

## CHAPTER 20: THE LIVED EXPERIENCE OF HUMAN DIGNITY

Edmund D. Pellegrino

*The problem in question is that of understanding what happens to human dignity in the process of technicalization to which man today is delivered.* -Gabriel Marcel<sup>1</sup>

Gabriel Marcel wrote these words in 1963 when biotechnology was a set of optimistic promissory notes, and bioethics had yet to be born. Humans then only dimly foresaw, usually in literary fancies, that technology could grow to overshadow its makers. They were still secure in the confidence they inherited from the Renaissance humanists that human beings were the only creatures endowed with reason and the freedom to use it to determine their own destiny.<sup>2</sup> That freedom, they thought, placed us firmly between the angels and the apes and endowed us with an inherent dignity that set us apart from both.

Today dignity has become problematic, and its future is questioned. Biotechnology has expanded beyond anything heretofore imagined so that its powers threaten to overshadow humanity itself. Bioethics has expanded beyond its medical confines to challenge humanity's claims to a unique dignity and to the moral entitlements such a status entails. Together biotechnology and bioethics are reshaping what it is to be human and what human being is.

As a result, among the intensive debates that roil contemporary culture, there are few that are not intimately related to Marcel's question. Even a cursory and incomplete survey of those debates, e.g., the controversies concerning embryonic stem cell research, preimplantation genetic diagnosis, enhancements of human physical or mental capabilities, the practice of regenerative medicine, the uses of nanotechnology, and re-engineering the human species, suffices to underscore this assertion. Some believe that we must explore every possibility these technologies offer; others think certain technologies should never be pursued. For some, the decisions must rest on traditional ethical analyses grounded in classical notions of human dignity; others see such ethical constraints as outmoded limitations on human freedom and progress.

Technology may exalt or imperil human dignity, depending on what we take human dignity to be. Is dignity simply a matter of the degree of biological complexity an animal possesses? Or is it a quality that can only be predicated of humans? Is it the imprint of a personal God on the beings He has created? Or is it simply the fortuitous outcome of the intersections of the laws of chance variation and natural selection? Is the whole notion of human dignity a useless remnant of the days before autonomy became the signal mark of our humanity? Is the idea of dignity too vague to have meaning or, worse, an illicit and covert intrusion of religion into bioethics, as Ruth Macklin would have it?<sup>3</sup>

Whatever one's perspective, the fact remains that biotechnology and bioethics converge whenever humans decide whether a given technological advance is good or bad for humans as humans. Most of the dissonance between and among bioethical systems today rests on how we see human dignity. In the end, the edifices of bioethical systems are grounded in some idea of the purposes and destiny of human life. This is, of course, the anthropological question: "What are human beings?" Our answers provide the templates for decisions we make about which technologies we believe contribute to, or detract from, our flourishing as the kind of being we are.<sup>4</sup>

To understand what happens to human dignity in Marcel's sense, we must understand human dignity not only abstractly as a concept and an idea, but also as an experience, a lived reality of human life. All too often, dignity, like many of the more precious but intangible phenomena of human life, is taken for granted. Only when it is threatened, demeaned, or wrenched forcibly from us do we understand how inseparable our dignity is from our humanity.

For many centuries, and especially the last, a multitude of humans have experienced the degradation of the human spirit that follows from the systematic deprivation of human dignity. To illustrate, one need only mention the Holocaust, slavery, genocide and ethnic cleansings, and the political murders of massive numbers of dissidents by the ideological tyrannies of Maoism, National Socialism, and Stalinism.<sup>5</sup> To the victims, the resulting indignities were the cause of horrific suffering. To the rest of us, their sufferings were so crushingly obvious that to ignore them would have undermined- and in some cases did undermine-our own dignity as well.

The *Universal Declaration of Human Rights* of the United Nations in 1948,<sup>6</sup> and the recent *UNESCO Declaration on Bioethics and Human Rights*,<sup>7</sup> gave clear voice to our moral revulsion. Both documents make human dignity the first principle and the inescapable grounding for all human rights. Remarkably, these declarations were agreed upon between and among nations of vastly different religions, cultures, metaphysical beliefs and historical backgrounds.<sup>8</sup>

It took the collective lived experience of the loss of human dignity to focus the world's attention on its full meaning. Only in this way could flesh be put on the abstract concept. However, without the abstract concept to stimulate critical reflection, the lived experience would have been without meaning for those who were, themselves, not deprived of dignity. But it was the lived experience that gave dignity its axiomatic credibility. As John Keats had so acutely observed:

Axioms in philosophy are not axioms until they are proven on our pulses; we read fine things but never feel them fully until we have gone the same steps as their author.<sup>9</sup>

Keats's poetic insight connecting thought and experience was reinforced more than a century later when philosophers became more interested in the phenomena of human existence and experience.

One of these philosophers, Gabriel Marcel, linked philosophy with experience in this way:

[P]hilosophy is experience transmuted into thought.<sup>i</sup>

and

Philosophy is a certain way for experience to recognize itself.<sup>ii</sup>

I will focus here on the lived experience of dignity. By a "lived experience" I mean the way human dignity is perceived by human beings as they respond to the valuations of their worth and worthiness by others or by themselves. From a philosophical perspective, a focus on experience re-embeds the concept in the complex daily life from which that concept was extracted. Neither the concept alone nor the experience alone can transmit the full meaning of the word. As a lived experience, dignity is the product of intra- and inter-subjectivity. The underlying conviction of this essay is that the intelligibility of so elusive a notion as dignity must be grounded in our lived experiences of dignity either personally or collectively or, as the rest of the world experienced the Holocaust and the other horrors of the last century, vicariously.

This will require an effort to philosophize about dignity as a concept arising from, and returning to, experience in the real world of everyday life. My aim is thereby to supplement the conceptual analyses so ably conducted in the majority of essays in this collection. I do not suggest that such phenomenological reflections can replace theory. But concepts do and must stand in a dialectical relationship to the lived experience of dignity. In this I proceed in parallel with Rebecca Dresser's reflections in this volume on the experiences of seriously ill patients, including her own.<sup>iii</sup> I also believe that the lived experience of dignity inevitably raises the thorniest questions about our place in the cosmos and our stance toward divinity. These questions have been probed with remarkable acuity and candor in a recent dialogue between Jürgen Habermas and Cardinal Joseph Ratzinger (now of course Pope Benedict XVI), and I offer some concluding reflections on the future of human dignity in the light of the conversation between these eminent thinkers.

