimable value who establishes an openness
to relations with others (and, for some, especially to God); yet, he also exists in a
community. Jacques Maritain claimed that the very idea of personhood requires
membership in community—that is, community itself arises out of the dignity of the
human person, and not simply out of need. The common good is for the person—it
reaches beyond society and each person in turn transcends his participation in that
society:

A single human soul is worth more than the whole universe of material goods. There is
nothing higher than the immortal soul, save God. With respect to the eternal destiny of the
soul, society exists for each person and is subordinated to it.\footnote{Maritan, cited above, 61. See also, Wojtyla’s own words (EV, 101): “The Gospel of life is for the whole of human society. To be actively pro-life is to contribute to the renewal of society through the promotion of the common good. It is impossible to further the common good without acknowledging and defending the right to life...a society lacks solid foundations when, on the one hand, it asserts such values as the dignity of the human person, justice and peace, and then, on the other hand, radically acts to the contrary by allowing or tolerating a variety of ways in which human life is devalued and violated, especially where it is weak or marginalized. [my emphasis].“}

We must reflect at this juncture on the nature of what Karol Wojtyla calls the I-Thou
dimension of community. First of all, we are, as persons, intimately connected with
another, precisely because the Thou is “another I.” Because this “other I” could be
any other I, in a sense, a relation to another is also a relation to all human beings.
Because I identify with the other, “the thou contributes to my [own] self-
affirmation.” With EPAS, the opposite is true, since one party can be seen as perceiving the devalued self, and the other affirming that assessment. Thus, it is only through the experience of real love that we come face to face with human freedom in its fulfillment. As Dell’Oro eloquently writes:

The experience of love is an experience of transcendence because the Other is willed in its otherness, irreducible to my needs, my fulfillment, my sense of lack. Moral experience is, in this sense, a response to what is intrinsically valuable and must be affirmed in itself…Freedom released to its own true self in love shows that there is a freedom beyond autonomy.\footnote{491}

In this respect, every single member of the human community is important to us, and ought to be respected, and ought not to be deliberately killed no matter what their condition because of the reflexivity and reciprocity of the \textit{I-Thou} dimension to community. When we value and love them, we value and love ourselves in the process; and of course, the reverse is also true.\footnote{492} This is the case because our relation to the other is tied inextricably to the human act: “The human being—both the \textit{I} and the \textit{thou}—is not only an existing subject but also an acting subject, and in this acting the \textit{thou} becomes at every step an object for the \textit{I}.”\footnote{493} This is, in a sense, a

\footnote{490}PC, 241-243.

\footnote{491}Taylor and Dell’Oro, 25.

\footnote{492}Here, Dell’Oro (in Taylor and Dell’Oro, cited above, 25) cites rightly the work of Emanuel Levinas in providing additional insight: “[T]he call if the Other [is] an exodus, an experience of coming out of oneself toward the Other. [Levinas] understands that the relation between self and other must shift ontologically (I should say metaphysically) in favor of the primacy of the Other…Such is for Levinas the nobility, the dignity of the human.”

\footnote{493}PC, 244.
brief sketch of a philosophical justification for the Golden Rule. It is also yet another lens in which to view the physician-patient relationship. Seen in this light, the role of the physician (or broadly, the caregiver) becomes—rather than a passive relationship of informed consent, diagnosis and care—an ontologically dynamic experience. The caregiver reaches actively to draw the person to “another I” by grasping his value, and the vulnerable, terminal patient sees in the caregiver the mirror of himself: I am valued like her because she suffers with me.

Respect is given to the other precisely because the Thou is “another I,” one with self-determination, self-possession, and self-governance, and the basis for this mutual relationship within the community permeates the entire community with a normative meaning:

...there ought to be a mutual self-revelation of persons...The more profound, integral, and intense the bond between the I and the thou in these mutual relationships, and the more it takes on the character of trust...  

I propose that the I-Thou relation should thus be seen as a model blueprint for the doctor-patient relationship, one that engenders a profound respect for persons as moral subjects. This could certainly be part of the solution to the euthanasia problem, from the perspective of the health care community, and in fact from the community at large—to see the other as oneself. Only in this way will we discover Wojtyla’s vision of human dignity:

\[494 \text{PC, 245.}\]
...the _I_ and the _thou_ abide in a mutual affirmation of the transcendent value of the person (a value that may also be called _dignity_) and confirm this by their acts. Only such a relationship seems to deserve the name _communio personarum_.

_Solidarity_

A final aspect of the _we_ dimension of community is worth noting—namely, the concept of _solidarity_. As we have seen, EPAS can threaten the trust and solidarity found in the physician-patient relationship; those that desire EPAS for themselves are often motivated by a “loss of a sense of self” and “feelings of being a burden to others.”

If this is true, then it seems pressing that we incorporate into an ideal community, a solution to suffering which fosters solidarity between persons. Wojtyla claims that solidarity is a natural consequence of the fact that humans live and act together—it is contained in the actions of each person for the benefit of the whole, the actions for the “common good,” which elevate both the person who acts and the object(s) of action. Alasdair MacIntyre would take up this cause for

495 PC, 246.

496 See, for example, Kass (1), 35.

497 Pearlman et. al., cited above, esp. 236-238. See also Wilson, et. al., and McPherson et. al., cited above.

498 AP, 284-285. Others have viewed the notion of “solidarity” in a different way. R. Rorty, for example, in extending the notion of compassion to that of solidarity, suggests that solidarity involves a kind of “increasing sensitivity” to another. “Rorty thus finally proposes a new definition of a person in morality as ‘something that can be humiliated,’ meaning that he sees the only necessary shared social tie in the recognition of human sensitivity for another’s/other’s humiliation.” (Skof, Lenart, “From Compassion to Solidarity: The Ethical Self, Values, and the Society,” _Synthesis Philosophica_, 220
solidarity, in calling for a society which incorporates dependence into its social fabric. By contrast, a society which permits EPAS distorts the notion of “community.” The message sent to the dependent and vulnerable is that their experience is understood but alien; that there is empathy but not sympathy; that if dependency is perceived to be an intolerable burden by the person, then it is also intolerable for society. Instead, we ought to view vulnerability as an inseparable part of living in a communion with others—not a condition to escape from or fear. It is in the vulnerable sick person that we realize our own vulnerabilities, and in doing so, learn something of the value of humanity. Thus the terminally ill person can actually foster solidarity as well. Wojtyla understood this point well. In addressing patients and workers at a hospice facility in 1998, he noted:

No one who visits this hospice goes home disappointed. On the contrary, the visit is more than a tour. It becomes an encounter. By their mere presence, the sick, suffering, and terminally ill patients invite the visitor who meets them not to hide the reality of suffering and death from himself. He is encouraged to be aware of the limits of his own life and to face them openly. The hospice makes one understand that dying means living before death.

