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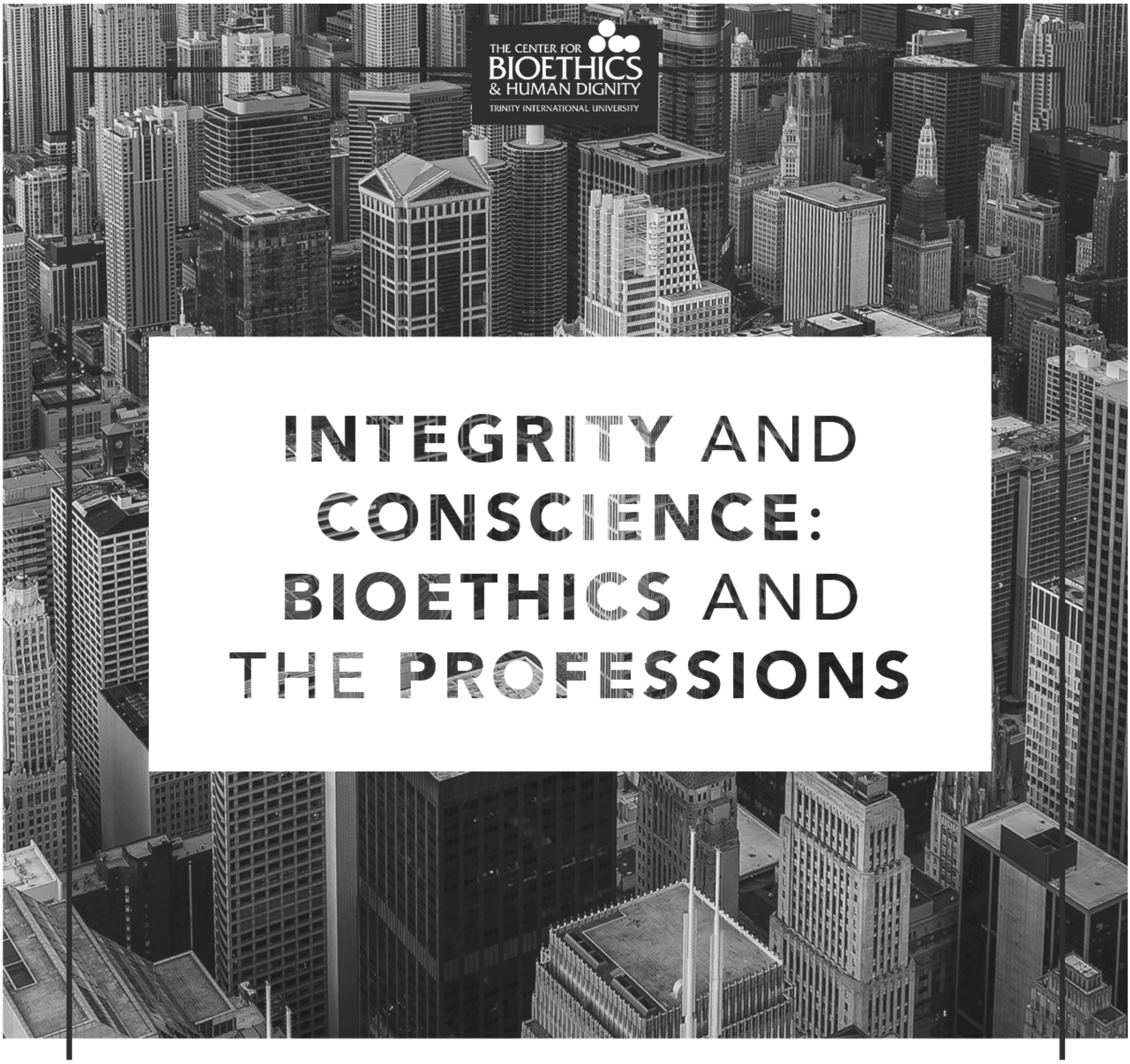
ERRATUM: *In the Spring 2020 issue of Ethics and Medicine, biographical information for Patrick Marmion was incorrectly stated on pages 3 and 26. Dr. Marmion's credentials are: Patrick Marmion, MD, MPH, FACPM. The Editorial Staff of Ethics & Medicine regret this error.*



CLINICAL ETHICS DILEMMA

Proposed Surgery During an International Pandemic

FERDINAND D. YATES, JR, MD, MA (BIOETHICS)

Editor's Note: This column presents a problematic medical-surgical case that may pose a medical-ethical dilemma for patients, families, and healthcare professionals. As these cases are based on real medical situations, identifying features and facts have been altered to preserve anonymity and to conform to professional medical standards. In this case, a family must weigh the benefits and burdens of a proposed surgical procedure.

Column Editor: Ferdinand D. Yates, Jr is an Active Associate Pediatrician at Children's Healthcare of Atlanta and is in private pediatric practice in the Atlanta area.

Question: Is it ever appropriate to perform a surgical procedure if it is not medically necessary?

Story

Nathaniel is presently an active 21-month-old infant. Overall, he has done exceedingly well since birth and has required no hospitalizations or surgeries. After the first several months of life, he began to develop increasing difficulty with nasal symptoms and sleeping difficulties, and ultimately developed perforated eardrums after having had several episodes of otitis media and treatment with appropriate antibiotics. There seemed, however, to be no problem with the infant's hearing. Nathaniel's father also had problems with his ears as a child, and ultimately required a tympanostomy tube placement.

Nathaniel's mother dutifully took him for several visits to the otolaryngologist, with the ultimate recommendation of the placement of myringotomy tubes. The operative procedure date was established. However, shortly thereafter, the procedure was postponed because of the onset of coronavirus (COVID-19), wherein all elective surgical procedures in the state were appropriately curtailed for the foreseeable future.

Nathaniel and his family did well (as well as any family with four young children could do) under a 'stay-to-home' statewide mandate. Interestingly, he showed no evidence of ear symptoms during that time (he had not been in daycare for nearly two months during the quarantine).

As the individual states' medical systems began to reopen for non-urgent procedures, Nathaniel's surgery was rescheduled. The otolaryngologist informed the mother that he had quite a backlog of cases and wanted to offer the earliest operating time to infants and young children. In preparation for the surgery, Nathaniel was seen by the otolaryngologist several days prior to the re-established surgical date. The doctor noted that the exam revealed no evidence of an ear infection and there was no perforation of the eardrums or ear drainage. Even though the COVID-19 situation seemed to be more quiescent at that time, there was no guarantee, should the surgery be declined, that Nathaniel would be awarded another block of operating room time in the foreseeable future.

The family has planned to relocate to another state due to a job-related move for the father. Unfortunately, the new job has sub-standard health insurance coverage that will not cover a pre-existing medical condition, and any surgical costs would have to be paid by the family. In addition, the parents have no recommendations for surgical subspecialty care at the new location.

Nathaniel's mother, a highly-qualified BSN, asks her father, a medical ethicist, whether or not she should go forward with Nathaniel's proposed surgery to place the myringotomy tubes.

Discussion

This situation involving elective surgery for the patient has two clear-cut options: to allow the surgical procedure or to decline the procedure.

In performing the surgical procedure, Nathaniel's family would enjoy the certainty of the myringotomy tube placement being done under a controlled and non-urgent situation. Knowing that this surgery has minimal operative time and risk of anesthesia, being done in the face of minimal persistent effusion certainly adds to the ease and success of the procedure. Additionally, the family would enjoy the peace of mind knowing that their current healthcare coverage would relieve any (or at least provide minimal) financial responsibility for the parents.

Also, knowing that the surgical procedure would be accomplished before the upcoming move, the parents would also be able to enjoy the comfort of knowing the benefits of this completed surgery. There should (barring unforeseen events) be minimal urgent need for the identification of a necessary medical-surgical procedure during the early time of the relocation to the new community

In declining the elective surgical procedure at this time, Nathaniel and his family need to recognize an entirely different set of potential consequences. If the mother were to change her mind (after having declined the procedure), and then request that the surgical procedure be done prior to relocating, this option may no longer be possible. The doctor may not have any residual operating room time as he is attempting to catchup on his backlog of postponed surgeries. Furthermore, should there be a recurrence of COVID-19 [an additional wave of infections], elective surgical procedure may—once again—be postponed. Also, in not doing the surgery at this time, the issue of potentially unnecessary surgery is no longer germane, and the patient would have no risk of the operative procedure or any subsequent medical care related to the placement of myringotomy tubes.

Without the myringotomy tube placement, there is the possibility of persistent unrecognized ear problems. This, however, seems highly unlikely in the face of the medical knowledge in the patient's family and the recognized intention of appropriate well-child care in the new location. Nonetheless, declining the procedure does raise the possibility of future surgery under less-than-optimal conditions, primarily because the family will have minimal immediate information about medical care in the new community. Again, the specter of sub-optimal insurance coverage is also unavoidable.

It appears to be the case (as in many other infants and young children) that there is increased frequency and problem with ear infections when the child is in a daycare setting. With the upcoming relocation, the family's older three children will be in the school where their father will be teaching. This provides a situation under which Nathaniel may have the luxury of remaining at home for a defined period and during which a daycare setting will not be necessary. This period should grant Nathaniel some time to mature and, perhaps, have less exposure to illness. Nathaniel's mother would be able to daily access her son's hearing, speech, development, and gait (all of which may be impacted by unrecognized persistent ear infections).

Recommendations

There are two approaches that are permissible in this situation:

- It is permissible to reasonably take the approach of declining the surgical procedure;
- It is permissible to reasonably take the approach of allowing the surgical procedure;

Denouement

The mother elected to decline the surgical procedure as she was unable to justify the potential risks for her son under the present clinical setting.

Nathaniel has done exceedingly well in the interval of 'shelter-in-place' during the COVID-19 pandemic. In part this was likely due to healthy siblings and minimal exposure to other sick children.

The child has had no evidence of any other ear symptoms. The child's speech and hearing, including his gait and balance, have all developed along standard developmental guidelines.

The move is proceeding according to schedule, and the family will be in the new location shortly.

Ferdinand D. Yates, Jr, MD, MA (Bioethics), is a retired pediatrician who has contributed to bioethics education in medical schools, colleges, hospitals, and through professional societies. He earned MA in Bioethics from Trinity International University and was Professor of Clinical Pediatrics at the State University of New York at Buffalo.