## THINKING ABOUT THE EXPERIENCE OF DIGNITY: GABRIEL MARCEL AND JOHN NEWMAN

At the outset, it is essential to indicate my concurrence with the concept of intrinsic dignity set forth by Sulmasy<sup>iv</sup> on the basis of the theory of natural kinds, by Lee and George on the basis of natural law,<sup>v</sup> and by Meilaender on the basis of man's special relation with his Creator. Each of these authors makes a clear distinction between intrinsic human dignity and attributed or imputed dignity. From their viewpoints, intrinsic human dignity is expressive of the inherent worth present in all humans simply by virtue of their being human. Intrinsic dignity cannot be gained or lost, expanded or diminished. It is independent of human opinions about a person's worth. It is the inherent grounding for the moral entitlements of every human to respect for one's person, one's rights, and one's equal treatment under the law in a just political order.

Extrinsic or imputed dignity, on the other hand, is the assessment of the worth or status humans assign to each other or to themselves.<sup>10</sup> It is based on external measures of worth or value as perceived in a person's behavior, social status, appearance, etc. It sums up certain perceived attributes judged admirable or condemnable by other persons, by culture, by political or social criteria, by fashion, or by membership in certain groups. Imputed dignity can be gained or lost simply by one's own self-judgment or by the judgment of others.

It can be taken away or granted by law or social convention or by one's opinion of one's own worth in comparison with others.

All of us make imputed judgments of value or worth consciously and unconsciously. These judgments affect the way we respond to others and to our own inner selves. Together, these judgments and responses are the phenomena that make up our lived world of the experience of dignity. Imputations of dignity have no essential relationship to intrinsic dignity, from which

they are ontologically distinct. To conflate intrinsic and extrinsic dignity is especially dangerous in bioethics, where what we think it is to be human is the basis of what we think ought and ought not to be done.

The intricacies of attempts both to define the concept and to characterize the experience of human dignity are amply demonstrated in a brilliant essay written some years ago by the philosopher Aurel Kolnai.<sup>11</sup> Kolnai sets out a dazzling array of metaphors and images evoked by the concepts and the experiences of both dignity and indignity. It would be an error to take Kolnai's exhaustive description of the richness of the "conceptual aura or halo" of details that "cluster round the phenomenon" as grounds for abandoning the project of clarifying the meaning of dignity.<sup>12</sup>

Instead, Kolnai provides us with a rich mosaic of lived experiences that underlie any abstract concept of human dignity. It becomes clear that neither the concept, nor the lived experiences from which the concept was abstracted, can by themselves yield the full meaning of the term. Thinking about dignity entails an oscillatory reflection between what can be deduced logically and deductively on the one hand and what must be existentially and concretely experienced on the other.

Two philosophers, in my opinion, have articulated well this oscillatory mode of cognition-on the one hand empirico-psychological, and on the other logico-deductive. I refer here to John Henry Newman with his notion of the "illative sense" and to Gabriel Marcel with his signature distinction between "mystery" and "problem." A brief excursus into their ways of thinking seems helpful in our project of understanding human dignity and its loss.

Human experiences of dignity and indignity are the deep wells from which the abstract conceptions of both inherent and attributed dignity are retrieved. But abstraction by its nature moves us away from the experience itself. A return to experience for an evaluation of the adequacy of our conception is in order so as to complete the meanings of the concept. This "reality check" is necessary to avoid an error that worried Marcel:

I think the philosopher who first discovers certain truths and then sets out to expound them in their dialectical or systematic interconnections always runs the risk of profoundly altering the nature of the truths he has discovered.<sup>13</sup>

Marcel is admittedly an elusive thinker. I do not suggest that his critique of conventional philosophical modes of thinking is destructive of those modes. Rather, I think it invites us to look a little more fully into his attempt to understand the presence and absence of dignity in human experiences. To this end, we might look briefly at the hallmark distinction of Marcel's thought-his distinction between a "mystery" and a "problem."<sup>14</sup>

For Marcel a "problem" is a question that can be examined objectively. It is susceptible to the scientific method of observation, experiment, and deduction. He calls this method the examination of experience by "primary" reflection.

A "mystery" on the other hand, is a question not susceptible to purely objective analysis. It involves what is given and experienced but cannot be totally objectified. The word "mystery" does not mean an infused truth, a revelation in the religious sense, nor is it shorthand for the unknowable or a flight into total subjectivity. A mystery is examined, as it were, from "within," as the concrete experience of a person as person.<sup>15</sup> It is examined by secondary reflection, ". replunging into the ocean's immediacy from which its concepts are scooped up at the same time [it] re-establishes the primacy of the existential."<sup>16</sup> This contrasts with primary reflection, which makes concepts by abstraction from concrete details to arrive at ideas and essences. Abstraction done in this way tends to reify the concept. 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. In this way primary and secondary reflection complement each other.

Marcel's insistence on concrete experience and the ways of thinking about it is analogous in some ways to John Henry Newman's thinking in his well known work on the "Grammar of Assent."<sup>17</sup> In that work, Newman recognizes two ways of arriving at truths and giving assent to them. The first is notional, belonging to the world of the intellect, depending on abstraction, syllogistic reasoning, and proofs. The other way is through individual experiences of individual things, acts, and feelings. Here assent to a truth is through the immediacy of our perceptions. It does not depend solely on the notional form of reasoning. Rather, assent arises from implicit inference which perceives the relations between things and ideas without formal syllogistic proof.

For Newman's non-notional way of thinking about experience we must use inferential thinking that involves our whole person. Newman ascribes this non-notional thinking to an illative sense.<sup>18</sup> This sense is an internal guide to inferential thinking. This he takes to be an acquired capacity to make non-syllogistic inferences that nonetheless reveal truths about the way things are in the world. Newman's illative sense is a guide to prudential reasoning and decision-making. Newman's way of philosophizing about experience is closer to clinical thinking with its emphasis on prudence. It is in Newman's insistence on remaining within the horizon of experience that he most resembles Marcel.