Vol. 20 (1); 2005: 141-150, quoted from 148.). This is obviously a vastly different view of the person from Wojtyla’s account, where the person is central and the very raison d’être of community.

MacIntyre, cited above, 130.

“Living Before Death”: Palliative Care and the Hospice Movement

The case I will present below will argue that access to, and improvement of, palliative care (including hospice) represents one practical solution to the problem of euthanasia and assisted suicide. Palliative care is a highly specific approach to the physical, psychological, and, crucially, the existential suffering that patients identify as a concern at the end of life:

In a recent focus group study about what was important in care at the end of life, patients cited a variety of concerns, including freedom from pain and the opportunity to choose their place of death. They also pointed out two other factors that had not been previously well identified: their desire to be cared for ‘as whole person,’ with attention to their spiritual, religious, and cultural beliefs, and their wish to be identified as contributing to, and maintaining a role in society. No longer having a social role is described by patients as a major reason they view themselves as a burden not only to their families, but to themselves.501

A strong societal commitment to the palliative care movement is consistent with the notion of an authentic community I have outlined above and places the suffering person at the center of compassionate care, in a society which continually affirms her value. The World Health Organization defines palliative care in this way:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care: provides relief

501 Foley, Kathleen, in Foley and Hendin, cited above, 301-302.
from pain and other distressing symptoms; affirms life and regards dying as a normal process; *intends neither to hasten or postpone death*; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated; will enhance quality of life, and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. [my emphasis]502

In 1997, a WHO study, *Cancer Pain Relief and Palliative Care*, clearly separated EPAS from palliative care, urging member states not to even consider EPAS “until they had assured for their citizens the availability of services for pain relief and palliative care.”503 Those who work in the field of palliative care “are experts in the domains of communication; symptom management; coordination of care, including hospice and community resources; psychosocial and spiritual realms; grief and bereavement; and legal and ethical concerns. Typical teams may include a physician, nurse, social worker, chaplain, bereavement counselor, volunteer, pharmacist, and


Thus, palliative care as a branch of medical practice represents a very broad attentiveness to the biopsychosocial needs of the patient. Palliative care is always an active intervention. It is not simply “letting the patient die,” nor is it necessarily applied only in the last six months of life. Rather, palliative medicine can and should be operative in any patient “for whom curative treatment is no longer the goal of care.”

Palliative care teams have seen a significant increase in number since 2000 and are present in a variety of different settings—from hospitals to home care programs. The Supreme Court, in denying a right to assisted suicide, has, according to one author, even established a “constitutional right to palliative care.” This expansion represents just one component of “success” in palliative care: there is also access and quality. A recent evidence-based review indicated a variety of areas where effective palliation could be improved, including more regular assessment of pain, better use of available pharmacological agents for pain, dyspnea, and

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504 Morrison and Morrison, cited above, 984.

505 Post and Dubler, cited above, 18. One outstanding example of comprehensive, effective palliative care of which I am personally familiar is the FOOTPRINTS program at Cardinal Glennon Children’s Hospital, in St. Louis. See Toce, Suzanne, and Collins, Mary Ann, “The FOOTPRINTS model of Pediatric Palliative Care,” *Journal of Palliative Medicine*, Vol. 6 (6); Dec. 2003: 989-1000.

506 Morrison and Morrison, 997-998. This review of palliative care and pain management states that the number US hospitals with palliative care teams increased from 15% to 25% between 2000 and 2003. Of course, this fact indicates that much more still needs to be done to make palliative care universally accessible.

depression, and improved advance care planning.\textsuperscript{508} The “palliative care movement” takes its roots from hospice programs, which began in the US in the early 1970s.

Hospice, in turn, is seen as a “key subset” of palliative care.\textsuperscript{509} The hospice movement can be traced back to the European Middle Ages, born out of a Christian sense of duty to the sick and suffering.\textsuperscript{510} Then, “hospice” and “hospital” were nearly synonymous, faithful to their Latin root (\textit{hospitalis}, meaning “friendly” or “welcoming”); a hospice was a place (usually along a pilgrimage route) that a sufferer came to rest, receive food and drink, sometimes recover, and sometimes die. Although for most, 1967 marks the beginning of the modern hospice movement with the opening of St. Christopher’s Hospice in London. Its founder, Cicely Saunders, notes that concepts of the modern hospice were already established by the mid-nineteenth century (Jeanne Garnier’s “\textit{Calvaries},” [1842]), and variations of “home hospice” were operating soon after than.\textsuperscript{511}


\textsuperscript{509} Morrison and Morrison, 998: “In this sense, all those receiving hospice are receiving palliative care, but not all those receiving palliative care are receiving hospice.”

\textsuperscript{510} See Herranz, Jesus, “Palliative Care: Origins, Precedents, and the History of a Christian Approach,” \textit{Dolentium Hominum}, Vol. 20 (1); 2005: 54-63. Herranz’s historical analysis also shows how the concept of palliative care has been, since its inception, compatible with a Catholic philosophical interpretation of suffering and death.

Hospice in the US is defined by the Medicare Hospice Benefit (1982) and may have one of four aspects: (1) inpatient care; (2) continuous care; (3) home care; and (4) respite. Ninety-percent of hospice care in the US occurs in the home setting. The hospice patient must have a natural prognosis of 6 months or less, and must agree to a treatment plan of palliation, rather than “life-prolonging” or “disease modifying interventions.” As of 2006, the number of hospices in the US reached nearly four thousand, with over 1 million patients served. There are then, alternatives extant in society such as hospice, which reflect the norm of solidarity and are an authentic community response to the pain and suffering of terminal illness. The hospice movement expresses a community’s acknowledgement of another’s suffering and is motivated by the continued dignity of the sufferer: “Hospice work arose from this conviction. Its goal is to respect the dignity of the elderly, sick, and dying by helping them to understand their own suffering as a process of growth and fulfillment in life.” But a commitment to hospice care is more than that—it is a cultural lesson that creates, in Wojtyla’s words, “a community of suffering” that can reflect back to society and teach it:

512 Acknowledging the difficulty of defining “the end of life,” and its various definitions for the purpose of hospice enrollment, the authors of one review article noted that many clinicians are asking the question “Would it be a surprise if this patient were to die within 6 months?” (See Lorenz, Karl, cited above, 150.)

513 Morrison and Morrison, 998. The authors note that some hospices define “palliation” broader than others, to include, for example, blood transfusions and tube feeding.

514 Morrison and Morrison, 998. Hospices serve most Americans who die from cancer, and 10% of all other adult deaths. (See Lorenz, Karl, et. al., cited above, 147.)