GREY MATTERS

MEDICINE MASKED: ETHICAL IMPLICATIONS OF HALF-HIDDEN FACES DURING A PANDEMIC

WILLIAM P. CHESHIRE, JR., MD, MA

"[T]he face is what forbids us to kill." — Emmanuel Levinas[1]

Abstract

The most visible change to medicine in 2020 has rendered human faces only half-visible. In an effort to reduce transmission of the SARS-CoV-2 virus, healthcare professionals everywhere, and patients too, are now wearing face masks covering the nose and mouth whenever meeting in person. Masks block germs, but they can also block communication, as positive emotions are conveyed by the lower part of the face. When the mouth is covered, smiles are hidden. Expressions of intent may seem ambiguous, of concern neutral, of empathy imperceptible. Although medically necessary during an infectious pandemic, masks shroud a vital feature of our shared sense of humanity and may lessen the perception of presence at the bedside. In order that the face-to-face healing encounter is not reduced to a rendezvous of the hemi-anonymous, masked caregivers must be especially intentional in their eye contact, tone of voice, and chosen words.

Introduction

During the COVID-19 global pandemic, in combination with handwashing and eye protection, face masks have become necessary apparel for healthcare professionals to prevent transmission of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).[2] As the mouth both breathes and speaks, a barrier to potentially infectious respiratory droplets can also be a barrier to communication. This is obvious to the hearing-impaired, who rely on reading lips to interpret words they cannot clearly hear. Masks also modify communication in subtle ways in which the wearer may be unaware. The masking of facial expressions can alter how the wearer is perceived.

A Brief History of Masks

Throughout history and in nearly all cultures, masks have been fashioned for purposes dramatic, magical, religious, social, political, symbolic, and utilitarian. In pre-technological cultures, the wearing of masks in religious ceremonies was believed to impart to the wearer the spirit or qualities of the animal or god represented.[3] This universal imitative instinct was manifest also on the stages of ancient Greece and Rome, where, for dramatic effect, actors wore masks both tragic and comic. Ornate painted masks are a distinctive feature of Japanese musical drama. Unlike the human face, stage masks are rigid, conveying a fixed expression and attitude.

By concealing the wearer's face, masks foster a sense of disinhibition. When masquerading, it becomes easier to violate social norms in public. Some burglars and anarchists wear masks, not to put on a new persona, but to disguise their identities and escape detection. Executioners wore masks to conceal their identity, thus evading the possibility of retribution by associates of prisoners sentenced to death as well as distancing themselves psychologically from the act of killing. In some cultural contexts, violence done by a mask-wearer is understood to have been committed, not by the human but by the mask.[4]

Masks have also served as protection against threats. Samurai warriors wore fierce masks into battle. The Chinese would place terrifying paper masks over the faces of their children to frighten away the demon believed to cause smallpox.[5] In 17th century Europe, physicians who treated victims of the bubonic plague wore protective masks with glass eye apertures and long beak-shaped noses stuffed with aromatic herbs and spices believed—incorrectly—to purify the air they inhaled through the mask.[6] In the 20th century, in response to the deployment of poisonous gases in World War I, the Allies developed gas masks consisting of a rubberized fabric face covering supporting two circular eyepieces and fitted with a cannister through which the wearer breathes. As mechanical barriers, these masks sometimes protected. As caricatures of the human face, they could also frighten. Many a science fiction movie has sent chills down the spines of its viewers by casting a villain with grotesque goggles covering or substituting for eyes and a low-pitched, strained, mechanical breathing apparatus obscuring the mouth.

During the 1918 influenza pandemic, mask ordinances required people to wear cloth or gauze masks when in public. Similar rules are in place in 2020. As in 1918, the efficacy of masking has been both promoted and questioned, and compliance has been far from universal. Such masks do not appear frightening. They indicate protection, both for and from the wearer. They also conceal part of the face.

Medical Mimicry

“Masked facies” refers to the reduced spontaneous facial expression, or hypomimia, that occurs in people with Parkinson disease. Other forms of facial motor impairment, such as Bell’s palsy, myotonic dystrophy, myasthenia gravis, and the muscle weakness caused by injections of botulinum toxin, can reduce emotional facial expressions. Weakness of the facial muscles, especially if bilateral, can create a false appearance of affective neutrality or negativity.

False facial expressions can be produced also by activating facial muscles. Applying the principle of galvanism, by which electrodes brought into contact with a frog cause the legs to twitch, the 19th century French neurologist Guillaume-Benjamin Duchenne placed electrical probes over the muscles of the human face and triggered muscular contractions that produced specific facial expressions. As the camera had recently been invented, he published a photographic atlas of exaggerated and, at times, grotesque electrically induced facial expressions, which he believed to reflect the “gymnastics of the soul.”[7]

Duchenne may be the only neurologist to have had a facial expression named after him. A “Duchenne smile” refers to a full, or genuine, smile in which the eyes squint as the corners of the lips are drawn upward. It is possible to feign a smile by raising the corners of the lips—a voluntary action that one can manipulate—but such a smile is incomplete. A genuine smile, by contrast, also recruits the orbicularis oculi muscles to cause the outer corners of the eyes to squint slightly—an involuntary gesture signaling joy.[8]

The Neuroscience of Facial Expression

Whereas Duchenne mapped the facial muscular components of human emotion, in recent decades research has employed electromyography to define with even greater precision the orchestrations of facial movements encoding specific emotions. By placing electrodes on the surface of the skin and analyzing the patterns of electrical signals generated by contracting muscles beneath the skin, neuropsychologists have identified two groups of facial muscles that correspond most closely to specific emotional states. The corrugator muscles, which are located above the eyebrows and contract the forehead into wrinkles, correlate with negative affect and are active when someone feels sad, unhappy, or depressed. The zygomatic muscles, which draw the corners of the mouth upward and outward, correlate with positive affect and are active when someone is smiling or feels happy.[9] These muscles were active even when observers could not consciously discriminate among emotional states.

More recently, neuropsychologists have employed functional magnetic resonance imaging (fMRI) to map the brain networks that correspond to displaying and perceiving basic human emotions. As one would expect, the visual cortex was highly active, as well as the fusiform face area in the inferior temporal cortex. Many additional brain regions were recruited, including the temporoparietal cortex, anterior cingulate gyrus, lentiform nucleus, prefrontal regions, and cerebellum. Whereas viewing fearful, happy, or sad faces activated the amygdala, viewing disgusted or angry faces activated the insula.[10]

Another line of research utilizes a bubble or tile technique of masking and revealing parts of viewed faces. Observers shown bubbles revealing randomly sampled portions of faces were most likely to identify correctly the emotional state of the face when presented with the eye or mouth regions.[11] Of these, images of the mouth area were found to be the most important cue for accurately identifying both static and dynamic facial expressions.[12]

Facial expressions are a basic means of nonverbal communication. When viewing the facial expressions of others, one can feel intuitively what they are feeling. The neurobiological basis of this mimetic function is the mirror neuron system, which contributes to empathy, or the ability to share the feelings of others.[13] When subjects were shown disgusted, neutral, or pleased facial expressions during fMRI, their self-reported empathy correlated with neural activity in the anterior insula and adjacent frontal operculum, suggesting that these brain regions contribute to the mapping of others' emotional states onto one's own internal emotional state.[14]

Effect of Masks on Relational Communication

It is reasonable, therefore, to ask whether concealing part of the face by wearing face masks hinders nonverbal communication during medical care. A research team in Hong Kong has put this question to the test. In a controlled study of 1030 patients who were randomized to primary care clinical consultations with physicians either wearing or not wearing face masks, a significant negative effect for masks was found in patients' perception of physician empathy.[15] They concluded that wearing masks diminished the positive effects of relational continuity.[16]

Although not empirically verified to date, research mapping regions of facial activation to specific emotions suggests that masks might not only restrict emotional communication in general, but also introduce a negative bias. As the upper part of the face conveys the strongest signals of negative emotions, and (with the exception of the squint of a genuine smile) the lower part of the face conveys the strongest signals of positive emotions, face masks may filter emotional expression by allowing negative emotions to be displayed while concealing positive emotions. When wearing a mask that covers the lower face, forehead wrinkling remains visible, while smiles disappear. Mask-wearers might thus be misunderstood to show negative emotions more often than positive emotions.

In what further ways universal masking influences the relational aspect of medical care is, at this time, a matter of speculation, but personal experience can offer some preliminary insights. Early in the pandemic, patients surrounded by healthcare professionals wearing masks might have felt a surge of fear. Entering a hospital or clinic and seeing everyone wearing masks, some may have wondered whether they had just stepped into an infectious zone where doctors were taking extraordinary precautions. Some may have wondered whether they themselves were viewed as a potential source of contagion. Such thoughts are unlikely to make a patient feel safe and comfortable. However, as the public has grown accustomed to seeing and wearing masks, medical encounters have settled into a "new normal," and most patients understand that the purpose of face masks is not to create distance from them, but to protect them. As the perceived meaning of the mask has shifted from insulation to obligation, wearing masks has the potential to reinforce relational bonding and trust.

Effect of Masks on Ethics

The potential influences of masks on medical ethics may be subtle and more difficult to discern. Masks can confer a sense of anonymity, and feeling that one is anonymous can change one's behavior. Psychological research has shown that masks can function as disinhibiting props, reducing one's sense of moral responsibility for one's actions. Subjects in a psychological experiment who were asked to wear sunglasses behaved less generously than those who did not.[17] In another study, children on Halloween were offered a bowl of candy and told that they could take only two pieces; those wearing masks were more likely to break the rule and take more candy than those whose faces were visible.[18]

Embedded in the medical profession, however, are strong safeguards against the potential anonymizing effect of face masks. Physicians initiate the medical relationship by making themselves known, and most wear identifying badges displaying their faces. The physician's signature on a prescription pad, or its digitally authenticated equivalent, affirms that he or she bears responsibility for medical decisions, even if his or her face is unseen.

If, however, physician-assisted suicide or euthanasia were to become a legal option, would a masked physician feel less personally culpable for making a recommendation for death? Would a physician who meets in person with a patient whose display of humanity is partly concealed by a mask be more or less likely to choose interventions that hasten that patient's death?

There remains an occasional ambiguity in medical practice of the caregiver's intent, an ambiguity rendered more opaque by the mask. The patient may not be able to tell whether the physician is smiling or frowning, approving or disapproving. The mask thus creates opportunities for misjudging or misunderstanding.

Conclusion

Sir William Osler advised physicians to cultivate the manner of imperturbability, by which he meant "coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility, impassiveness. . . . The physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients."[19] The face mask may conceal the expression of emotion, but it cannot produce the virtue of imperturbability. Healthcare professionals wearing masks, in order not to appear indifferent to their patients, must be even more intentional in the use of eye contact, comforting tone of voice, steady demeanor, and judiciously chosen words.