Marcel, Newman, and others who emphasize the lived experiences of human persons make us appreciate what Collins said of Marcel: "The full force of evidence is not realized until it is envisaged as being in the inquirer's life and conduct."<sup>19</sup> Or, to put it another way:

One transcends experience by means of concepts which make experience possible and are only meaningful in relation to experience.<sup>20</sup>

To invoke the reflections of Marcel and Newman on experience is not to suggest that intuitive thinking can entirely replace abstract thinking. What is crucial is to recognize the bipolarity of human dignity between its concept and its lived experience and to respect the dynamic oscillation between the two. How to comport ourselves with respect to the dignity of any human being does not admit of a formulaic resolution. It is instead a prudential judgment, which is the focus of Marcel's and Newman's reflections. The distinction I outlined above between human dignity as inherent in what it means to be human and the way dignity is perceived and imputed to ourselves and others holds conceptually. But even then we must appreciate that inherent and perceived dignity will often overlap and can be confused partially or totally with each other. This will become especially apparent as we move next to the lived experience of dignity.

## **DIGNITY AND THE HUMAN PREDICAMENT OF ILLNESS**

Against this background of Marcel's and Newman's ways of thinking about experience and Kolnai's reflections on the phenomenon, we can now turn to the experience of dignity and its real and apparent loss in the clinical encounter. I will draw on personal experience as I have observed the challenges to dignity in my patients in the midst of the realities of illness and healing. Such experience is to be examined, as Marcel suggests, by secondary reflection, which involves the subject. I will focus on the patients' perceptions of the experience of dignity.

As I indicated earlier, humans become most acutely aware of their own dignity and that of others when it is threatened by the acts and opinions of their fellow humans or by the circumstances of one's life, work, social, political or community life, or by the way one reacts to the exigencies of those encounters. What is most significant for our understanding of our own or another's dignity is that we experience them only in community with others. Assessment of my own dignity is disclosed in the personal encounter with another. The experience of dignity is inescapably a phenomenon of intersubjectivity. Only in the encounter with others do we gain knowledge of how we value each other and ourselves. The personal and intersubjective nature of the experience of dignity thus fits the idea of "mystery" as Marcel has conceived it. We cannot objectify our experience of our own dignity or another person's attributions, nor explain it fully, simply by classifying it or treating it as a problem to be "solved" psychologically or sociologically or by any other empirical or analytical methodology. We apprehend the reality of a particular experience of dignity by non-syllogistic inference in Newman's sense. In any case, as John Crosby has so aptly pointed out, it is not just the external qualities or behavior that carry worth or admirability but the particular human person who has them: "When we speak of the dignity of the human person we do not speak of a goodness for the human person but of a goodness human persons have in themselves."<sup>21</sup>

## **DIGNITY AND THE CLINICAL EXPERIENCE**

Some of the more complex experiences of dignity are those most relevant for bioethics. They are epitomized in the clinical encounter. The central relationship is the one between patient and physician, though nurses and other health professionals also participate to varying degrees. The person in need, the being around whom the drama centers, is a patient, someone literally bearing a burden, suffering and in distress, anxious, frightened, and no longer able to cope without professional help.

The clinical encounter is a confrontation, a face-to-face encounter between someone who professes to heal and someone in need of healing. Its locus is the doctor-patient, or nurse-patient, relationship. It is a phenomenon of intersubjectivity, and it is in this sense that it is a locus for the experience of human dignity and its loss. The doctor-patient relationship is paradigmatic for other "healing" relationships, those that involve humans in states of need and vulnerability. The same perceptions of threats to or loss of dignity accompany those myriad encounters in which one person seeks the help of another. In all these relationships there are always the silent questions: How will my plight be perceived? Has my vulnerability diminished the respect I deserve as a fellow human being? Is my need for help perceived as a manifestation of a physiological or psychological weakness? Does that perception erode my dignity in the eyes of the one whose help I need?

It is especially as a petitioner that the person's dignity is "on the line." Consciously or unconsciously, merely admitting the need for help places a person in a state of vulnerability. The patient's perception of his or her independence and freedom are exposed, by necessity, to the full view of another person. How another person responds to our need can sustain or undermine our perception of our own dignity.

The patient is in a state of unusual vulnerability, a predicament that compels entry into a relationship of inequality in knowledge and power. This predicament must be confronted by submitting to the danger of loss of a patient's imputed dignity. Such disproportionate allotment of power is especially problematic in democratic societies. In those societies, personal autonomy is a cherished right, as is the right to privacy. Both can be threatened or endangered by the doctor's or the nurse's orders. However, our autonomy cannot exist apart from our humanity. Its moral force is rooted in our inherent dignity as humans. To experience a loss of autonomy is to experience a loss of only our imputed dignity. Although we are sometimes tempted to conflate our imputed with our inherent dignity, our inherent dignity as human beings cannot be lost. In times of suffering, disfigurement, or certainty of death, patients often lose their confidence in their own worth or dignity. The gravity of that experience obliges physicians, nurses, family and friends to reassure the patient that his intrinsic dignity is enduring and inviolable. For that assurance to be authentic the patient must be treated with dignity to the end.

Patients know that, in the end, they must take some doctor's advice. Before making that choice, they may diligently search the doctor's credentials, qualifications and practice record, but there is a moment of truth that patients cannot avoid. Whether one is president of the most powerful country in the world, or a peasant tilling the soil, one ultimately needs to accept, or refuse, another person's medical advice as authoritative. The patient's dignity as a rational being is preserved by others respecting his or her freedom to make that choice. But that dignity is endangered by having to do so in a human relationship of inequality.

The challenge to one's perceptions of one's own dignity is exacerbated by the guilt one may feel for being sick in the first place. Guilt leads to self-deprecation, to feelings of unworthiness, and even to the misperception of a loss of inherent dignity. Sickness exposes us to our mortality, the one unmovable boundary to our pride. In an age when the pursuit of health has become something of a cult, to become sick can suggest that we have failed at prevention somewhere- not enough dieting or exercise, "bad genes," or emotional instability.