Willingness to accept the limits imposed by birth and death, learning to say ‘yes’ to the basic passivity of our life, does not lead to alienation. It is rather the acceptance of one’s own humanity in its full truth with the riches that belong to every phase of earthly life. Even in the frailty of the last hour, human life is never ‘meaningless’ or ‘useless.’ A fundamental lesson for our society…can be learned precisely from patients who are seriously ill and dying. They remind us that no one [save God] can determine the value or non-value of another person’s life, not even his own.\textsuperscript{516}

A social commitment to palliative care, including hospice, is certainly not a panacea, but it represents a good “moral starting point,” a step in the right direction. It would be wrong to suggest that palliative care practices are perfect or ideal or that improving palliative care options at the end of life is a “simple fix.” On the contrary, textbooks have been written about the need to improve and expand palliative care and hospice care, the details of which go beyond the scope of this study.\textsuperscript{517}

If the relief of isolation and the perception of an eroding autonomy are crucial to diminishing the inherency of legalizing EPAS, then the \textit{communication} of oneself in solidarity with the patient is critical for the health care providers. Empirical

\textsuperscript{516} Pope John Paul II, “Message to the Sick and Suffering,” cited above, 3.

\textsuperscript{517} For an interesting analysis of some of the conceptual or philosophical barriers to improving palliative care, see Zimmermann, Camilla, and Wennberg, Richard, “Integrating Palliative Care: A Postmodern Perspective,” \textit{American Journal of Hospice and Palliative Medicine}, Vol. 23 (4); August/September 2006: 255-258. Zimmermann and Wennberg identify three “false dichotomies” that pose problems to integrating palliative care with medicine as a whole: (1) the dichotomy between naturalized versus medicalized death (they propose that palliative and hospice care can successfully integrate modern technology); (2) the dichotomy between research-oriented care versus clinical care (they suggest that hospice patients should still have access to research seeking to improve their condition and quality of life); and (3) the dichotomy of denying death (“medicine”) versus accepting death with palliative care (they suggest that patients need not explicitly acknowledge that death is near in order to be treated with palliative care).
evidence suggests that hospitalists, residents, and nurses all have significant
cognitive, attitudinal, and psychological barriers to ideal palliative care. Yet, these
studies also indicate that barriers could be overcome with better training in the use of
palliative medicines; information and education about hospice eligibility; and greater
emphasis on communication skills between families, patients, and providers—as
well as between providers (e.g., physicians and nurses).

Communicating solidarity can occur in a variety of ways, from sitting and listening to the concerns of the dying
at the bedside (presence), to more frequent bedside checks (attentiveness), to
delivering bad news in a sensitive way (empathy), to interacting with the patient’s
family in a way which conveys the universal love for the person (sympathy). All of
these things may require practice and re-emphasis—training which could certainly
be improved in medical schools, residencies, and hospitals today.

Charles Von Gunten proposes three improvements to palliative care, directly
related to the empirical data indicating why patients’ symptoms remain unrelieved at
the end of life. These solutions include (1) providing better health care professional
training to recognize and relieve terminal symptoms; (2) obtaining additional
evidence-based data on precisely which symptoms need relief in the terminally ill;

518 See Espinosa, Laura, et. al., “Barriers to Intensive Care Unit Nurses Providing Terminal Care: An
Integrated Literature Review,” Critical Care Nursing Quarterly, Vol. 31 (1); 2008: 83-93; See also
Cherlin, Emily, et. al., “Common Myths about Caring for Patients with Terminal Illness:
Opportunities to Improve Care in the Hospital Setting,” Journal of Hospital Medicine, Vol. 2 (6);

519 See for example, Wood, Emily, et. al., “Enhancing palliative Care Education in Medical School
Curricula: Implementation of the Palliative Education Assessment Tool,” Academic Medicine, Vol. 77
(4); April 2002: 285-291. See also, Morrison and Morrison, cited above, 997.
and (3) encouraging better utilization of existing palliative care resources, such as hospice.\textsuperscript{520} For example, Van Gunten cites studies that show that patients who were enrolled in hospice programs had much better pain control than those cared for in a hospital, nursing home, or home health system. “Yet, the evidence base upon which all of these systems draws is the same. The data illustrate that there is something significant about the system that is different among these four settings. Exactly what [from an empirical standpoint] hospice programs do that is different from other settings is unknown.”\textsuperscript{521}

There are also other legal, regulatory and financial problems within the palliative care system, ranging from a lack of standardization of practices, to poor compensation from insurance companies, to Medicare reimbursement rules which require patients to have 6 months or less to live and give up access to all other medical therapies.\textsuperscript{522} Proposals to ameliorate these problems have been offered in the literature, and a detailed analysis of palliative care reform goes beyond the scope of this study. It is fair to say, while acknowledging current problems, assessments as to

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520 Von Gunten, cited above, S-90-93.
521 Von Gunten, cited above, S-93.
522 The Medicare rules have led to patient reluctance to enroll in hospice, due to fears lack of continuity with long-term providers. It has also spurned fears of audits by hospice facilities because patients are “living to long.” The “unintended consequence of this government oversight has been to force hospices into admitting patients often ‘on the brink of death,’ limiting their ability to provide comprehensive care to patients and families early in the dying process.” (Foley, in Foley and Hendin, 308)
\end{flushright}
the practical nature of legal, regulatory and financial improvements remain optimistic.\textsuperscript{523}

\textit{Objections to Palliative Care and Hospice as a Solution to the EPAS Debate}

Since the early 1990s, when interest in PAS resurfaced in the United States, opponents of the movement have offered, with varying justifications, commitment to palliative care as a morally acceptable alternative to EPAS. John Conley, for example, years ago described the stark contrast between assisted suicide and hospice care:

The hospice movement permits patients with terminal illness to accept their impending death in a rich social environment...Many hospices are currently experimenting with new forms of solidarity...The key contribution of the hospice is its social network of preparation for death in communion with one’s basic communities of identity...[by contrast, so-called] good death floats on the fable of the island self. It blindly obeys a society for which the sick are unsupportable burdens and which veils its will to kill behind the mask of freedom.\textsuperscript{524}

It is also equally fair to say that proponents of EPAS have responded to—even anticipated—these arguments, and many authors have leveled several counterarguments against the claim that hospice care and palliation would be a better

\textsuperscript{523} See Foley, Kathleen and Hendin, Herbert, “Changing the Culture,” in Foley and Hendin, cited above, 312-332.

\textsuperscript{524} Conley, 14-15.
alternative than EPAS. I will discuss what I consider to be the two most significant of these counterarguments, although my list is certainly not exhaustive.\footnote{See, for example, Putnam, Constance, \textit{Hospice or Hemlock?: Searching for Heroic Compassion}, (Westport, CT: Praeger Publishing) 2002. Putnam critiques the hospice movement’s philosophy of separating assisted-suicide from hospice, ultimately arguing that this constitutes a false dichotomy, and that, as Timothy Quill (the author of the foreword) puts it, “compassion and self-determination are complementary and not incompatible.”(xii)}

\textit{(1) EPAS and palliative care are not mutually exclusive.}

There are several distinct “prongs” of argumentation under this heading which require further elaboration.