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GUEST COMMENTARY

A Forgotten Crown of Glory: The Elderly and COVID-19

JUSTIN CHU, MA

The nursing home where I worked this past summer was fortunate. The long-term care facility shielded its residents from the chaos of the pandemic unfolding outside and managed to avoid any positive COVID-19 cases among its residents and staff for the summer. Of course, this came at a cost. Visitors were barred, activities were canceled, and residents were largely made to stay in their rooms. Even though residents received the same medical care as before—physicians still inspected wounds and nurses continued to pass medications—their mental health and overall wellbeing noticeably diminished. No longer able to enjoy bingo or attend religious services, they sat in their rooms watching TV, becoming more confused by the day.

Other nursing homes have encountered greater medically-related difficulties. By October of 2020, nearly 50% of COVID-19 deaths occur in nursing homes, with Britain losing approximately 5% of its nursing home population to the virus.[1] During those early months of the pandemic in the US, residents and employees of nursing homes accounted for 35% of COVID deaths in the country.[2] The elderly in general were afflicted by the disease at a disproportionate rate, and this knowledge caused many to shelter in their homes uncertain about when they might be able to leave.[3]

Although the COVID-19 pandemic presents a situation of exceptional magnitude, the mental and physical hardships of the elderly are anything but novel. With necessary support dreadfully lacking, governments and societies must attend to the needs of society's elderly. Changes in both attitude and policy towards the elderly are appropriate for society to achieve humane care for those approaching old age.

With dementia is on the rise among the aging population,[4] increasing numbers of elderly adults are placed into the care of nursing homes by family members unable or unwilling to care for them. In fact, one million residents with dementia were in American care homes in 2017.[5] These nursing homes, in turn, are often underfunded and understaffed, a fact made all too evident as they struggled to maintain rigorous testing and sufficient PPE stores during the pandemic.[6] (I was expected to use the same surgical mask for five shifts, keeping it in a paper bag when I was not working.)

Societal stigmatization of the elderly, especially those with dementia, became increasingly clear during the pandemic. People downplayed the harm of the virus as only affecting old people, as if this was no cause for concern.[7] For those with dementia, this dehumanization is the norm, as they are often looked upon as less than human with their impaired mental cognition. In countries with legal euthanasia or assisted suicide, this disregard for their judgments and wishes can be the brink to allowing for their death.[8]

Clearly, the elderly remain at risk for more than just COVID-19. Solutions to this problem should address both policy and public attitudes. Policy measures ought to focus on expanding access to care. While the market-driven economy of the US makes it easy to revert to business models that undercut care while maximizing profits, access to care for the elderly should focus on models that prioritize the patient.[9] This would allow flexibility in cases where certain types of care, such as at-home care, would be more beneficial than institutionalized care. Policymakers should also seek to ensure adequate staffing and supplying of nursing homes, which are typically neglected compared to hospitals.[10]

However, policy measures alone will not help elderly adults. Public attitudes must shift towards once again recognizing the elderly, especially those with dementia, as human. I am not suggesting that comments such as "the virus only affects the elderly" necessarily mean to dehumanize them. However, while this observation may be useful for targeted policy, it must not be used to denigrate the elderly demographic as lacking economic or productive value.[11] The elderly, even those with dementia, still deserve medical care. Society must reverse the notion that resources should be reserved for the economically pragmatic. If the U.S. is to solve its nursing home crisis, it must first attend to its attitude crisis towards the people living in the homes.

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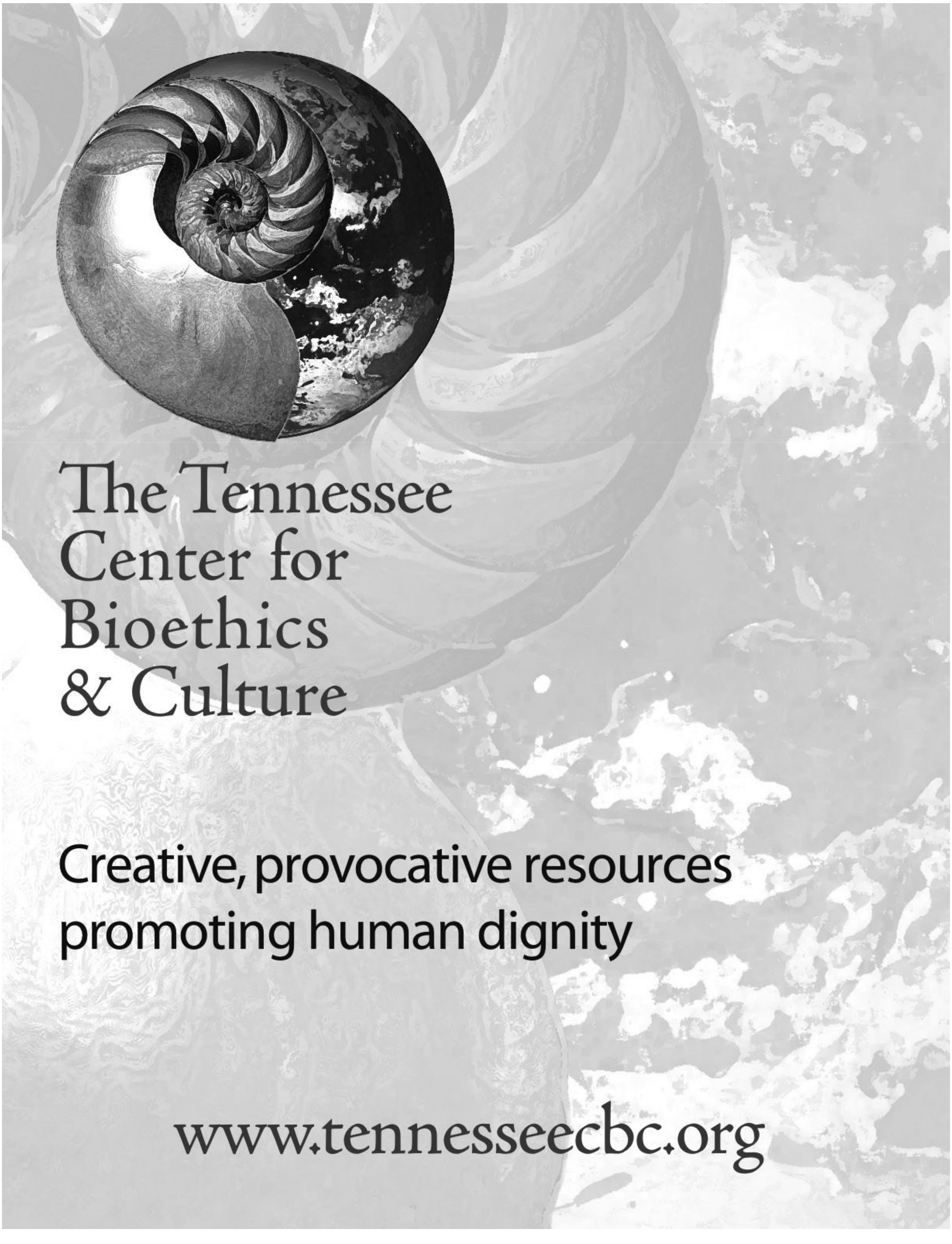

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Triage in a Pandemic: Equity, Utility, or Both?

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Abstract

In terms of the setting of priorities for resource allocation, two general principles are important. These are *equity* and *utility.* Based on these two concepts, there are two historically discrete models for triage of limited resources. These are the French egalitarian model based on equity and the British military model based on utility. Modern paramedic and emergency room care in multiple casualty situations favors the triage model based on utility. Modern ICU care favors the triage model based on equity. There are issues to be addressed in both triage responses. In a pandemic, both the utilitarian model and the equity model are active, and their applicability changes as the trajectory of the pandemic progresses.

Keywords: *Pandemic, triage, equity, utility*

Introduction

'Triage' is the process of deciding the order or priority of treatment of ill or injured patients, usually in settings where available resources are not limitless. 'Pandemic' refers to an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.

In terms of deliberation aimed at the setting of priorities for resource allocation, two general principles are important. These are *equity* and *utility* (Verweij 2009). *Equity*, as the basis for triage, aims for an allocation of resources which is fair, right, and just—for example, mitigating health disparities and avoiding discrimination on non-medical grounds. Equity is not the same as equality. Equity means allocating resources based on the needs of the recipients. Equality means giving everyone exactly the same resources. *Utility*, as the basis for triage, aims for an allocation of resources which maximizes one or more outcomes—for example, number of lives saved.

Although Kant and other duty-based ethicists have argued that humans should be seen as ends in themselves and hence intrinsically valuable (Kant 1956, 62–65), traditionally principles of triage in multiple casualty situations are utilitarian (NYTFLL 2015, 33; Bazyar, Farrokhi, and Khankeh 2019; Clarkson and Williams. 2020). In situations of multiple casualties, limited resources (for example, numbers of trained rescuers and available equipment for resuscitation) are directed to salvage the greatest number of lives. This utilitarian response thus requires compromise of ethical principles centered upon the autonomous health needs of any one individual, in favour of the aggregated health needs of the greater number. For example, following a motor vehicle accident, four patients are moderately injured but will likely live with sufficient resuscitation, while one is severely injured and will likely take most of the resuscitative team's resources. The four patients are prioritised for treatment over the one very severely injured patient. This argument can only run so far though. Consider now that although the four have been resuscitated, to survive long term each requires an organ transplant—one a heart, one a liver, one a kidney, and the fourth a lung. You know there is one young healthy patient waiting in your clinic for a check-up. Despite the obvious utilitarian attraction, it is impermissible to harvest four of her organs in order to save the four accident victims.

Historically, there are two distinct models for triage of limited resources, based on conceptions of equity and of utility. These are regularly, but erroneously, conflated (Jonsen 1990; Baker and Strosberg 1992). After explaining the difference, I will argue that in a world pandemic both models are active, but their applicability changes as the trajectory of the pandemic progresses.

Models for Triage

The *egalitarian model* dates from the Napoleonic era, where Baron Dominique Jean Larrey saw privileged officers being carried in early by their manservants, though less-severely injured than poorer soldiers who had to get themselves to the hospital tents. He set out to prioritize treatment of the most dangerously wounded first. Larrey's model is thus based on equity, without regard for "rank or distinction" (Beecher 1969, 110; Kirby 2010, 758).