Which, how many, and to what extent have I allowed those things to escape my control? Shouldn't I be ashamed of neglecting my health? This is a question often implied, even if not overtly asked.

Shame is another experience that adds to the distress of being ill, because illness weakens the safeguards that our sense of shame puts between the public and private perceptions of who we are.<sup>22</sup> It is this sense of the invasion of our protected, carefully controlled, private space that undermines our personal perceptions of dignity. The health care professional has become an observer whom we are forced to admit into the privacy of our bodies. Speaking of shame, Erwin Straus sees it as "...a protective against the public in all its forms."<sup>23</sup> It is, in Straus's terms, an original feature of human existence, while shamelessness is an acquired behavior.<sup>24</sup>

This sense of shame as a shield against loss of dignity is immediately challenged when we take on the status of patient. Usually, we must disrobe and expose our body to expert scrutiny with all its imperfections revealed. What we are and who we are is suppressed in the objectification of our person that a scientific appraisal of our physical state might demand. We may be infantilized, especially if we are elderly, but even if we are in our prime. The hospital routine, the order of procedures, and the vast array of "policies" may engulf us despite the best efforts of our care providers.

The experiences of threats to and loss of dignity are well-known to hospital patients. They begin with the haughty receptionist, continue with the admitting clerk and the interrogation about insurance, and are followed by lying on the gurney waiting in the hall for the x-ray technician. Being the "next case" does little to reassure us. There are subtle variations in the list of cumulative assaults on one's sense of dignity. I have heard the litany from my own patients, and know it from personal experience. It takes a stronger perception of one's inherent dignity than most of us possess not to feel humiliated. "Humiliation" is the word I hear most often from patients describing the experience of being ill and seeking help.

Most patients survive those routine humiliations, but there are many occasions when the experience entails deeper repercussions and, hence, much greater moral significance. Chronic illness, mental illness, dying, and death are occasions when the patient's perception of loss of his or her dignity is deep enough and persistent enough to be, itself, an additional source of suffering. This suffering is often more distressing than the pains, discomfort, or disability caused by the disease itself. Cumulative assaults on the dignity of the dying are often the reason for a desperate request for euthanasia or assisted suicide as well as for the prevalence of clinical depression among dying patients.

Perceptions of loss of dignity also contribute significantly to a person's assessment of the quality of his or her life and can dramatically shape their decisions to accept or reject even effective treatment. When patients have the capacity for decision-making, their assessment of the quality of their lives is dispositive. No one can ethically make quality of life decisions for an autonomous patient.

With those who have never had, or have lost, the capacity for decision-making-the retarded, the demented, those in states of serious brain dysfunction-surrogate decisions are necessary but perilous. They can overtly, or covertly, signify a devaluation of

the "worth" of the patient with which the patient might, or might not, agree. In such cases, the temptation to treat the patient as one would treat oneself is strong but problematic.

In a sincere attempt to reassure a patient anxious about the loss of dignity in the impersonal milieu of modern medical care, a physician will sometimes promise to treat the patient "as he would his own mother." Ordinarily, such a well-intentioned promise is understood as such by the patient. In some situations, however, this kind of intention can distort the application of the "Golden Rule." In fact, the doctor's values may not at all be those of his patient. Rather, the doctor is obliged to learn of the patient's wishes and adhere to them- unless they violate the physician's personal and professional moral integrity. When such an impasse occurs, the physician should make his position known so that either the patient can discharge him, or the doctor can ask to be relieved of his responsibility to provide care.

Caution must also be observed by physicians tempted to use a "best interests" standard as decided by "reasonable people." What is often hidden behind such notions, unintentionally one hopes, is a confusion of the intrinsic dignity of the patient with the dignity imputed by the physician or other observers.

Finally, all decisions about a "dignified death," or a "dignified life," or a "quality" life, are perilous when made by a surrogate and even when made by the patient himself. Sensitivity to the subtle differences between inherent and perceived dignity must be developed in physicians and all who minister to the sick or to persons in distress for any reason.

Ascertaining the patient's own quality-of-life choices does not entail an obligation on the part of physicians to suppress their moral beliefs in deference to the patient's wishes. This would violate the dignity inherent in each physician; how, ethically, to deal with such conflicts is a question for another occasion.

## CHRONIC ILLNESS

Any serious illness is an assault on the whole person, one that challenges the image we have fashioned of ourselves over a lifetime. That image is pieced together carefully to form a synthesis of who we think we are, who we wish to be, and who we are in fact. Our aspirations are carefully molded to fit our physical, mental, or social limitations. Throughout life, we repair or adjust our image as it is challenged by the events in our lived world. Most of us reach some sort of equilibrium between our hoped-for worthiness and our worthiness as judged by others. We settle somewhere between the dignity we would prefer to have attributed to us and the dignity we possess in the eyes of the world we live in.

Serious illness shatters that equilibrium. It forces upon us a new image of ourselves, often drastically altered compared to our old self-image. The business mogul who suffers a massive heart attack, the truck driver who has had his first epileptic episode, the housewife and mother whose lymphoma is outpacing her chemotherapy- each suffers an ontological assault. The image they cherish of their own worth and the worth of their lives to others is forcibly shattered.

Some patients can renovate their self-images. Many cannot, or do not, do so. Too many lose all sense of personal worth and despair of regaining identifiable dignity. They often become depressed or suicidal. Others present heroic examples of recapturing a new sense of dignity and grow with the experience. Still others fear dying without dignity. The way each responds becomes a determinant of the dignity, or indignity, others impute to them.

As disease becomes chronic and unrelenting and progresses to foreseeable death, the experience of indignity becomes more insistent. It becomes ever harder to believe in one's underlying inherent dignity. It is difficult to controvert the ravages of a long illness- emaciation, loss of appetite, inability to care for one's most personal needs, overwhelming weakness and fatigue, and the deterioration of physiognomy and affect. Those realities powerfully force the conclusion of personal unworthiness on the patient.