\textit{(a) EPAS advocates argue that there ought to be no practical distinction between the coexistence of PAS or euthanasia and palliative care, although the two are conceptually distinct.}

For example, evidence from Oregon has suggested that the separation between hospice and PAS may not be so stark; one author notes that “three quarters of the patients who have died under [Oregon’s] Death with Dignity Act have been simultaneously enrolled in hospice programmes. [Physician-assisted dying] might be offered as an option within palliative care, for those for whom pain relief is not the primary issue.”\footnote{Steinbock, B., “The case for physician-assisted suicide: not (yet) proven,” \textit{Journal of Medical Ethics}, Vol. 31, 2005: 237.} So why not simply change the definition (WHO’s definition, or whomever’s) to \textit{include} EPAS? Marcia Angell argued:
I am also concerned that the hospice and palliative care movement, as it has grown in importance and influence, has developed a mindset typical of many specialized disciplines: a professional pride that borders on hubris and rigidity…This ideal of the good death [espoused by the palliative care movement] does not leave much room for patients for whom control and independence are highly important—people like my father, people who dread dying more than they fear death…But it is wrong to assume that all people will approach death the same way. Some will, indeed, become hospice patients, but others will rail against the dying process until the end, and they will want that end to come sooner. They too are human. We should be careful not to impose our view of the good death on others.527

My response to this argument is as follows. First, the philosophy of EPAS and that of the palliative care movement are not simply conceptually incompatible, they necessarily contradict each other and sometimes seek to explicitly undermine each other. EPAS advocates argue that when pain and suffering cannot be relieved, or life cannot be lived in a dignified way, the compassionate response which respects autonomy is to hasten the patient’s death, either by her own hand or that of another. Palliative care suggests that nearly all pain can be relieved, and for intractable pain and suffering, the solution is a comprehensive attentiveness to the person’s biopsychosocial-spiritual needs, while patients can always be treated with dignity.

How can the two notions be integrated into a rational whole?528 The hospice and

527 Angell, cited above in Quill (3), 22.

528 I am reminded here of the current debate over sexual abstinence-only education versus a contraceptive-based approach that acknowledges the need for attempting sexual abstinence first. For proponents of sexual abstinence, the belief is that the very philosophy of chastity is undermined when an option for sexual intercourse prior to marriage is offered simultaneously, or with the assumption that sexual abstinence will fail. Perhaps another example will help to clarify: when counseling against smoking (a known harm), no responsible physician also offers (simultaneously, or after the fact) the
palliative care movements find hope in a person-to-person intimacy; the EPAS movement claims that, at some point, the hope for a meaningful life is lost.

Michael Burgess lends support to this idea, noting from a sociological point of view, that “medicalization” of active euthanasia may undermine priorities in palliative care:

Medicalization is a method of social analysis which evaluates the effects of accepting a technology or practice as a response to particular individual needs…Active euthanasia provides a technical response to those whose suffering is intolerable and interminable…It is possible that acceptance and use of active euthanasia may result in the restricting of relevant medical interventions and of research into palliative methods. Despite the best intentions of professionals dedicated to palliative care, funding priorities and institutional policies could render some palliative needs orphans of funding and research opportunities…Similarly, the promotion of a medical or healthcare response may result in a reduction of attention to, and funding for the remaining social and personal problems. 529

The philosophies also differ on a larger, “macro,” level if we recall the distinction between society and community. A society where each person looks out for his or her own needs, and interact as independent persons who happen to come together for particular needs and goals is a philosophy of alienation. This stands in sharp contrast to a community of persons who acknowledge and embrace their intersubjective dependence (participation) and come together for one another. Earlier, I had

option of smoking low-tar cigarettes, or chewing tobacco. If cigarettes are known to kill and be “bad for you,” how can any form of it be offered at the same time a physician hopes to convince the patient to avoid any tobacco?

suggested that theoretically (re)defining the marital relationship is a good analogy to (re)defining the doctor-patient relationship. In that example, we saw that inserting something like “infidelity” into the definition of marriage would undermine the very things which marriage exists for, its fundamental meaning; likewise the incorporation of EPAS into the physician-patient relationship contradicts the phenomenologically-discovered basis for that relationship. Applying the same reasoning here, the integration of EPAS with palliative care undermines what “palliative care” means and prevents deepening our commitment to it.

Second, the option of EPAS as an extension of palliative care will likely place additional psychological pressure on patients to choose it over hospice or comprehensive palliation. EPAS offers the “quick way out,” and to a patient who is suffering and already feeling like a burden, this option may appear more attractive. EPAS may also appear more attractive to physicians, family members, and even society. As we have seen in the qualitative studies cited above, families and physicians feel pressured to act to hasten death, including acting in the “best interests of society.” This would be particularly true in socialized or nationalized health care systems, where economic costs become paramount.530

530 I am aware that a recent study, published by proponents of EPAS (Margaret Battin, Agnes Heide, and Linda Ganzini, et. al., “Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact of patients in ‘vulnerable’ groups,” Journal of Medical Ethics, Vol. 33; 2007: 591-597.) has claimed that vulnerable populations are not at greater risk, based on empirical evidence from Oregon and the Netherlands. A comprehensive look at the data and subsequent claims of this study is beyond the scope of this work. However, it should be noted that there are serious flaws in the claims the authors make. Battin, et. al., for example, did not perform a meta-analysis of the data and did not summarize or standardize the different studies to allow them to be comparable to one another, or to any other qualitative or quantitative studies. They admit that “substantial differences in the
Third, the empirical evidence from Oregon indicating that many terminally ill patients are enrolled in hospice and then choose PAS is actually troubling, not reassuring. It suggests that the terminally ill may be abandoning hospice care (prematurely) since “another option” is readily available to them. If the patients choose PAS because of a failure of hospice, then we would be hard-pressed to push to remedy those failures. Why should we improve palliative care, if another purportedly morally acceptable, less burdensome option (for the patient, family, physician, and society) is accessible?

Fourth, we must ask why we should include EPAS (a morally problematic option) within palliative care (a morally licit option). What are the risks versus the benefits? Proponents will say that the Argument from Autonomy is reason enough to act now, but if I am right, then the Argument from Autonomy rests on a dubious anthropology and does not alone justify EPAS. Also, we should consider the possibility that inclusion under the rubric of palliative care would act as a reflexive, independently legitimizing factor for EPAS. Thus, we must recall our rational duty to prudential judgment in ethical decision making. To incorporate EPAS as an option methodologies of the source studies make it impossible to determine the certainty of the actual incidence of assisted dying in several of the vulnerable groups studied.” (594). Despite this acknowledgement, they go on to assert that, for example, there is no evidence of heightened risk of the elderly being pressured into consenting to EPAS. However, what they have done to make that claim is to simply say that (only) 10% of those who died by PAS in Oregon were older than 85 years, whereas in Oregon 21% of all deaths were of people in this category. A similar comparison was done in the Netherlands. (594). Simply comparing rates of EPAS to the general population leaves crucial several open questions: (1) What were the qualitative factors that went into the decision of the elderly to choose EPAS versus to die naturally? (2) What is the estimated rate of involuntary EPAS in these areas? (3) How does a number like the “percentage of elderly people who choose EPAS” give us confidence about the pressure legalization might have on the decision-making process prior to choice—particularly in light of data from empirical studies about why people choose EPAS (“hopelessness,” “feeling like a burden,” etc.).
within palliative care is at best, morally unsafe, and, if I have been right thus far, is at worst, morally unsound.