The *utilitarian model* dates from the 18th Century, where the British hospitalists John Aitken and Thomas Percival aimed to maximize utility, which in warfare is success in battle. So, priority treatment was given to those who can most expeditiously be returned to active duty in order to defend the compound, over those who had more severe injuries preventing their rapid return to active duty (Churchill 1952; Kirby 2010, 758). Thus in Northern Africa during World War 2, prioritizing the war effort, penicillin was given to those soldiers laid low with syphilis, in preference to those with war injuries (Beecher 1969, 280–281). This utilitarian model of triage prioritises the greatest good for the greatest number.

Shifting Models in a Pandemic: Utility Early

As noted above, in modern paramedic or emergency room care of multiple casualty situations, the utilitarian (British military) triage model which aims for the greatest good for the greatest number via saving the greatest number of casualties, is favoured.

Since at least the 2003 emergence of SARS 1, pandemic preparedness priorities also favour the utilitarian model of saving as many lives as possible (Kass et al. 2008, 228; Verweij 2009; Kirby 2010, 758; Fiest et al. 2020, 412). Arguably, this is good both for individuals and for the community (with caveats about quality of life). Within the utilitarian triage model, the treatment of healthcare workers (HCWs) is prioritised so as to return them to the front line, where they can potentially save more lives. Ancillary benefits accruing to the prioritisation of HCWs are that they are encouraged to turn up for work, safe in the knowledge they will be prioritised for treatment if infected.

As the pandemic approach to triage, prioritising the saving of as many lives as possible appears simple and clear, and is likely to help inspire confidence in health departments and government policies. Medical exclusion criteria aside, two points of clarification to the phrase 'save as many lives as possible' are important.

First, giving consideration to incorporating into 'number of lives saved' a measure of number of years of life saved and number of quality-adjusted or disability-adjusted years of life saved, is potentially important. There are precedents for this consideration. Guidelines for the allocation of lungs for transplantation allow for expected duration of survival after transplantation ("the difference between expected lifetime with versus without a transplant"), not simply avoidance of death ("expected lifetime without a transplant") (Egan et al. 2006, 1226).

Second, public health initiatives during a pandemic such as border closures, self-isolation, social distancing, and working from home inflict significant collateral financial and social damage on society and our way of life. Hence, from the perspective of governments, allocation of resources in a pandemic under the utilitarian model could move beyond mere numbers and quality of lives saved, and could aim at saving as many specific lives as possible. This is in order to maximize specific utilities—utilities which are potentially useful in the post-pandemic recovery phase. These might include prioritising saving the lives of workers in border protection and policing in order to maintain the law, order, and the safety of citizens. Community or public goods such as happiness or economic viability may be prioritised, as may social infrastructure. Hence prioritising lives to be saved as those who work in sanitation, counselling, or entertainment; or financial security such as workers in banks and other financial institutions, over saving 'average' citizens (Kass et al. 2008). Guidelines from the University of Pittsburgh assign a priority score for allocation of a ventilator that incorporates giving priority to individuals who perform tasks vital to the public health response (White and Halpern 2020, 7).

Ideally, determining the actual basis for utilitarian triage decisions about prioritisation of certain lives over others from a community or public good perspective would be based upon a clear and transparent articulation of the outcomes to be maximised. Kirsten Fiest's et al. (2020) recent systematic review of the allocation of intensive care resources during an infectious disease outbreak identified 83 articles. Of these, 30 explicitly stated which ethical principles guided the development of their triage criteria. Twenty based their protocols on the basis of helping the greatest number to survive (stewardship), 5 based resource allocation on societal contributions (reciprocity), and only 4 reported engaging the public to prioritize triage criteria (Fiest et al. 2020, 8–9). Additionally, despite prior experience of influenza epidemics, many institutional COVID-19 policies may have been determined within a relatively short space of time (Antommaria et al. 2020, 193). This suggests that the societal and governmental utility priorities above are uncommonly discussed in this context. Our era is characterized by an expansion of world travel and migration, which has brought people from widely disparate cultures and belief-systems into our communities. The resultant socio-cultural, ethno-national, and religious diversity is both deep-reaching and results in conflicting conceptions of equality versus justice and liberty versus autonomy; bringing about a far-reaching moral pluralism (Walker and Lovat 2019, 72). Achieving consensual agreement as to which utilitarian outcomes should be prioritised is important, but will likely be both challenging and time-consuming.

Shifting Models in a Pandemic: Equity Later

In modern ICU care, efforts are made to restrict admissions to the very sick and to accelerate the discharge of less severely ill patients (Kirby 2010, 758). This is done in order to give critical care priority to very sick individuals, who are expected to benefit the most from such intervention (while not thought to be futile). Once the patient is no longer severely unwell and becomes only moderately unwell, they are discharged from the ICU to an intermediate-level care unit. Thus, current ICU triage practice is closer to the egalitarian (French) model for triage than the utilitarian model in that admission is based solely upon the severity of illness, resources are allocated according to need, and there is no discrimination based upon officer status vs. enlisted man—than to the utilitarian model (Kirby 2010, 758).

The changing applicability of triage models based on utility and equity to a health service or hospital, as the course of a pandemic progresses, may be equally applicable to an individual patient. Consider an adult with diabetes, lung, and heart disease. In a pandemic she is more vulnerable to infection and once infected, has a poorer survival prognosis. The equity model for triage would point toward priority vaccination aiming to prevent disease. However, once infected, with a poorer survival prognosis and limited resources, arguably the utilitarian model would point away from active treatment.

Shifting Models in a Pandemic: Utility Revisited

In summary thus far, although the utilitarian model for triage of limited resources may begin the pandemic response, once a patient is ill enough to reach an ICU, the basis for triage switches to the egalitarian model, wherein the most severely ill (but not futile) patients are given priority admission into an ICU, and less-severe patients are not admitted.

Taking this thinking one step further, as the pandemic relentlessly progresses, a more complex decision-making situation may arise involving re-allocation of resources. Consider a military hospital which accepts civilian patients for treatment, but in a battlefield surge must transfer civilian patients under their care to a local hospital which may not have the expertise or equipment to keep them alive, in order to follow their duty to prioritize the care of injured soldiers (O'Mathúna 2016, 10). In a pandemic, although only required in a particularly dark scenario, existing guidelines acknowledge that if there is a shortfall in available ventilators, there may arise the need to re-allocate existing ventilators to those with greater survival prognosis, rather than have the situations where "patients unlikely to survive were allowed indefinite use of ventilators" (White and Lo 2020, 1774; NYTFLL 2015, 61–71; White and Halpern 2020, 3–4).

In 2006 in the UK, it was estimated that during an influenza pandemic, between four and five times the number of ventilated intensive care beds would be required than were available (Marsh 2006). In 2020 in the US, it was estimated that during COVID-19, each available ventilator might be required to service between 1.4 and 31 patients (Truog, Mitchell, and Daley 2020, 1973). Thus, it may be that decisions need to be made about limiting the duration of care for patients who do not improve rapidly (Marsh 2006, 791). It could reach the point where switching off the ventilator of someone already on life-support, in order to benefit someone else with a better survival prognosis, may be required. Or, monitoring and then taking someone off their ventilator if they are not progressing well enough or sufficiently quickly using indices such as the Sequential Organ Failure Assessment (SOFA). Of 29 US hospitals with a ventilator triage policy and associated with the Association of Bioethics Program Directors, 95% used a version of the SOFA score (Antommaria et al. 2020, 191) plus discrete time intervals for reassessment. Once taken off life support, the ventilator-dependent patient would then die. These actions are difficult to justify under traditional ethical frameworks. From the perspective of the patient already on the ventilator, the action breaches the principles of autonomy (the removal of ventilator support is not taken at the patient's or relative's request), beneficence, non-maleficence (because death will follow), and justice (the removal of ventilator support is not taken because treatment is deemed futile, and in ordinary, non-pandemic times, the ventilation would have continued). One solution widely proposed is triage teams or committees, discrete from the clinical care teams, to make the decision.

My point here is that arguably, the triage model is challenged once more. The triage model for getting *into* the ICU in the latter stages of a pandemic is based on equity—treating the most seriously ill (matching resources to those with the greatest need). While the triage model for getting *out of* the ICU (involuntarily) switches back to triage based on utility—saving the most lives.

Conclusion

There are issues to be addressed about both the triage response founded on equity and the triage response founded on utility. Both of the two underlying models of triage have challenges in their practical application. In a pandemic, both models are active, and their applicability changes as the trajectory of the pandemic progresses.

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Kindness and the Ethics of Physician-Assisted Suicide

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Abstract

In this paper I explain four features of kindness by examining how four artworks depict them: Giotto di Bondone's painting of St. Francis of Assisi giving his robe to a beggar, the character Bishop Charles-Francois Myriel in Victor Hugo's *Les Misérables*, the person Adam in William Shakespeare's *As You Like It*, and the role of Sonya Semyonovna Marmeladov in Fyodor Dostoevsky's *Crime and Punishment*. These four examples describe kindness as supererogatory, altruistic, a belief about how the world ought to be, and the possibility of unction. With this understanding of kindness, I examine the most likely moral motives of the physician in physician-assisted suicide and find that the practice does not display the four characteristics of kindness but rather displays the emotion (though it may be sincere) of condescending pity towards the unfortunate people who deem their lives are devoid of the value to live.

Introduction

On November 1, 2014 Brittany Maynard took her life with the assistance of a physician. She was diagnosed with a terminal brain tumor and decided she did not want to live long enough for the tumor to kill her. Since physician-assisted suicide was not legal in California at the time, she moved to Oregon to receive the procedure. The right-to-die organization, *Compassion and Choices* took up her case and made her a popular and national figure for their cause. Their main argument was if she has the right to end her life and, thus, not to suffer unnecessarily, then it is an act of compassion from others and society to allow her to do so.

I do not doubt the compassion people showed Brittany during the ordeal, but I want to analyze what kind of compassion is implied in physician-assisted suicide and what the ethical ramifications of it are.[1] My main point is that the particular compassion often associated with physician-assisted suicide is more an act of pity than kindness, and, consequently, does not exhibit the profound ethical features of kindness. Overall, I want to analyze the ethics of physician-assisted suicide from the perspective of the importance we give to kindness as a special and important aspect of our efforts to experience meaningfully and rightly the world.

To make this case, I first discuss the nature of kindness and then ethically analyze physician-assisted suicide. I aim to show, first, that kindness expresses the excellence of a person altruistically committed to affirming the value of others in ways that reveal the way the world ought to be, and, in some instances, provide an unction upon others. Furthermore, I then show with this description of kindness that physician-assisted suicide does not exhibit these features of kindness.