None of these phenomena occurs in isolation. Health professionals, friends, family, and fellow patients are all participants. Seriously ill and dying patients are acutely sensitive to the way others in their presence react to them. The visitor's look of shock on entering the patient's room, the poorly disguised pity, the slight turning away of the eyes, the ever shorter visits, the struggle to say something meaningful, the mournful countenance, the recoil from bodily contact- those reactions all sustain the patient's conviction that she or he is no longer a respected, needed, or wanted member of their community or society. These phenomena feed the patient's perception of being a burden and even an embarrassment to his family, friends, and physicians.

Some patients may act "nobly" and "with dignity," while others may not. But in all, the experience of indignity is a reality for the patient and for those who witness the patient's experience of illness and dying. The way these witnesses respond to their experience of the decline of their patient, friend, or family member has serious consequences for that patient's perception of his worth. Those in the patient's presence are inevitably co-actors and participants in the unfolding drama. As such they incur certain ethical obligations to which I shall turn shortly. For the moment, it suffices to say that the observer's intended or

unintended signals of body language, word, and countenance are all too often affirmations for the patient of his perceived loss of dignity.

Another facet of the experience of threat to or of a loss of a human being's dignity is the spiritual crisis that accompanies impending death. This crisis accompanies every serious illness and especially the approach of death. The term "spiritual" is used here in its broadest sense, extending from the religious and mystical to the acknowledgement of a transcendent reality of some sort beyond human cognition. That reality may be a personal God or some blind force of nature or simply a sense of identity with the mystery of the cosmos.

In the clinical confrontation with one's own finitude that dying or the threat of dying forces upon us, there is an unavoidable personal challenge to human dignity. What is the meaning of our personal existence? Is there any meaning? If there is a God, does God care at all? Have we been created and left alone in the universe? Is there anything after death? What is it? Religious believers, atheists, agnostics, materialists, cynics and skeptics, nihilists—all face those questions in some form. Each does so in a particular way. They are the same questions so poignantly addressed in that most poetic lament by Job—Why, oh Lord? Why me? Why now?<sup>25</sup>

## **ETHICAL OBLIGATION AND THE EXPERIENCE OF DIGNITY AND INDIGNITY**

Our focus on the experiential dimensions of human dignity must not lead to the erroneous conclusion that dignity and indignity are irrelevant for those who cannot consciously experience them. Those in comatose states, in states of total or partial brain damage, those with various forms of dementia, the mentally retarded, as well as the infant and the very young child, all retain their inherent dignity. The concept of dignity to which I subscribe assigns an inalienable, inherent dignity to all human beings simply by virtue of being the kinds of beings they are. None of the patho-physiological mechanisms that impair the human capacity for conscious experience can alter dignity. Patho-physiological abnormalities of consciousness are in the realm of imputed or attributed dignity; they are not about intrinsic or inherent dignity.

Most of the essayists in this anthology have deduced certain ethical implications from the particular construal of human dignity they favor. That is wholly legitimate for the analysis of dignity as a problem in Marcel's sense of the term. But in addition, if we wish to probe dignity as a mystery in Marcel's sense, we must locate some of those obligations in concrete experience. This is not to disparage the deductive-conceptual model but to add to it the immediacy of a lived experience.

Karol Wojtyla (Pope John Paul II) saw the ethical experience this way:

Every human action involves a particular lived experience that goes by the name of ethical experience. This whole lived experience has a thorough empirical character.<sup>26</sup>

Later on in his essay he goes directly to the core of ethical experience in the moral agent:

[T]he 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.<sup>27</sup>

The clinical encounter, because of its ubiquity and intensity, is a locus of the ethical experience to which Wojtyla refers. The "acting persons" in this case are the patient herself or himself, the physician, nurse, and other health professionals, and the non-professional observers—family, friends, and visitors. Again, the observation we make in the clinical encounter can analogously, if not precisely, relate to other situations such as those of the disabled person; the person without access to health care; the cultural or ethnic outcast; and those deprived in any way, physically or emotionally, by the mores of the society in which they live. Thus, loss or perceived loss of dignity is a common phenomenon in encounters between lawyer and client, priest and penitent, teacher and student. In each instance, dependent and vulnerable humans needing help must expose their fragile sense of self-worth to the gaze of others.

## **PRESERVING HUMAN DIGNITY, PREVENTING INDIGNITY**

Toward the end of his pointed indictment of the corrosive effects of modern mass society on human dignity, Marcel has this to say:

It is within the scope of each of us within his own proper field, in his profession, to pursue an unrelaxing struggle for the dignity of man against everything that today threatens to annihilate man and his dignity.<sup>28</sup>

Marcel goes on to urge that this struggle be carried out in the field of law. But the struggle to which Marcel calls the professions is most acutely needed today in bioethics and medicine. In medicine, the concept and the experience of human dignity as the foundation for biomedical ethics is facing its most serious challenges. In law, the corrosion of human dignity weakens human rights; but in medicine, its corrosion weakens human beings' humanity itself-i.e., the foundations for both the rights and the obligations inherent in humans as humans. Medical practice and the clinical encounter are paradigm occasions where the defense of dignity must be pursued with diligence. Attention should also, of course, be given to encounters with other health professionals and with family, friends, and all who enter the patient's experience of illness, suffering, and dying.

The preservation of human dignity and the prevention of indignity are obligations built into the ends of medicine. The ends of medicine are focused on the good of the patient as a human person. Medicine's ends are ultimate, intermediate, and proximate. Ultimately, medicine aims to restore health; its intermediate aim is to cure, ameliorate, or prevent illness. Most proximately, it is to make a right and good healing decision, for a particular patient in a particular clinical encounter. Any behavior that frustrates those ends or causes suffering is a violation of the moral trust patients must place in physicians if they are to be helped. This is the trust physicians implicitly or explicitly promise to live up to when they offer to be of assistance. It is the source of physicians' obligation to be faithful to their promise to help.

To be faithful to that trust, the physician must avoid the vice of arrogance, one of the most frequent complaints I hear from patients. The inequality of power and knowledge between doctors and patients feeds the inordinate pride and self-importance that most physicians exhibit at one time or another. Self-importance is an intoxicant for the young physician and can become an addiction for the older ones. Self-importance tempts to certitude where only probabilities exist. It demeans the patient as well as fellow health professionals and adds to the indignity of the illness itself. It entraps the physician in the cage of pride, which breeds false pretensions of infallibility. It also endangers the healing relationship, since error or misstep can no longer be admitted. Ultimately, arrogance subverts and subordinates the good of the patient to the preservation of the physician's own self-image.