(b) **EPAS proponents claim that certain aspects of palliative care, such as terminal or palliative sedation, are conceptually indistinct from EPAS, and therefore if one is tolerated, the other ought to be also.**

Terminal sedation has been defined as administering sedatives which induce unconsciousness in the imminently dying terminally ill, conscious patient with intolerable symptoms or unrelieved suffering. It is generally accepted to have the following characteristics: (1) alternative means of relieving suffering or symptoms by standard palliative care have failed or are intolerable; (2) “this therapy has a dose-dependent side effect of sedation that is a foreseen but unintended consequence of trying to relieve the patient’s symptoms”; (3) the patient’s death is imminent (at the most, a lifespan of a few weeks); and (4) “this therapy may be coupled with the withdrawing of withholding of life-sustaining treatments that are ineffective or

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531 Some authors have chosen to use “palliative sedation” rather than “terminal sedation” to clarify that the former does not intend to cause the patient’s death. Yet, the terms have been conflated. One author argues that “palliative sedation” should be available for patients who are terminally ill but “moribund, in cases involving the withdrawal of artificial nutrition and hydration, and in cases involving existential distress rather than physical symptoms.” (Lo, Bernard, and Rubenfeld, Gordon, “Palliative Sedation in Dying Patients: We Turn to It When Everything Else Hasn’t Worked,” *Journal of the American Medical Association*, Vol. 294(14); October 12, 2005: 1810-1816, quote from 1813.) Another author defines “terminal sedation” as “bringing the patient into deep sedation while forgoing artificial nutrition and hydration,” without reference to intent at all. (See Rietjens, Judith, et. al., “Terminal Sedation and Euthanasia: A Comparison of Clinical Practices,” *Archives of Internal Medicine*, Vol. 166; April 10, 2006: 749-753. [Henceforth, Reitjens (2)])

532 See Lo and Rubenfeld, cited above, 1812.
disproportionately burdensome.\textsuperscript{533} An example of appropriate terminal sedation is proffered by Jansen and Sulmasy: a terminal patient, imminently dying, has an intractable symptom (e.g., myoclonus). The physician treats this symptom with benzodiazepines, which, as a side-effect, precipitate a coma; the patient dies a few days later.\textsuperscript{534}

Other authors, such as Timothy Quill, have altered these conditions to include what they term “voluntary stopping eating and drinking.”\textsuperscript{535} In these cases, the patient has no underlying condition that interferes with digestion or absorption, but wishes to end their life by stopping eating and drinking. The physician advises the patient they may (legally, ethically) stop eating and drinking and prescribes sedating medication to make death “as comfortable as possible”; the patient subsequently dies.

In addition, Quill and others have proposed what Jansen and Sulmasy call “sedation toward death”: a practice in which “1) the patient need not be imminently dying; 2) the symptoms believed to be refractory to treatment are simply the consciousness that one is not yet dead; 3) the patient’s physician selects therapy

\textsuperscript{533} Jansen, Lynn, and Sulmasy, Daniel P., “Sedation, Alimentation, Hydration, and Equivocation: Careful Conversation about Care at the End of Life,” \textit{Annals of Internal Medicine}, Vol. 136; 2002: 845-849. [Henceforth, Jansen and Sulmasy (2)], quotes from (845); See also Lo and Rubenfeld, 1812.

\textsuperscript{534} Jansen and Sulmasy (2), 846.

\textsuperscript{535} See Quill (7), cited above.
intended to render the patient unconscious as a means of treating refractory symptoms; and 4) other life-sustaining treatments are withdrawn to hasten death.”

Despite what Quill and other proponents of EPAS argue, there is clearly an intuitive moral difference between palliative sedation, voluntary stopping of eating and drinking, and sedation toward death. The Principle of the Double Effect is, as Jansen and Sulmasy point out, “the best, albeit not necessarily the only” explanation of the differences between the three. The latter two methods of sedation violate the Principle of the Double Effect by their (1) intention; (2) use of the bad effect (ending the patient’s life) as a means of achieving the good effect (the relief of suffering); and (3) violation of the Principle’s proportionality requirement. In addition, voluntary stopping of eating and drinking may be seen as a collaboration in suicide, which most clinicians (although not all) would be opposed to.

536 Jansen and Sulmasy (2), 845.

537 The Principle of the Double Effect was summarized in Chapter II. The debates surrounding its use are beyond the scope of this work, although it should be noted that Quill rejects the principle [See Quill (8)]. Sulmasy defends the Principle and its use in several excellent papers; his footnotes 6-11 in Jansen and Sulmasy (2) cite further defenses. See Sulmasy, Daniel P., “The Rule of Double Effect: Clearing Up the Double Talk,” Archives of Internal Medicine, Vol. 159; March 22, 1999: 545-550. [Henceforth, Sulmasy (6)]. See also Sulmasy, Daniel P., “Double Effect—Intent is the Solution, Not the Problem,” Journal of Law, Medicine, and Ethics, Vol. 28(1); Spring 2000: 26-30. [Henceforth, Sulmasy (7)]. Mark Carr and Gina Mohr offer another defense of its use in appropriate palliative sedation in “Palliative Sedation as a Part of a Continuum of Palliative Care,” Journal of Palliative Medicine, Vol. 11 (1); 2008: 76-81.

538 “Reasonable clinicians will disagree about what constitutes a proportionate reason, but the need to treat existential suffering clearly is not sufficient. If it were, then it would be ethically and medically appropriate to terminally sedate a patient with no underlying physiological condition.” (Jansen and Sulmasy (2), 847).