Artistic Examples of Kindness

I believe art has the unique capacity to inform us about the nature of reality. It does not merely describe events, objects, or impressions. It exposes a universal dimension of the human experience implied or embedded in the events, objects, and impressions. Aristotle correctly expresses this capacity of art by contrasting the cognitive productions of art with history:

> From what has been said it will be seen that the poet's [artist's] function is to describe, not the thing that has happened, but a kind of thing that might happen, i.e. what is possible as being probable or necessary. The distinction between historian and poet is not in the one writing prose and the other verse—you might put the work of Herodotus into verse, and it would still be a species of history; it consists really in this, that the one describes the thing that has been, and the other a kind of thing that might be. Hence poetry is something more philosophic and of graver import than history, since its statements are of the nature rather of universals, whereas those of history are singulars.[2]

Art presents universal features of the human experience of the world, and in the aesthetic experience of an artwork, the artwork provokes us to consider the proper ways to view and act in the world. An experience with art exposes us to a powerful but undefined meaning of the human experience in the world. Even though we can identify kindness when we experience it, we cannot account for its unique reality with a strictly historical (or natural-scientific) description of it. We need to see how it is lived, how it shapes people's lives in various morally demanding situations, and art can help us understand the features of kindness by arresting us to acknowledge and react to the aesthetic experience generated by the artwork. With this understanding of art, I use four art works to learn four essential characteristics about kindness.[3]

First, there is the incident rendered in the painting by Giotto di Bondone of St. Francis of Assisi giving his robe to a beggar. Most biographies of St. Francis describe this event, and thus it becomes emblematic of St. Francis' character.[4] In 1297 Giotto paints 28 scenes of St. Francis' life, and the giving of the robe is the second: "Scene 2: St. Francis Giving his Mantle to a Poor Man." The painting focuses on St. Francis' eyes. The blue sky and valley in the background form a "v" pointing directly at his right eye, which looks intently into the beggar's eyes. The real gift is not the robe but the overflowing of St. Francis' personhood in the act of affirming the beggar. G. K. Chesterton says of St. Francis, "It is perhaps the chief suggestion of this book that St. Francis walked the world like the Pardon of God. I mean that his appearance marked the moment when [people] could be reconciled not only to God but to nature and, most difficult of all, to themselves."[5] St. Francis' impact on the poor, ill, and outcast enables a reconciliation and connection to nature, others, and God, creating a sense of belonging and wholeness to their lives.

Second, Bishop Charles-Francois Myriel plays one of the most significant events in Victor Hugo's monumental story of *Les Misérables*. Instead of having Jean Valjean arrested for stealing his silver candlestick holders, he unexpectedly gives them to him after the police catch him. Myriel senses that what Jean Valjean needs at that moment is not punishment but grace, not condemnation but a nudging towards his true destiny, that he in fact is not a thief but a desperate person in search of his true human self-worth. This act contributes to Jean Valjean's transformation from a bitter and hateful person into one of deep faith and love.

Third, in Shakespeare's *As You Like It,* the old servant Adam plays somewhat an insignificant role. He is caught between the conflicting brothers, Orlando and Oliver, and finally sides with Orlando, sensing the true fatherly blessing of Sir Rowland de Boys belongs with the younger son. As Orlando is about to leave the home for the forest of Arden, Adam offers Orlando his service and life's savings of 500 crowns, knowing that his sacrifice is justified. "Take that, and He that doth the ravens feed, yea, providently caters for the sparrow, be comfort to my age!" (II, 3, 43-45). As they depart, Adam muses to himself, "Yet Fortune cannot recompense me better than to die well and not my master's debtor" (II, 3, 75-76). Adam realizes providence has led him to act generously towards Orlando, that his bonding with Orlando is the way life ought to be. On the way to the forest of Arden, Orlando stumbles onto the Duke Senior and others eating. The Duke invites him to join them, but Orlando delays, saying he must feed Adam first, because "Who after me hath many a weary step limp'd in pure love: (II, 7. 130-131). Unlike so many in the play who hide their identities and their plans, Adam is transparent in his commitment to Orlando.

Fourth, perhaps one of the most unforgettable and unlikely kind figures in all literature is Sonya Semyonovna Marmeladov of Fyodor Dostoevsky's *Crime and Punishment*. She is vulnerable, poor, uncomely, and driven to prostitution to care for her parents and siblings. Yet, she has a quality of ease and generosity to people that make her attractive and infectious towards others. After Rodion Romanovich Raskolnikov confesses his insidious murders (of an old woman, a money-lender, and Sonya's friend Lizaveta) to her, she is not horrified by him but in fact cares for him. She tells him publicly to confess his murder and assault against the earth by kissing the ground of the Haymaker Square of St. Petersburg, and, after he is eventually arrested and sentenced to prison, she follows him to Siberia (where they marry). At the prison town the villagers are drawn to her special quality of wholeness and tenderness. She embodies an affection of acceptance, which transcends the normal rules that govern human relationships.

Each of these figures exemplifies kindness and stands out for their unique character and actions.

Kind Acts and Kind People

One of the reasons we praise kind people is because their actions reflect their character. If we were to realize a supposedly kind act was done for selfish or mercenary reasons, we might be thankful, but we would not call the person a kind person. Ludwig Wittgenstein, the Cambridge philosopher, once said of G.E. Moore (another Cambridge philosopher) that he was kindly but not kind and, consequently, did not have warm feelings towards Moore.[6] Moore was known for his gentle and graceful ways, but, according to Wittgenstein, he lacked something. What was it?

Supererogatory

We would think St. Francis disingenuous if, after giving his mantle to the beggar, he asked for payment or said he was only following a duty to help people. His act was kind because it was beyond what we would think would be ordinary obligations owed to people. Immanuel Kant's famous definition of duty as that which is universally obligatory upon us without exceptions would say that the beggar is in fact no different than anyone else, that St. Francis owed the same kind of respect to everyone. A true dutiful act does not acknowledge the peculiarities or circumstances of the situation but does conform to a universal maxim that veils us (so to speak) to the particular time and place, lest our actions be motived by prejudice or selfishness.[7] The Kantian sense of duty recognizes why we should respect the dignity of all persons, but it does not clarify why we do acts of kindness. That is because they are supererogatory.

Kind acts are "above" the universalizable maxims of Kant's categorical imperative. Yet, they have a sense of duty to them. Sensing in the encounter a forceful obligation, St. Francis feels compelled to give his mantle. It is not that St. Francis senses the dignity of all humanity in the beggar, but that he has the capacity to recognize that the appropriate response in the situation is to act in a way that he could not universalize (that is, the giving of his mantle) but that he must do. He has the capacity because he cares for the beggar. It is a form of duty but not one defined by a universalizable maxim. It is defined by care for the other.

Care is not merely sympathizing for others. We can be emotionally influenced by others and their situations and not necessarily act towards them in a beneficial way. However, if we care, we understand and commiserate with the other's situation. We realize they are experiencing something that ought not be, that there is a disunity of body and spirit, a fracturing of their health, important relationships, and connection to others and reality. In caring for them, we experience a similar state, not necessarily in an identical way but in an analogous way. We envision what life would be if we also were "walking in their shoes." Because we know that "there but by the grace of God go I," we are drawn to help, heal, and affirm their worth as a healthy being united in body and soul. This natural attraction of a caring person towards people who need care obligates us to act. Instead of a universalizable duty, it is a caring duty, which is relative, situational, and idiosyncratic. Just as Kant explains the compulsion of the universalizable maxims based on our intellectual state as rational agents (that is, we can universalize a maxim), kindness acknowledges the deep compulsion of being a caring person. We would not think a person who lacks the emotional ability or volitional desire to sympathize with another's state to be acting kindly, even if their actions benefit another.

Because kindness is a duty-of-caring, its motives aim to bring affirmation and wholeness to the person.[8] Consequently, they are not trite. We would not call St. Francis' action truly kind if he tells the beggar that he was merely trying to assuage his guilt for not helping a beggar the day before or that he had many mantles to give away. Assuaging our guilt and giving out of our abundance are not unethical actions and, in fact, may be ordinary and common place explanations for why we act benevolently towards the underprivileged, but they are not kind actions. Kind actions are "above" the ordinary and common place motivations for moral acts. They arise from the care of others and are what is needed relative to the situation so as to bring affirmation and, when relevant, healing to the other person. Because kindness is supererogatory, the ethics of kindness is truly situational ethics.

Conclusion—kindness is motivated by a duty-of-caring to bring wholeness to a particular situation.

Altruistic

We not only admire Bishop Myriel, but he also inspires us. We admire people for what they accomplish and represent, but it is the conjunction of their right motives and aims towards what is good that inspire. Victor Hugo uses Myriel's actions toward Jean Valjean as a necessary part of the narrative about a transformed man in the midst of the French revolution. For us to explain Jean Valjean's character and sacrificial actions, we need to recognize the pivotal role Myriel plays in his earlier life. His act not only excuses Jean Valjean from his crime, but also inspires him to change from hate and bitterness to the love of others and faith in God. Myriel's act is more than a benefit to him. A judge in a court of law could have pardoned Jean Valjean of his crime and, thus, could have altered his life from a life in prison to a free life. The judge's decision would have had beneficial consequences, but it would not have converted him away from hate and fear to love and faith. Because Jean Valjean realizes Myriel's act is truly altruistic, that he has no ulterior motive and no intention of gaining in stature or reputation, Myriel thus inspires him to change.

Myriel nickname is "Monseigneur Bienvenu," a name revealing his nature. He welcomes people into his own life (his future, emotions, and hopes). The narrator summarizes the Bishop's approach to life: "There are men who toil at extracting gold; he toiled at the extraction of pity. Universal misery was his mine. The sadness which reigned everywhere was but an excuse for unfailing kindness. Love each other; he declared this to be complete, desired nothing further, and that was the whole of his doctrine."[9] Myriel's kindness to Jean Valjean springs from his altruistic approach to others.