Physicians, instead, must be the unfailing advocates and defenders of patient dignity. They must be cognizant of those many times when the "system," the "team," or the "teaching hospital" may function to the detriment of the patient's self-esteem. Physicians are not guiltless if their staff and those around them in any way demean patients who lack education or financial means, or are elderly, or easily confused, or experience language barriers, etc. The therapeutic process begins when a patient in need calls the doctor's office and is greeted by the physician's receptionist or is admitted to the hospital. Some patients are robbed of their dignity right at the entry point by the attitude and tone of voice that greets them.

What patient has not, at one time or another, experienced the telephone rebuff, the refusal of personal contact with the doctor, or the supercilious interrogations of the person at "the front desk"? Some of this may be the result of a response to patient agitation and anxiety, to be sure, but frustration with a patient's personality is a weak excuse for treating patients with disrespect. Other weak excuses include being busy, wrestling with one's own problems, or simply being temperamentally unsuited to dealing with fellow human beings in distress.

Too many physicians distance themselves from the actions of those who act in their name on the basis of lack of time, difficulty in "getting good help," or simple insensitivity to anything not susceptible to resolution by a prescription or a procedure. More seriously, the behavior of his or her team may be a reflection of the physician's arrogance. Obviously, physicians cannot observe everything, but the devoted patient advocacy expected of the ethical physician dictates a higher degree of vigilance than is now common.

The physician is also obliged to respect the other professionals with whom she or he works for the good of the patient. The nurse, technician, social worker, chaplain, psychologist, etc., have justifiable pride in their expertise and recognize how essential they are to the patient's care. The day is happily past when physicians could discount the dignity of other health professionals with impunity. On the other hand, we cannot allow respect for our fellow workers to obscure those occasions when they may be incompetent, abusive, or insensitive to the dignity of those they treat. If we physicians do not move to correct the injurious behavior of health care workers who assault patient dignity, we ourselves are complicit in their misbehavior.

Physicians cannot ignore those many assaults on human dignity, intrinsic as well as attributed, that are taken for granted in the bureaucratic, commercialized, and impersonal places that hospitals have, all too often, become. Some of this is indeed unavoidable, given the complex nature of contemporary medical care. But physicians, administrators, and policy-makers must always ask, "What is the impact of our organization or 'system' on the care of the persons they were designed to help?" A more collective sense of shared responsibility for the "dehumanization," the "depersonalization," or the "alienation" that the sick feel in today's health and medical care institutions must fall on the physician. Physicians can exert enormous moral influence if they take their advocacy role seriously as part of their common professional ethic.

The physician plays a central role here: seeing the patient in his or her weakest moments, assessing the physical ravages of the disease, and prognosticating its severity and likely outcome. The physician decides when treatment has become futile, when



the patient's private affairs must be put in order, and when care in a hospice is to be considered. At each step, the physician must try to bolster the patient against a sense of unworthiness and guilt. The physician must avoid false humor, unrealistic expectations, and the temptation to avoid the ultimate questions. Somehow, the physician must be truthful and realistic and, at the same time, try to mitigate the impact of the mounting evidence of the patient's decline. The patient must always feel worthy of the physician's time and attention.

In many ways, the most important doctoring occurs just when it becomes obvious that the patient's finitude must be confronted. How this is done while respecting the patient as a human person is the subject of much thought today. My aim here is not to provide a lexically ordered list of obligations. Rather, it is to establish a grounding for a serious ethical obligation to protect the patient against the loss of dignity that leads to despair and, often, to a desperate plea for relief by euthanasia or assisted suicide.<sup>29</sup>

A final, and often neglected, obligation of physicians is to help family and friends to understand that the ways they respond to the patient's plight and vulnerability are important determinants of the degree to which the patient will feel alienated from the human community. All who enter the patient's presence can become complicit in the patient's loss of self-worth.

In teaching institutions, students and residents will look to their clinical teachers for guidance in protecting patient dignity. Clinical teachers must be aware that arrogance, indifference, and ineptitude can lead patients to feel alienated and undignified, reduced to lesser members of the human community. All who enter the presence of the seriously ill person become accomplices if the patient feels a loss of dignity. Unconsciously, the members of the health care team thus can contribute to the patient's sense of unworthiness.

The need to sensitize physicians and other health professionals is an urgent one in today's mechanized experience of illness. All caregivers now rotate constantly. The patient must constantly re-establish identity relationships. The preservation of dignity becomes increasingly more difficult. Physicians must have the humility to recognize that other health professionals, family, and friends will often be more sensitive to this predicament.

This latter admonition is highly relevant in teaching institutions. Students and medical residents must be taught in settings in which human dignity is expressly addressed. Students will easily learn good and bad habits. Indifference, ineptitude, and arrogance are transmissible. Courses designed to teach compassion, intercultural competency, and the like may help. But, ultimately, students and residents model their attitudes about patient care on their clinical teachers' behavior. The same is true of the institutions within which they take their first steps as clinicians. The virtues of dignity-responsive care can only be learned in personal and institutional settings that sustain those virtues.

## DIGNITY IN A POST-SECULAR SOCIETY

This essay has focused primarily on only one common lived experience of dignity and indignity. That is because the clinical experience is, or will be, familiar to everyone either personally or in the lives of family and friends. Lived experiences of the same kind are encountered in other professional relationships, e.g., in law, ministry, and teaching. Even more universally, the experience of dignity is a reality in every conceivable kind of human relationship. Whatever concept of dignity one favors will, in the end, be abstracted from a concrete experience.

This account of human dignity has shown the untenability of two of the rash assertions in Ruth Macklin's diatribe against the idea of human dignity. First, can an experience so ubiquitous, and momentous, for all human beings be so summarily discounted? The question answers itself. And, second, can it be replaced by autonomy? Emphatically not. Humans possess autonomy because of their intrinsic dignity; they are not dignified because they are autonomous. Holocaust victims did not lose their dignity or the rights that it entailed because they were despoiled of their autonomy. Nor do infants, the comatose, or the brain-damaged lack dignity because they are not fully autonomous.