539 This is suicide rather than PAS, since the patient is the actor, and the starvation is the cause of death—not a lethal dose of medication. “There is a difference between respecting the rights of a
Furthermore, we must recall the distinction between types of suffering made in Chapter III—between neuro-cognitive suffering and agent-narrative suffering—and what accepting the distinction requires. In accepting that one of medicine’s goals is not merely to relieve suffering but to *restore the patient to health*, and that that restoration must involve treatment which is tailored to the type of suffering involved, voluntary stopping of eating and drinking, and sedation toward death should be rejected. Both view stopping suffering as the ultimate goal of medicine, and both use pharmacological methods to treat a type of suffering (agent-narrative) for which such use is inappropriate. In contrast, palliative care offers a different approach:

The starting point of clinical ethics, as also of clinical practice, is the consideration of patients in their full particularity, what Charles Fried has called the principle of personal care. The complete palliative physician holds together two seemingly incompatible excellences: sensitivity to signals of the patient’s body, and receptivity to a life in crisis…

Empirical evidence also highlights the difference between terminal sedation as it is practiced and euthanasia—and how terminal sedation is often used inappropriately. One study from Holland demonstrated, for example, that in 17% of cases defined as “terminal sedation,” the physicians had an explicit intention of hastening death. Furthermore, the request for terminal sedation was initiated by the patient in only 34% of cases; in 27% of cases, the physician brought up terminal sedation, and the

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patient to refuse a treatment and telling the patient that a treatment is a permissible option.” (Jansen and Sulmasy (2), 848.)

540 Roy, David J., “Euthanasia and withholding treatment,” in Doyle et. al., cited above, 84.
patient agreed. In 61% of cases, the physician simply discussed his decision to terminally sedate. In 4% of cases, involuntary terminal sedation was performed. Abuses of palliative sedation therefore appear widespread in practice. Thus, the use of terminal or palliative sedation, in order to be morally licit in palliative care, must (1) clearly be defined (e.g., to exclude the intent to hasten death and to withdraw food and drink only if medically burdensome or not beneficial); (2) be applied only in the terminal stages of illness, when death is imminent; (3) have the consent of the patient or the patient’s proxy.

(c) EPAS advocates argue that EPAS should be offered along with options for hospice and palliative care because it is ultimately the patient’s choice that matters.

This prong of argumentation is based on the Argument from Autonomy, as I have outlined above. The argument claims that it should not matter whether hospice care or palliation is necessarily available or even effective; what matters is whether this is the patient’s preference or not. Marcia Angell articulates this position:

There is no right way to die, and there should be no schism between advocates for better palliative care and advocates for making the choice of assisted suicide available. Surely every effort should be made to improve palliative care…When those efforts are unavailing and suffering patients desperately long to end their lives, they should have the choice to do so…Good palliative care and the availability of physician-assisted suicide are no more

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541 Reitjens (2), 750.
mutually exclusive than good cardiologic care and the availability of a heart transplantation. To require dying patients to endure unrelievable suffering regardless of their wishes, is callous and unseemly.\textsuperscript{542}

If EPAS is to be justified at all, the argument goes, it must be chosen “freely,” and this requires it be offered as an option to all terminally ill persons. My response begins with a reference to Chapter I, where I demonstrated the inadequacy of the Argument from Autonomy as a justification for EPAS. A physician must be attentive not merely to the fact that a patient chooses, but also to the fact that a patient chooses well. Furthermore, the empirically demonstrated fact that for some, EPAS actually undermines autonomy in the form of involuntary euthanasia or coercion is another strong argument to not offer the two options side by side.\textsuperscript{543} Apart from this, proponents of EPAS universally accept hospice and palliative care as generally morally unproblematic, whereas the debate over EPAS is still largely unresolved. The burden of proof is high, then, and rests with EPAS advocates, to show why as a matter of good public policy and moral prudence we ought to accept an ethically suspect option on par with one which is morally licit.

\textsuperscript{542} Angell, cited above in Quill (3), 23.

\textsuperscript{543} The two most common reasons people in the United States favor legalizing euthanasia are fear of being dependent and fear of dying painfully. (See Blendon, RJ, et. al., “Should physicians aid their patients in dying? The public perspective,” \textit{Journal of the American Medical Association}, Vo. 267; 1992: 2658-2662.) One wonders whether the legalization of euthanasia or PAS thus places a subtle coercive pressure on patients to choose this option. Recent evidence from Holland also indicates that reasons for patient requests for euthanasia included dependency (33\%) and “did not want to bother relatives” (15\%). (Reitjens (2), 750-752)
(d) Although improved palliative care may help some (even most) patients, the fact that some patients still receive no relief from suffering and a loss of dignity demands a compassionate response of hastened death.544,545

Both opponents and proponents acknowledge that empirical evidence exists that a small percentage of terminally ill patients do in fact live with severe pain at the time of death. As we have already discussed, this may be due to a lack of access or proper utilization of palliative care resources. Palliative sedation, if used with proper intent, can be seen, as two authors put it, as the “end-point of a palliative care-palliative sedation continuum”:

[P]alliative care will never fail if palliative sedation is included as an essential element. In other words, when palliative sedation is understood to be the final therapy at the end of the continuum of palliative care there can be no failure.546

Even if all or most cases of pain can be relieved at the end of life, there are also cases of (agent-narrative) suffering that will remain, even with a commitment to palliative and hospice care.

544 Quill and Battin, in Quill (3): “Most experts in pain management believe that 95 to 98 percent of pain among those who are terminally ill can be adequately relieved using modern pain management, which is a remarkable track record—unless you are unfortunate enough to be in the 2 to 5 percent for whom it is unsuccessful.” (323) Later, the authors argue that “Strong philosophical, ethical, and religious principles—especially autonomy, mercy, and nonabandonment—support access to physician-assisted death as a last resort for those circumstances in which suffering becomes intolerable to a dying patient who has access to palliative care.” (328)

545 Notice that (c) rests with the Argument from Autonomy; (d) combines the Argument from Compassion, the Argument from the Evil of Suffering, and the Argument from the Loss of Dignity. My arguments in Chapters I-IV offer additional reasons for rejecting the compatibility of EPAS and palliative care.

546 Carr and Mohr, cited above, 76, 80.
Thus, much of the power of this “angle” of argumentation rests on the retelling of exceptional cases: “Euthanasia advocates try to use the individual case to demonstrate that there are some cases of rational or justifiable assisted suicide or euthanasia. If they can demonstrate that there are some such cases, they believe that would justify legalizing euthanasia.”

We must consider, then, whether an “exception to the rule” (i.e., an exceptional case) justifies abandoning the rule altogether in favor of a new one.

The first thing to consider is whether such “exceptions” are really *exceptional* at all—that is, do they make the case for EPAS more persuasive? Pellegrino, for example, has showed that in Quill’s personal narrative describing physician-assisted suicide for his patient Diane, Quill himself “was not totally immune to some of the psychodynamic dangers” which physicians face in assisting patients in dying.

Hendin reveals in his detailed analysis of a Dutch documentary on euthanasia, and a *New York Times Magazine* story about a case of PAS in the US, that the supposedly objective story-telling was heavily biased in favor of EPAS. Worse, the telling itself revealed many of the dangers of EPAS we have been discussing thus far (subtle coercion, the relief of *others* at the decision to die, etc.).