Altruism has two possible meanings—pure and teleological. Pure altruism implies that we can act with total harmonic intentions, that we do not experience any conflicts of motives, and that the decision is not between different and competing motivations but only one motive. Although we might imagine some trivial instances of pure altruism (for example, saying hello to a stranger), serious ethical decisions are complex and deal with competing motives because of our own memories of successes and failures of past ethical decisions, and because of our own need to be affirmed and acknowledged as the ethical persons we try to be. We would not think Myriel to be less kind in his decision toward Jean Valjean, if we were told that he desired more than anything for his life to be pleasing to God, to be a Good Samaritan, to preach liberty to the captives. We can still be kind and have conflicting motives (for example, the need to be loved and the need to give love) in our actions. In fact, as long as we know Myriel's ultimate purpose is to save Jean Valjean, we would still think Myriel to be kind, even if we learned his action springs from a repressed feeling of guilt due to past failures to help a similar desperate person. It is possible to align our motives, even those in conflict with acts of kindness, to an overriding purpose. This would be teleological altruism.[10]

Teleological altruism is not merely a benevolent or beneficent act. We can wish well of others and not feel the need to act selflessly or exceedingly generous towards them. Also, we can aim to do good towards another and not necessarily disregard any positive benefits the act may confer on us. Although Myriel is both benevolent and beneficent towards Jean Valjean, his action indicates another characteristic. His gracious forgiveness starts a course of life that changes Jean Valjean. In this way, kindness is a blessing to another in that it creates a moment of acceptance, appreciation, and affirmation that has germinative power to change the person. Although kindness may be small acts or go unnoticed by others (even the recipient), part of kindness' uniqueness is that its impact transcends the immediate needs. A kind act inspires us to believe that there is a purpose greater than the moment and circumstances, that the act starts a process in people, and onto the others they influence, that shows love is better than hate, that hope is better than cynicism, and that forgiveness is better than vengeance.

Because kindness is not a universalizable duty (in the Kantian sense) nor a calculated maneuver to reach another goal, it reveals the dedication of the doer to introduce an affirmation, acknowledgement, or aid toward someone else. A kind person embodies the goal of the kind act, and thus altruistically serves the purpose of the action. The person and act conjoin in the manifestation of kindness and creates effects that last longer than the deed and continue to generate the affirmation, acknowledgement, and sense of importance. People like Myriel inspire us about the possible goodness even of thieves like Jean Valjean because they have made tangible the goodness of life, people, and the world by giving of themselves to that mission.

Kind acts and kind people reveal a certain kind of goodness. It is not a utilitarian goodness in which the maximization of people's preferences and desires are materialized. That makes goodness a percentage of preferential units and also is more reflective of what people at certain times and places prefer or desire. The satisfaction people experience in receiving a kind act is not reducible to an increasing of tangible and measurable preferential units. We are not appreciative of kind acts because they have increased our desires or pleasures. Rather, kindness does something else—it displays an affirmation about life's purpose more pervasive and permanent than our immediate desires and pleasures.

Kant's notion of goodness helps us understand this aspect of kindness. Kant believes we all sense the moral law within us; that is, we acknowledge, though cannot prove by pure reason, a *summon bonum*, a state in which people are free and moral ends in themselves and in which all people are motivated to act in ways for everyone's goodness because they too are moral agents.[11] Kindness affirms the desire of life itself and worth of human existence in the moment of kindness. In receiving it, we recognize that the kind person believes in human goodness and aims to materialize it in the situation. Kind acts create the experience of the *summon bonum* in the specific situation by materializing what ought to be in terms of affirming the possibility of goodness for the recipient, whether the deed is small or large.

Although Myriel does not play a specifiable role in the novel's plot after Jean Valjean's journey away from the Bishop, his act of kindness endures and continues to create through Jean Valjean's own acts of kindness moments of affirmation, acknowledgement, and care. It is because kind people act selflessly, committed toward an aim of affirming the goodness of the person or the moment that the action does not continually refer back to the giver nor must it always bear their names. It has a life of its own and thus propagates the goodness it creates into future events.[12]

Conclusion—kindness is a teleologically altruistic action that materializes goodness in a particular situation.

The Way the World Ought to Be

Even though Adam is a secondary character in Shakespeare's *As You Like It*, his role is provocative and indicates an important aspect of kindness. After II, 7, Adam is not seen or mentioned again. He does not enter the forest of Arden, where what is good in people is intensified (sort of a salvaged, pastoral Garden of Eden). What Adam is good at (that is, kindness), he is already manifesting. Because he does not need the mysterious powers of Arden to display the way the world ought to be, Adam is the most Edenic figure of the play.[13] In 2.3.58, Orlando says of Adam that he is "the constant service of the antique world," the antique world of the Garden of Eden that occasionally appears in the midst of hurtful plots, sibling hatred, and family dissolution, revealing what should be the case in a fallen world.

Adam's generosity to Orlando is helpful but not essential for Orlando to travel to the forest of Arden and eventually to marry Rosalind. In fact, although we can see that Adam acts benevolently towards Orlando, his actions are not needed and are not a required beneficence. They are not a utilitarian necessity. His love is pure not because Orlando needs his service or life's savings, but because Adam's motive reveals what should be the case between them. Orlando is now a total orphan, without father, mother, and cast out by his elder brother Oliver, but Adam seeks to ground Orlando in a reality that will not evaporate nor disappear once they leave the home of Sir Rowland. His kindness endeavors to create a situation according to the way Orlando's destiny ought to be.

Shakespeare never tells us why he chooses the name Adam, but the allusion to the First Adam suggests Shakespeare might have a point in mind. Adam's behavior to Orlando indicates how people ought to act. Obviously, the allusion is not to the Adam who eats the forbidden fruit and is cursed and exiled for doing so. It is to Adam's prelapsarian state, the "antique world" of what ought to be. His actions represent a sense of the primal order between people, of how people ought to act towards each other, and, thus, his actions are part of a providential plan to bring kindness into the family of Sir Rowland.

If Orlando had acted in a similar way towards Adam (perhaps only half of his life-savings instead), we would not call it kindness. Orlando is the son of power and privilege; Adam is a life-long servant. Orlando's generosity would definitely have been beneficial to Adam, but it would be the benevolence of a more powerful person to a lesser person, of a socially superior person to an inferior one. That would be pity, not kindness. Orlando's *nobise oblige* would be helpful to Adam but would not raise his social status, because Orlando would still be the son of the house. However, in acts of kindness, people who may be different in many ways are equal in their worth as persons. It creates an occasion where social status is secondary to the bonding of two people in the state of affairs.[14]

The way in which Halley Faust differentiates kindness from compassion helps us understand how kindness creates equality between and among people. Faust argues that though a compassionate person emotionally identifies with another, compassion by itself tends to pity the other and thus creates inequality between the people. However, in that kindness does not require emotional identification, it does not paternalistically condescend towards the other in need. "By not requiring an emotional attachment, [it] frees us from the concern about judging a patient even when judgment might be a natural inclination."[15] Because kindness cultivates an environment indicative of the way the world ought to be, Faust is right to describe how kindness cultivates equality among people, whereas compassionate pity perpetuates a patronizing disposition.

However, I think Faust overstates his point by insisting that kindness does not involve emotional identification. Not all emotions are the same. In pity we feel sympathy for others, not because we see them as equals in social status or virtue but because we see them as pitiful, an estimation definitely not consistent with kindness. Yet, in experiencing people and even the world as it ought to be, we experience the profound emotions of wonder and gratefulness that such a world is possible amidst the "whips and scorns of time." Thus, these emotions would be concomitant with kind actions. Hence, we can imagine Adam's inner state to be filled with wonder and gratitude, when he realizes that "Fortune [could not have] recompense[d] [him] better than to die well and not [his] master's debtor." (II.3.75)

Because kindness creates equality between and among people, we should think of it as an attribute of a new state of affairs and not merely a feature adorned to the state. In all likelihood, we would not experience at that moment the new state without the act of kindness. The act materializes the new occasion. Kindness is a necessary attribute of what ought to be, rather than an appendix that is unessential to the situation. We thus should think of the word kind in the phrase a "kind act" as an attributive adjective and not a predicative one. That is, kindness is not like the color of a car which does not reveal the essential function of the car. Rather, kindness is like the adjective good in the phrase a "good car." Kindness expresses the purpose of the event, and in its action, reveals the reality of what it is: an attribute.[16]

Since kindness manifests our belief in what ought to be, it serves as a regulative ideal for our moral actions and goals. Even though Orlando is in a state of affairs which ought not to have been (that is, orphaned from home), Adam knows that it is wrong and that the true state of what ought to be is needed. Thus, he acts with this ideal in mind. Adam does not need to know fully what providence ordains for Orlando or himself, nor the exact details of the *summum bonum* so to act out of pure love, out of kindness. Yet, he needs to know that the ideal can be practically realized in his act of kindness. Even though we may not be able to prove metaphysically the existence of a kind world, kindness acts as though there is one, and, thus, kindness becomes normative for actions that aim for the ideal life.[17]

For instance, we would not say that the world is the way it ought to be on the whole, if we were apathetic or indifferent towards others. Disenchanted people who believe they live in a disenchanted world are not motivated to act as though they could create the world into what it ought to be. They can act kindly on occasions to others but not with the conviction they reveal the moral purpose of the world, not as "the constant service of the antique world."

Also, we would not say the same if we acted primarily out of pity towards others. Of course, acts of pity may bring benefit to others, but they do not overcome the divisions among people. They reinforce them. However, we are more likely to think the world is the way it ought to be when people act kindly towards each other. In this sense, William S. Hamrick calls kindness a "regulative ideal." Kindness indicates the possibility of morality achieving its ideal expression. "Therefore, even if we are not always capable of achieving it, we should not stop trying to bring into existence a world in which it is always realizable."[18] Because kindness is the experience of what ought to be, kind people do not lose hope when situations are not the way they ought to be.

Kindness presupposes this ontology, and without this conviction, we would not be motivated to act kindly, though we might be moved to show pity to the suffering. If we believe the world were totally "nasty, brutish and short," without purpose, inherent beauty, or the possibility of providence, we could not account for kind actions. If we were nihilist, believing the world to be devoid of moral norms and the possibility of an objective meaningful moral life, then we would not feel the obligation to act from kindness. Without the belief that the world morally ought to be a certain way, we would not act kindly, but with the belief, we persist in trying to materialize it through kind acts.[19] In that kindness indicates the way the world ought to be, it thus suggests that a divine order of kindness underlies our experiences of creation and that kind acts accentuate that order.

Conclusion—kindness testifies in a specific circumstance to the way the world ought to be.

A Kind Soul

Sonya is a kind soul. "A sort of *insatiable* compassion, if one may so express it, was reflected in every feature of her face."[20] Dostoevsky presents her not necessarily as a religiously or morally pure person. She is a prostitute. However, she plays an important role—the presence of unction that leads to the transformation of Raskolnikov. It is not her actions or her social status that contribute. It is her presence.