Macklin's third assault on dignity, her demand that it be banished from public discourse because it has religious overtones, is equally off the mark. Such a prohibition ignores the fact that religious faith is part of being human for millions. For them, as William James observed, ".religious experiences are absolutely authoritative over the individuals to whom they come."<sup>30</sup> These experiences will inevitably become public because they are elemental to the identities of the persons who hold them. That is why, as Stephen Carter has shown, ". religion has always been in the public square."<sup>31</sup>

Religious faith does in fact go beyond the canons of discourse that secularization would impose. But it cannot be ignored on that account. Secularists cannot deny the connection between moral belief and moral practice. The trajectory of modern culture is toward secularization, but the reality is that we now live, and will live, in a post-secular society. In that society, neither religion nor secularism will triumph over the other. They are almost certain to exist side-by-side for the foreseeable future, and their interrelations will be complex. As Jürgen Habermas has emphasized, a post-secular society will require "a complementary

learning process" in which both sides "take seriously each other's contributions to controversial subjects in the public debate."<sup>32</sup>

Dignity, and the possibilities of its loss or erosion, are ineradicable phenomena of being human. The question for bioethics and contemporary culture is not how to eliminate dignity from public discourse but how to understand and acknowledge the variations in its meanings. The consequences for society, and for the way it meets the ethical challenges of biotechnology, are enormous.

Two contrary, but not necessarily contradictory, world views will dominate the discourse in our post-secular civilization. Two images of human dignity compete for moral authority. One is the scientific, the other the religious. Neither is likely to capitulate to the other. Is a productive dialogue and dialectic between these two world views possible, and how is it to be conducted?

Extremists on both sides, militant atheists and intransigent dogmatists, insist there can be no common ground. More responsible proponents of both views hope for a productive dialogue and appeal to the necessity of a common ground in the public arena, even while metaphysical foundations remain disputed. One hopeful sign is the recent dialogue between two of Europe's most eminent thinkers. One is the social philosopher and non-believer, Jürgen Habermas; the other is the Roman Catholic theologian and now Pope Benedict XVI, Joseph Ratzinger.<sup>33</sup>

Each thinker expresses genuine interest in the insights of the other. Each remains faithful to the metaphysical presuppositions of his own world. Both sincerely believe that each view can gain something from the other. Each recognizes the need for a "translation" of his ideas into the language of the other.

Interestingly, both use the concept of dignity as a subject for their "translational" methodology. The philosopher Habermas puts it this way:

One such translation that salvages the substance of a term is the translation of the concept of "man in the image of God" into that of the identical dignity of all men that deserves unconditional respect. This goes beyond the borders of one particular religious fellowship and makes the substance of biblical concepts accessible to the general public who have other faiths and those who have none.<sup>34</sup>

Ratzinger puts the same thought this way:

One final element of the natural law that claimed (at least in the modern period) that it was ultimately a rational law has remained, namely, *human rights*. These are incomprehensible without the presupposition that man qua man, thanks simply to his membership in the "species" man, is the subject of rights and that his being bears within itself values and norms that must be discovered-but not invented. Today we ought perhaps amplify the doctrine of human rights with a doctrine of human obligations and human limitations.<sup>35</sup>

Throughout their dialogue, both participants are frank about some of the weaknesses and even the "pathologies" of their own positions. They deprecate the hubris that inhibits the kind of dialogue they seek, and they acknowledge the necessity to be open to each other without relinquishing their independence.

In another place, Habermas warns us against the hubris that makes a misinterpretation of human dignity an invitation to the latent illusion of humans that ultimately they will be their own deity. Speaking of genetic engineering, Habermas issues a warning with which Benedict XVI could agree:

Would not the first human being to determine, *at his own discretion*, the natural essence of another human being at the same time destroy the equal freedoms that exist among persons of equal birth in order to ensure their difference?<sup>36</sup>

These are extraordinary men, neither of whom can be accused of eager compromise in the service of empty intellectual irenicism. They are acutely aware of the need to find a common ground and a common language-one that will recognize the perdurability of the concept of human dignity in an age of technology. Their willingness to seek practical truths of ethical action while holding to different world views should embolden all of us who hope to ease strife, indecision, and injustice in our use of biotechnology for human good.

That such a hope is not entirely fanciful is clear from the agreement in the declarations of the UN and UNESCO that both in the foundation of human rights and in bioethics, human dignity is the first principle. To arrive at this conclusion the participating nations did, indeed, use a translational methodology akin to that used by Habermas and Ratzinger, even while each held to its own metaphysical beliefs.

Sadly, the world had to experience the massive deprivations of human dignity of World War II and the world scene following it to understand human dignity in a way no purely conceptual analysis could. To paraphrase John Keats, dignity became an axiom only when it was "proven" on the "pulses" of the whole world. Only when we all had gone some way on the "same steps" did we grasp how intimately our humanity was embedded in our inherent dignity. We then understood what happens to dignity when humanity is "delivered" to tyrannical regimes; let us hope we will not also have to learn what happens to human dignity when humanity is delivered to "the process of technicalization," the "problem" that troubled Marcel.

---

## FOOTNOTES

- i. Gabriel Marcel, *Du refus a l'invocation* (Paris, Gallimard, 1970 [1940]), p. 39: "Le point de départ d'une philosophie authentique-et j'entends par là une philosophie qui est l'expérience transmutée en pensée, c'est cependant la reconnaissance aussi lucide que possible de cette situation paradoxale qui non seulement est la mienne, mais *me fait moi*."
- ii. Gabriel Marcel, op. cit., p. 25: "La philosophie, c'est bien une certaine façon pour l'expérience de se reconnaître, de s'appréhender-mais à quelle niveau d'elle-même."
- iii. See Rebecca Dresser's essay in this volume.
- iv. See Daniel P. Sulmasy's essay in this volume.
- v. See the essay by Patrick Lee and Robert P. George in this volume. § See Gilbert Meilaender's essay in this volume.