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547 Hendin, cited above, 23. See also, Quill (1), Anonymous, “Its Over Debbie,” and the Dax Cowart case I have cited above.

548 Pellegrino(4), 874-875.

549 Hendin, cited above. In addition, there are also physical dangers in dying by EPAS. David Roy points out that the idea that EPAS “will faultlessly deliver patients a tranquil death” may be an “illusion,” based on recent empirical studies: “A recent study has found that complications, such as myoclonus and vomiting, occurred in 7 percent of cases of assisted suicide in the Netherlands.
require more than a simple retelling. They may test a rule; in certain instances, they may lead us to find principles which will discard a moral rule. They cannot “make the case” alone, lest we run the risk of the emotionally-dominated decision-making I have critiqued in Chapter II or revert to simple casuistry.

Take this example: A Caucasian man lives in a socio-economically depressed part of town, where the residents are primarily African-American. One day, he is mugged, severely beaten, and permanently disabled by a group of young teenagers who mock him all the while. Because they are teenagers, they spend some time in a juvenile facility and are released. Due to his hospitalization and disability, the victim ultimately loses his apartment and his job. This is a very tragic story indeed. Now suppose that the man decides that it was because the teens were Black that they did this to him, and he comes to hate all African-Americans; he believes they should be separated from other races to create a better quality of life for all. Would such a story “make the case” for racial segregation (even as a “special exception”)? Most would say no, because “the rule” (“All persons have equal dignity”) is not sufficiently challenged by the case. Could there ever be a case that would challenge such a rule? Moral or cultural relativists aside, most rational people would say “no” again. Thus,

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Problems with completion of assisted suicide, such as a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient, occurred in 16 percent of cases of assisted suicide. In the practice of euthanasia in the Netherlands, complications occurred in 3 percent and problems with completion occurred in 6 percent of cases... The authors comment that unexpected events can be traumatic.”(Roy, cited above, 92. The referenced study is Groenewoud, J.H., et. al., “Clinical problems with the performance of physician-assisted suicide and euthanasia in the Netherlands, New England Journal of Medicine, Vol. 342; 2000: 551-556.)
“controversy” over cases in EPAS likely point to an antecedent lack of commitment to the moral rule itself, rather than to the strength of the individual cases.

Finally, basing social policy on “the narrow focus on the particular situation in which one person, a physician, wants to do good for another person, a patient requesting release from unbearable suffering,” ignores, as Roy argues, “second-order” links between values and scientific or social change:

This narrow and naïve focus of attention is blind to what Loren Graham, writing about eugenics and genetics in Russia and Germany during the 1920s, has called ‘second-order’ links between changing values and the uses a society can make of a science or social policy. Second-order links are difficult to see. They depend upon existing, and changing, political and social situations, and upon the persuasiveness of current, and emerging, philosophies and ideologies, however flawed they might be. A societal acceptance of euthanasia or physician-assisted suicide…are influenced by a society’s economic situation, by its health care system, and by its management of health care technology. The abuses which a law permitting euthanasia could come to serve depend upon second-order links between such a law and latent, or later emergent, ideologies of human insensitivity.\(^{550}\)

In short, the impact of a decision to allow EPAS based on the exception to a rule does not offer any security for the vulnerable or ensure that the principles in operation for the case at hand will be applicable, practical, or utilized when the case is generalized to society.

\(^{550}\) Roy, in Doyle, cited above, 93.
(2) Contrary to what opponents suggest, the legalization of EPAS has improved, or will improve, palliative care.

Torsten Nielsen, in proposing guidelines for legalizing euthanasia in Canada, suggests that one reason Canada should legalize euthanasia is to “protect and enshrine palliative care.”

Ganzini’s 2001 study in Oregon indicates that thirty percent of Oregon physicians surveyed self-reported that they had increased referrals to hospice, and three-fourths said they had made efforts to improve their knowledge of pain medicines since the Oregon Death with Dignity Act has passed in 1997. A study of Oregon hospice nurses and social workers showed that these professionals’ appraisal of Oregon physicians’ interest in palliation and competence in caring for hospice patients had improved over the 5 years since the passage of Oregon’s Death with Dignity Act:

Seventy-seven percent [of hospice nurses and social workers surveyed] said physicians were more willing to refer to hospice whereas only 3% of professionals assessed physicians as less willing to refer to hospice over the previous five years…Taken together [the results] offer

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552 Ganzini, L., et. al., “Oregon physician’s attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act,” *Journal of the American Medical Association*, Vol. 285; 2001: 2363-2369. [Henceforth, Ganzini (3)]. Ganzini does not indicate that the reason they increased referrals or improved knowledge of pain medicines was because of the Oregon Death with Dignity Act. There was no further investigation to determine whether physicians cognitive knowledge had actually improved, nor evidence to suggest that the physician’s self-appraisals of referrals to hospice were, in fact, made.
further support for the encouraging conclusion that palliative care in Oregon has improved in the span from 1997 to 2001 when our survey was conducted.\textsuperscript{553}

The methodical problems with these empirical studies notwithstanding (see footnotes), there are other reasons why we should be suspicious of this argument. First, the same counterarguments I have given with respect to Objection (1) above, apply in this case (for example, that the philosophies of EPAS and hospice care undermine one another).

Second, the cause of the increase in interest in palliative care in Oregon (or any other country where euthanasia or PAS is legal) is not precisely known—it is an open question. Thus, it is just as plausible to suggest that PAS has galvanized the opposition to EPAS, which has spurred the interest among physicians in improving palliative care. This possibility is buttressed by the fact that palliative care physicians, internists, and oncologists have significantly higher opposition to EPAS than other subspecialty groups.\textsuperscript{554} Furthermore, history suggests that other contentious social issues such as the legalization of abortion, for example, may

\begin{footnotesize}
\begin{enumerate}
\item Goy, Elizabeth, et. al., “Oregon hospice nurses and social workers’ assessment of physician progress in palliative care over the past 5 years,” \textit{Palliative and Supportive Care}, Vol. 1; 2003: 215-219. Despite claiming that palliative care has improved since passage of the Act, the next sentence from the quotation above states that “Our data do not allow attribution of this positive change directly to the ODDA.”(217). Furthermore, Goy’s study was also fraught with methodological and philosophical weaknesses. First, the study is a survey of the observations of a certain set of professionals of the behavior of another set of professionals, and thus, the authors admit, “the precision and validity of these impressions cannot be verified.”(219) Second, since the authors cannot verify that the increase in interest in palliation was caused by the passage of the ODDA, the data simply does not support their conclusion, or the conclusion of other studies (Ganzini (3), for example), that legalization of PAS has \textit{not} eroded palliative care.