Sonya embodies the beauty of human existence that brings moral conviction and hope for the possibility of human goodness to people, to the villagers in Siberia as well as to Raskolnikov. She is beautiful not because her body is symmetrically and proportionally perfect or because she intellectually expresses timeless truths about God and the world, but because of the congruence of her love for others and her actions. This congruence displays her uniqueness, her soul, and why she gives healing and hope to people. Her deeds are blessings, an overlaying of her own wholeness of purpose and action upon others. Hamrick calls this the "aesthetic humanism" of kind people. "There is a nimbus of kindness around the kind person that equally radiates a world of kindness, and we have already looked at several example of how kindness can aestheticize the environment."[21] Analogous to the influence of art, a kind soul creates an aesthetic experience of the beauty of being a good person, a nimbus of kindness, and hence manifests a blessing to others.[22]

The kind soul is not made by one act of kindness, nor by two or three, etc. The kind soul is similar to Aristotle's great-souled person, who expects much, seeks much, and deserves much. That is, a great-souled person's nature drives them to experience the best aspects of life and society.[23] They are unique among people, not because they may be more just, temperate, or courageous, but because they acknowledge that life offers the chance of great pleasures and beauty, even amidst the squalor and depravity of life (as Sonya does in St. Petersburg and Siberia). The presence of great-souled people in a community indicates that there are not only such people of great expectations and potential for a life fully lived, but also that it is possible in society for the great-souled people to experience the fulfillment of their virtue.

In an analogous way the presence of kind-souled people indicates that we not only live among people who have the disposition and commitment to be kind, but that moments of unction and blessing are possible. They are the kind of people who seek goodness in human life, who want to experience it in their relationships, and who thrive in creating moments of human wholeness with others (that is, an integration into their self-understanding the value of themselves, others, their future, the world as a whole, and God). The moments they create reveal a life better lived than a life without kindness. Because we seek human fulfillment rather than its diminishment, the fact that kind souls live among us assures us that the best of human life, the affirmation of our worth and rightful place in the world, is possible.[24]

Of course, cruel and apathetic people also live among us, and we do not conscientiously argue that they live the way life ought to be lived. Even though kind souls may be unusual and few, because they make tangible the possibility of a blessed life, of a life influenced by the goodness of humanity and the possibility of the love of God in the world, they are an ideal of human behavior. They may come across as naïve and anomalous individuals in comparison to the worldly savvy and jaded population, but in terms of affirming the goodness of life and others, they live life as we know it ought to be lived.

Obviously, a cruel or apathetic person would not and probably could not become a kind soul. They either pervert or reject the possibility of blessing others, of manifesting in their lives the goodness of human life. Even if they did a kind act, we would not call them kind souls.[25] We would clearly misuse the phrase “kind soul” to call the disenchanted Meursault of Albert Camus’ *The Stranger* a kind soul, just because in the end he calmly accepts the absurdity of his life or to call the cruel and impulsive Lear of Shakespeare’s *King Lear* a kind soul just because in the end he shows love to Cordelia. If we were asked to choose an ideal person to model how we ought to live, we would not choose Meursault or King Lear, for they do not bless people, provide unction, or make the world better. However, Sonya does.

Of course, not many people are kind souls and ideal models for us. However, in that our habits of life shape our desires, if we habitually show acts of kindness, we may grow into kind souls. Sonya has the emotional and volitional desire to affirm others, and by her habit of life she becomes a kind soul, a blessing to Raskolnikov and the villagers of Siberia.

Conclusion—the kindness of a kind soul manifests in the person a blessing and unction upon others.

Summary

We know kindness is not the following:

1. *benevolence without action*; only to wish well towards others does not change their reality.
2. *beneficence without sincerity*; good deeds alone do not reveal a person’s character.
3. *duty without compassion*; mechanistically performing perfunctory acts does not move the other person’s affective center.
4. *pity*; condescending beneficial actions towards others empowers the actor, not the recipient.

We know kindness is the following:

1. *an exceeding affirmation of others*; kindness spotlights the unique and valuable personhood of others.
2. *oriented towards the other's well-being*; kind acts aim to materialize in others their best natures.
3. *a materialization of goodness*; kind acts reveal the way the world "ought to be".
4. and, *when a kind soul, an unction to others*; the presence of certain kind people manifests to others the possibilities of personal wholeness and future salvation.

Kindness and Physician-Assisted Suicide

I now want to apply the above analysis of kindness to the ethical issue of physician-assisted suicide. In particular, I focus on whether the physicians' acts are kind ones. It may be that physicians feel a duty to respect the rights of patients to determine when they should die, and it may be that physicians sympathize with the patients and thus want to assist them to die. Nonetheless, as I will try to show below, the physicians' acts are not kind ones.

Of the prominent and influential arguments for the ethical permissibility of physician-assisted suicide, scant attention is given to the primary moral motive of the physicians. Tom L. Beauchamp and James F. Childress argue that physicians can assist patients who wants to die as "a way of showing respect for the person's autonomous choices," and because of this respect, the physicians' assistance is just as much an act of caring for the patient who suffers in life and wishes for death as would curing a disease or healing an injury.[26]

Gregory Pence contrasts two fundamental roles of physicians—as healers or patients' advocates—and argues that the latter is more ethically compelling because it acknowledges the autonomous right of patients to determine the quality and length of their lives. Medicine is not primarily for healing but for the caring of patients. Pence adds, "The job of physicians is to help patients, and that therefore, physicians should help terminally ill patients die as they wish."[27]

Timothy E. Quill justifies his assistance (indirect) in the ending of Diane's life as a way of helping her courageous and inspiring dying process. He concludes as, "Diane taught me about the range of help I can provide if I know people well and if I allow them to say what they really want. She taught me about life."[28]

Dan W. Brock rejects the ethical distinction between killing and allowing to die, because patients' right of autonomy over their own lives should determine when to die. Patients know better what constitutes their well-being, and physicians should honor that. Brock states, "If self-determination is a fundamental value, then the great variability among people on this question makes it especially important that individuals control the manner, circumstances, and timing of their dying and death."[29]

The famous "The Philosopher's Brief" given before the United States Supreme Court in 1997 also bases its endorsement of physician-assisted suicide on the patients' autonomous decision to decide their time to die. It claims that "Each individual has a right to make the 'most intimate and personal choices central to personal dignity and autonomy.' That right encompasses the right to exercise some control over the time and manner of one's death."[30] Like Brock above, the authors of the brief reject the ethical difference between allowing to die and killing. Since the right of dying is left to the patient to determine, the distinction is moot.

In each case the physician's moral position is determined by the morally trumping autonomy of the patient. Even though they do not explain nor defend the presupposed ethical principle "for every right, there must be corresponding duty," they rely on it and assert that because patients have a right to die, the physicians must have a duty to assist them. If even the physician's assistance is called an act of care, it is not a care for the patient's health but for the patient's autonomous decision. When the decision is no longer to act as a healer but as a patient's advocate, patients determine the kind of care reflective of their own most fundamental value and how physicians should comply to it.

However, as is the case, physicians do not always defer to patients' autonomous requests. Physicians would probably not show the same kind of deference as given in physician-assisted suicide if the patient demanded an untested and questionable medical practice. It would be contrary to their professional role as healthcare providers.[31] Yet, patients would be choosing for their health, certainly a fundamental consideration for them. People think of the value of their lives in terms of their health and well-being. Thus, in requesting assistance to die and the untested, questionable treatments, the patients make autonomous decisions and expect their physicians to be their advocates. Is there a significant difference between patients asking doctors to assist them in dying and asking them to perform questionable medical procedures?

On one hand, the physicians would think the patient's request for questionable medical procedures would be inappropriate and wrong, but, on the other hand, the physicians would think the request to assist in the patient's death to be appropriate and right. Clearly then the difference is not determined by the patients' autonomous decision about what is most important to them, because in both scenarios, the patients are choosing fundamental rights—health and the right to die. Yet, if physicians reject performing a questionable procedure, they in fact would not be deferring to the patients' fundamental right of self-determination; they would be refusing to comply with the patients' autonomous choice. However, with physician-assisted suicide, physicians feel a duty to comply with the patients' autonomous choice.

The difference between the two reactions is that in refusing to do a questionable procedure the physician is affirming the patients' health and in acquiescing to assist in the patients' death the physician affirms the patients' conclusion that they have more dignity in dying than living in their undignified state. In the first, physicians affirm the value of the patients' life enough that they would refuse to do what the patients request, and, in the second, the physicians acknowledge that because the patients want to die, the patients' life is not worth sustaining. If their death is an act of dignity, then their continual living must be undignified. In complying to the patients' request, physicians affirm the indignity of the patients' life so as to endorse the dignity of their death, and in assisting patients to die, physicians would be saying that in the cases when death would be dignified, life must then be undignified, not worth keeping and, in fact, pitiful.[32]

Thus, the real issue for the physician is not the self-determination of the patients but rather their dignity or indignity. To justify physician-assisted suicide, physician would have to be able to determine when a life is not worth living, and in assisting the patients' dignified dying, the physician declares the patients' lack of valuable life. Physicians may feel sympathy for people who believe they lack the dignity to continue to live, and the same physicians may also feel sympathy for the well-being of the patients who request questionable procedures.

Yet, the motives for the sympathies are different. Physicians would not reject doing questionable procedures because they pity their patients. Rather, they value the patients' lives and health and thus reject the procedures. However, in physician-assisted suicide physicians pity the lives of their patients and thus perform the procedure to assist their dying. They would have to be able to determine that the patients' lives lack enough value of living so that they would have more value in dying with dignity, that the patients' lives are indeed undignified. Pity would then be the primary motivation in assisting patients to die.

At this point an advocate for physicians' role in assisted suicide could say that in some cases patients' lives are indeed not worth living, and that they are not only terminable (an ambiguous term) but in abject pain and cannot function with any deliberation and responsiveness to others. It would not only be an act of pity to assist them to die but an act of merciful compassion. Even though none of the above advocates for physician-assisted suicide make insufferable and interminable pain a necessary condition to justify physicians' contribution to the death of the patients, it is plausible that physicians could give such a justification, and thus might say that the patients should die because of their intolerable pain and suffering.