---

## ENDNOTES

1. Gabriel Marcel, *The Existential Background of Human Dignity* (Cambridge, Massachusetts: Harvard University Press, 1963), p. 158.
2. Paul Oskar Kristeller, *Renaissance Thought II, Papers on Humanism and the Arts* (New York: Harper and Row, 1965), pp. 108-109; Giovanni Pico Della Mirandola, *Oration on the Dignity of Man* (1486), trans. Robert Caponigri (Chicago: Henry Regnery, 1956); Eugenio Garin, "Italian Humanism," in *Philosophy and Civil Life in the Renaissance*, trans. Peter Munz (New York: Harper and Row, 1965), pp. 105-106.
3. Ruth Macklin, "Dignity is a Useless Concept," *BMJ* 327 (2003): 1419-1420.
4. Edmund D. Pellegrino, "Toward A Richer Bioethics," in *Health and Human Flourishing*, ed. Carol R. Taylor and Roberto Dell'Oro (Washington, D.C.: Georgetown University Press, 2006), pp. 247-269.
5. On the lived experience of human dignity in the context of the Holocaust, see Victor Frankl, *Man's Search for Meaning* (Boston: Beacon Press, 2006 [1959]). On the relevance of that era for bioethics, see Dónal P. O'Mathúna, "Human Dignity in the Nazi Era: Implications for Contemporary Bioethics," *BMC Medical Ethics* 7 (2006): 2, available online at: [www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1484488](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1484488).
6. United Nations General Assembly, *Universal Declaration of Human Rights*, General Assembly Resolution 217 A (III), 10 December, 1948 (New York: United Nations General Assembly Official Records, 1948), available online at [www.un.org/Overview/rights.html](http://www.un.org/Overview/rights.html).
7. *Universal Declaration on Bioethics and Human Rights*, adopted by acclamation at the 33rd session of the UNESCO General Conference, October 19, 2005; available online at [www.unesco.org/ibc](http://www.unesco.org/ibc).

8. See Jacques Maritain, *Man and the State* (Chicago: University of Chicago Press, 1951), p. 80.
9. John Keats, "Letter 64 to J. H. Reynolds, 3 May 1818" as cited in *Oxford Dictionary of Quotations*, 2nd ed. (London: Oxford University Press, 1955), p. 289.
10. Edmund D. Pellegrino, "The False Promise of Beneficent Killing," in *Regulating How We Die*, ed. Linda L. Emanuel (Cambridge, Massachusetts: Harvard University, 1998), pp. 71-91.
11. Aurel Kolnai, "Dignity," *Philosophy* 51 (1976): 251-271.
12. Ibid., p. 252.
13. Gabriel Marcel, *The Mystery of Being, Volume 1: Reflection and Mystery ( Gifford Lectures, 1949-50 )* (South Bend, Indiana: St. Augustine's Press, 2001).
14. Gabriel Marcel, *Being and Having: An Existentialist Diary*, trans. Katherine Farrer (New York: Harper and Row, 1965), pp. 100, 117, and 126 (first published in French as *Etre et avoir* in 1935); Kenneth T. Gallagher, *The Philosophy of Gabriel Marcel*, with a foreword by Gabriel Marcel (New York: Fordham University Press, 1975), Chapter 3.
15. Sydney Rome and Beatrice Rome, "Interrogations of John Wild," in *Philosophical Interrogations* (New York: Holt, Rinehart & Winston, 1964), p. 129.
16. Gallagher, op. cit., p. 43.
17. John Henry Newman, *An Essay in Aid of a Grammar of Assent* (Notre Dame, Indiana: University of Notre Dame Press, 2006), pp. 270-299 (first published in 1870 after a gestation of twenty years).
18. Bernard Lonergan later used Newman's illative sense as a stimulus for his own in-depth explorations of the idea of "insight." See Bernard J. Lonergan, *Verbum: Word and Idea in Aquinas*, ed. David Burrell (Notre Dame, Indiana: University of Notre Dame Press, 1967), p. 47.
19. James Collins, *The Existentialists* (Chicago: Henry Regnery, 1958), p. 150.
20. Alexei Kukuljevic, "De Levze's Metaphysics and the Reality of the Virtual," *Philosophy Today* 49 (2005): 146.
21. John F. Crosby, *The Selfhood of the Human Person* (Washington, D.C.: The Catholic University of America Press, 1996), p. 177. Crosby means here to distinguish relational goodness, that which is relative to one's own ends or to another's satisfaction, from the intrinsic goodness in itself that is the essence of human dignity.
22. Erwin W. Straus, *Phenomenological Psychology*, trans. Erling Eng (New York: Basic Books, 1966), pp. 217-224.
23. Ibid., p. 222.
24. Ibid., p. 223.
25. Edmund D. Pellegrino, "The Trials of Job: A Physician's Meditation," *Linacre Quarterly* 56 (1989): 76-88.
26. Karol Wojtyla, *Person and Community-Selected Essays*, trans. Theresa Sandok, OSM (New York: Peter Lang, 1994), p. 5.
27. Ibid., p. 38.
28. Gabriel Marcel, *Man Against Mass Society*, trans. George F. Fraser, with a foreword by Donald McCinnon (Chicago: Henry Regnery, 1967), p. 244.
29. Edmund D. Pellegrino, "The False Promise of Beneficent Killing," cited in note 10 above.

30. William James, *Varieties of Religious Experience* (1902), reprinted in *Philosophy of Religion: Selected Readings*, 3rd edition, ed. Michael Peterson, William Hasker, Bruce Reichenbach, and David Basinger (Oxford: Oxford University Press, 2006), p. 16. 31 Stephen Carter, *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion* (New York: Doubleday, 1993), p. 100.

32. See Habermas's contribution to Joseph Cardinal Ratzinger (Pope Benedict XVI) and Jürgen Habermas, *Dialectics of Secularization: On Reason and Religion*, ed. and with a foreword by Florian Schuller (San Francisco, California: Ignatius Press, 2006), pp. 46-47.

33. Ibid.

34. Jürgen Habermas, *The Future of Human Nature* (Cambridge: Polity Press, 2003), p. 41.

35. Ratzinger and Habermas, *Dialectics of Secularization*, p. 71.

36. Habermas, op. cit., p. 115.