\item See Emanuel (2), cited above.
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actually be responsible for interest (among providers, at least) in increasing the number and types of “abortion alternatives,” including adoption\(^{555}\) and counseling.\(^{556}\) Finally, even if we accept the premise that EPAS has caused an increased interest in palliative care, this is no more a justification for euthanasia than it would be to suggest that we ought to legalize crack cocaine to spur the growth and interest in drug rehabilitation centers or that we ought to make abortion even more accessible to encourage the growth of abortion alternative counseling centers and adoption agencies.

\(^{555}\) See Kaunitz, AM, et. al., “A physicians guide to adoption,” *Journal of the American Medical Association*, Vol. 258(4); 1987: 3537-3541. Interestingly, the interest in adoption among women with unintended pregnancies is low, and the number of children available to be adopted since *Roe v Wade* has decreased. This is thought to be due to two factors: (1) abortion has decreased the absolute number of “unwanted children”; (2) a significant number of single mothers are keeping their children, rather than offering them up for adoption. Whether this is a social reaction to the controversy over abortion is unknown.

When the community fails to declare itself to the dying, let the dying be brave enough to bear witness to the community, to rescue the community from its own diminished life.

--William F. May

Conclusion: The Passing of Karol Wojtyla as a Lesson for Humanity

On April 2, 2005, Pope John Paul II, Karol Wojtyla, passed away in Rome from septic shock and heart failure, complications related to a decades-long battle with Parkinson’s disease. Like other extraordinary persons in human history, Karol Wojtyla’s very life and death was perhaps the best and most convincing argument for the beliefs he espoused. Mohandas Gandhi argued for the political and social equality of the Indian people through nonviolence; his existence, his writings and action, and ultimately, his death, were definitive existential arguments against his colonial oppressors. Likewise, those people of the American South who believed that African-Americans were inferior in intellect, naturally violent, and deserved to be kept in the lower strata of a segregated society would be harder pressed to make a “credible” argument when faced with the monumental presence and life of Martin Luther King, Jr., as a living, breathing person. In writing about John Paul II’s death, one essayist put it this way:

As [Terri] Schiavo began to enter the point of no return, around March 30, the result of the removal of a feeding tube, John Paul II, affirming his dedication to life, had a feeding tube inserted…By barely outliving Terri Schiavo, he lived long enough to provide us with a stark
contrast, and to remind us of the value of life. The battle against atheistic Soviet Communism was the battle of the last century, commencing in 1917 and finishing in 1991. The moral battle of the next century will be the fight for the dignity of human life. John Paul II helped us win the last, and has left us words of wisdom, a coherent philosophy, and an example, to guide us in our new fight. In that way, then, the death of Pope John Paul II is a significant symbol, and a bridge — a bridge from one century to another. To the questions recently asked: Why is the pope hanging on? Why doesn’t he step down? John Paul II provided an answer just before Easter Sunday: He said he offered his suffering and continued life so that God’s divine design could continue to be carried out, just a bit longer. His faith or some kind of divine intuition told him that his work wasn’t done. Apparently, there were a few more things that needed to happen, ends that needed to be tied. It seems he might have been onto something.557

Karol Wojtyla felt that the value of the human person could be revealed through his moral acts—through the choice to do good, rather than merely having choices. In the ethical act lay the character of, and capacity for, freedom, which gave a person a special dignity. Physician-assisted suicide and euthanasia, as we have seen, offer persons a “false freedom,” one which equates self-determination and autonomy, with no link to truth; in rejecting EPAS in word and deed, Wojtyla demonstrated to the world what it means to truly be free.

Monsignor Albacete, a Puerto Rican physicist and priest and a close friend of Wojtyla’s, recalled a conversation with Wojtyla close to the time of his death:

The last conversation we had was in Rome. I was there because he was beatifying a Puerto

Rican, Carlos Manuel Rodríguez. I said, ‘I protest, Holy Father! I want to be the first Puerto Rican saint!’ He smiled, said nothing. Then I said, ‘You know, Holy Father, I’m feeling a little guilty. I’ve agreed to go on television after you’ve died to say something or other about you.’ He smiled again. Then he said, ‘How do they know that I will die first?’ He was able to joke. He was not afraid.558

Wojtyla did not ask for pity, nor did he lose his joy for life, even in his death. Through his public dying, he showed humankind that compassion went beyond empathy or pity, to embrace the person and endure suffering until the end.

Wojtyla’s masked facies and shuffling gait at the end of life revealed that the “athletic pope,” who in his earlier days expressed himself through drama and poetry, had experienced what many would call “existential suffering”—a reason to choose EPAS. For him, the very activities which he enjoyed most were stripped away, day by day. Was his suffering “useless?” Did it lack value or meaning? On the contrary, John Paul II’s magnificent dying fulfilled his prophetic words two decades earlier, and revealed something else:

When this body is gravely ill, totally incapacitated, and the person is almost incapable of living and acting, all the more do interior maturity and spiritual greatness become evident, constituting a touching lesson to those who are healthy and normal.559


559 SD, cited above.
Suffering has meaning, both to the sufferer and those who bear the suffering with him. It can, as Wojtyla argued, truly “unleash love in the world,” revealing the person in his vulnerability as a subject of value.560

The value of the person hits home with the discovery that the person who acts is a person who is unique, irreplaceable, ineffable—and this incommunicability reveals an intrinsic dignity that cannot be stripped away by debilitating or terminal illness. Wojtyla, even in his last days, continued to be dignified; more importantly, it was impossible to deny that he retained his dignity. Human dignity, then, far from being a “useless concept,” relegated to merely the ability to make choices, became a phenomenological event for humanity in the life, suffering, and death of Karol Wojtyla.

What are we to take away from this experience of dignity? That human illness—even suffering of the worst kind—cannot be ameliorated justly by killing the person who suffers or allowing them to kill themselves. Rather, medical professionals should take the lead in cooperating with civic leaders and ordinary citizens to devote time, research, financial resources, and educational training to improving palliative and hospice care for the dying—in this country and around the

560 Another journalist poignantly wrote, shortly before Wojtyla’s death: “In carrying on, John Paul also offers us a precious gift: his suffering. It is hard to see him suffer. But this pope does not ask for relief from his sufferings. To the contrary, a bishop once told me that the pope used to refuse medication precisely because it interfered with his suffering. He has a mystical relationship with his suffering, offering it up for us, and for the whole world — a world that increasingly embraces the culture of death, euthanasia, and the abortion of disabled fetuses, because it mistakenly believes there is no greater moral good than relief from suffering.” (Thiessen, Marc A., “The Blessed Sounds of Silence,” National Review Online, March 31, 2005; accessed on July 7, 2008: http://www.nationalreview.com/comment/thiessen200503311119.asp)
world. In doing so, we will truly begin to remind one another that the vulnerable and suffering “Thou” is in fact another “I,” a person with irresistible and undeniable value. Building this relationship, crucial not only in medicine, but in the establishment of a community of persons, will be essential to realizing Karol Wojtyla’s central legacy: “He reminded everyone that there is no such thing as a disposable human being.”561

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