However, the justification for physician-assisted suicide does not logically depend on the patients being in an intolerable state of pain and suffering. Rather, it depends on whether the patients' determination to die reveals that their lives are no longer valuable enough to keep alive. If I am correct in the above analysis that the patients' lack of a valuable life is the primary determination (that is, the sufficient condition) for justifying physician-assisted suicide, the patients' experience of insufferable and interminable pain is not a necessary condition for the ethical permissibility of physician-assisted suicide. It is not that they should die because they suffer greatly, but that, in their minds, they should die because they lack the value of life to continue to live. Their undignified life is the necessary condition for wanting to die, and that condition is the same whether the patients horribly suffer or not. Certainly, if they suffer greatly, it is expected that all people involved would naturally feel more compassion towards them, but the ethical justification for physician-assisted suicide does not depend on their compassionate motive to alleviate the patients' pain and suffering; it depends on whether the patients and physicians determine that the patients' death is more valuable to them than their lives in the current state.

To demonstrate this point, consider the probable responses from the patients and physicians if the procedure used in the assistance fails. For example, suppose the dosage of secobarbital tablets dissolved in water was not potent enough to cause death or that the antiemetic premedication did not stop the patients from vomiting up the drug. Those involved would not believe that another chance had been given to them so that they could restore value to their lives with dignity but, most likely, would feel the horrible regret of a failed action and the misery of having to decide to cause their deaths again. Because they believe that death is more valuable to them than their lives, and that their remaining dignity requires them to acknowledge their lives are not worth sustaining, the failed attempt would cause more anguish to their self-understanding as people who should die rather than live.

To make this point more precise, consider the different reactions between, on one hand, a failed attempt at physician-assisted suicide and, on the other hand, the unsuccessful efforts through extreme measures to abet or eliminate the causes of insufferable and seemingly interminable pain. In the latter case, the physicians may go to such extreme means to treat a disease or lessen the pain and suffering that they become aware the patients may die from their efforts.[33] However, they believe that the patients' lives are worth trying to save and that it is their vocational duty, even if death is the possible outcome of their actions, to do what it takes to use medicine or surgery to treat the illness or to ease the intolerable suffering and possibly restore the patients' health. If in their care, the patients die, the physicians do not presume they failed in their efforts to treat the patients with dignity by treating the sickness or by alleviating the horrible pain. Rather, they presume they did all they could do to preserve the value of the patients' lives. Moreover, if their efforts do indeed succeed and the excoriating pain and suffering subside and the patients can eventually return to some degree of health, the physicians and patients consider their efforts successful. Whether the patients live or die, the physicians actively try to affirm the lives of the patients, and by their efforts, they indicate that the patients still have dignity as persons to remain alive.[34]

In the above case, even though the patients' death may result after the physicians' efforts to treat the disease and end the intolerable suffering (for example, with extensive chemotherapy), the patients and physicians acknowledge that the patients' value as living persons was worth the risk. If the physicians' efforts in extreme care fail to save the patients' lives, they may regret the failure, but they do not deem the patients' lives not worth their best efforts to keep alive, and in fact could reason that by their efforts of extreme care, at least their patients' lives were no longer in the intolerable state of suffering.

However, in the case of physician-assisted suicide, if the procedure fails, the patients do not gain a newfound value of life and thus rediscover a dignity in continuing to live, but rather they are forced to acknowledge that the justification for trying the procedure in the first place still exists. The failure is not that the patients are still in suffering but that they are still alive. The motive and aim of physician-assisted suicide remains in place after a failed attempt at it—that is, the desire to end a life that no longer has enough value to continue to live.

After the experience, the physicians may feel great sympathy for the patients desiring assistance-to-die (as they may have felt before the experience), but the sympathy is more an act of pity than kindness. Even though pity may compel the physicians to show sympathy and care, pity is a dubious moral motivation. An examination of what two philosophers—Baruch Spinoza and Immanuel Kant—say about pity shows why it is a dubious moral motivation. .

The 17th century Dutch philosopher Spinoza thought that "pity in itself is useless and bad."[35] It is useless and bad because pity disorders our lives, it frustrates our rational efforts to experience in our understanding a "harmony with the order of nature as a whole"[36] (a balance in life by knowing the comprehensive nexus of all things). We experience this harmony when we contribute to the balance of all our emotions, aims, and relationships. Pity arises when upon seeing other peoples' pain and suffering we feel discombobulated and believe the proper balance of life is disturbed. So, we look upon others who suffer with a disdain for causing our discombobulation. It is because they have put us in such a situation that we have to do something for them that they cannot do for themselves that we try to alleviate their suffering. Consequently, we try quickly to end the imbalance in the person's situation so that we can regain our sense of equanimity and control. A piteous emotion thus reveals a disordering in our souls, because it reflects a disordering in reality, in the way all things should be. Thus, the emotion of pity is really a detrimental basis for moral action because it actually prevents all those involved to relate rightly to reality, to find a way to be in "harmony with the order of nature as a whole."

Immanuel Kant also disvalues the effects of pity on us. At the center of Kant's philosophy is the claim that we can know what is the moral law by ascertaining and acting according to what is universally a duty for all occasions. The moral law thus, according to Kant, demands that we treat all people with dignity, with the respect owed a rational person trying to know and live up to the moral law. But piteous feelings and actions towards others stem from a sense of superiority over others because of their deficiencies and inabilities. Hence, because pity does not acknowledge the inherent dignity of those in a pitiful state, the reality of the moral law would never compel us to act from pity towards others, and, consequently, a morally-right thinking person would "desire to be free from [pity]."[37] Even though pity may arouse strong sympathetic feeling, they do not spring from an ethical respect of the other but, rather, from a derogative attitude towards the other. Pity is always a condescending action of one who assumes to be superior to an inferior.

Spinoza and Kant's explanations explain why pity usually has a negative connotation. We say things like "don't pity me," "I don't want your pity," and "keep your pity to yourself." Because pity subserviates a person to another, it suggests a hierarchy of importance in which the superior person patronizes to the other and wants to show sympathy to the other, not because the other has inherent dignity as a living moral agent but because the superior person feels sorry for the other. Even though in the eyes of others an act of pity looks compassionate and caring (and indeed the person may feel sincere sympathy), the motivation to act from pity arises from a sense of patronizing care in which a superior person stoops to help an inferior person.

Pity more than kindness accurately defines the moral motivation in physician-assisted suicide. In the situations that lead to the act of physician-assisted suicide, patients are considered undignified in their lives and can only restore dignity in choosing the manner of death. In this sense, assisting their dying would be an act of *noblesse oblige*, an act of condescending to the pitiful state of the patient. By assuming a responsibility to assist the patients to die, physicians demonstrate their position of authority and influence, and in exercising their power as physicians, they may display and be sincerely motivated by a heartfelt pity for the patients. Even so, they also display to society that they have the professional position and power to determine when people's lives lack enough dignity to remain alive and, thus, that these people should exercise their right of self-determination to end their undignified lives. Although the physicians may believe they are acting as advocates for the patients' autonomous decisions to die, they are also communicating to society that some lives are so lacking in dignity that it would be better for them to die and possibly to gain some sense of dignity in the act of killing themselves.

This justification would encourage society to distinguish between lives worth valuing and those devoid of a future worth keeping, of lives deserving of the best of healthcare and those no longer worth the physicians' commitment to care for the goodness of their beings. It may be that the physicians believe they are affirming the dignity of their patients in assisting them to die, but in fact they make more widespread in society the belief that some people's lives lose dignity and lose a value worth affirming and maintaining. Ironically, by becoming primarily the patients' advocate in agreeing with their own assessment of their indignity, physicians increase the despair and depression that follows when people lose their sense of dignity and think suicide is their best and last autonomous action.

Hence, such actions by the physicians cannot be called acts of kindness. It fails the four aspects of kindness (explained above). First, assisting people to die who are pitiful in their lives is not a supererogatory act that demonstrates a duty to care for the patients' wholeness. In fact, the patients' wholeness (that is, the link between their present state with their future) is denied so that their death can be welcomed and justified. Subsequently, the physicians acknowledge a limit to their care for the patient, that the patients' determinations that their lives are not worth preserving qualifies the physicians' responsibility to render healthcare to the patients. When physicians understand their role in the situations that lead to consideration of physician-assisted suicide to be primarily an advocate for the patients rather than the patients' healer, they do not display the extra quality to a moral act that kindness conveys—the exceeding affirmation of the others' inherent worth as the persons they are. An advocate may be considerate and sympathetic, but parameters of advocacy are shaped by the contractual expectations of the relationship; that is, patients want and need something and the physicians provide it. However, physicians as kind healers would convey to patients that regardless of their situations and their expectations, the physicians act by motivations greater than just the professional role of being the patients' doctor; they endeavor to affirm the dignity of the patients, whether they are fighting to live or accepting their dying.

Second, the action is not an altruistic act that aims to increase the goodness of the patients. The patients' lives are devoid of enough goodness that would require the physicians to attempt to heal and maintain the patients' lives. In fact, in physician-assisted suicide, the physicians stop trying to heal or care for the patients' lives and, consequently, mold their professional actions according to the patients' autonomous decisions. By complying to the patients' wishes in such cases, physicians bend their professional role as healers and healthcare providers to the prevailing preeminence of the autonomous agent in current society. Instead of sacrificing their time and emotional state to show extraordinary care for dying patients, the physicians would be submitting to the societal hegemony of the right of the individual to determine not only their own lives but how the medical profession should treat them.[38]

Third, when physicians determine that patients' lives can be so miserable that the only dignity they can have is to cause their own deaths, they would not be showing in their action that this is the way the world ought to be. Rather, they would communicate that the patients' lives are the way the world ought not to be and it would thus be better for them to die. Although the physicians may be contributing to the desires of all involved and may help bring physical and emotional relief from an unwelcomed situation, they fail to communicate to the patients, families, friends, and society a more profound sense of the way the world ought to be.

For instance, consider the implications in deciding one of the two options—physicians can render care to allow patients to die or they can assist patients to kill themselves. In each case, death is the end. Death is obviously part of the way the world is, and, consequently, when we think of the way the world ought to be, we must recognize that death is a permanent state of our experience of living in the world. Thus, the issue is which of the two is more indicative of the way the world ought to be. The second option says the patients' lives are so devoid of the value of life that it would be better for them to end their lives before their natural death. The first option maintains that the patients' value of living remains with them until their natural death. The second option communicates that the value of living can be minimal enough to want to die and the first option communicates that the value of living is convincing enough that it is worth maintaining up to the patients' natural death. That is, it is more consistent with the way the world ought to be to affirm a view of the world that says life is valuable up to the natural end than a view that says the value of life is tenuous enough that it would be better in certain occasions to take one's life because it lacks the value of life. It is more indicative of the way the world ought to be for physicians to affirm the value of living in spite of unwelcomed situations than to say those situations can erase from a person the value of living. Thus, the first option (that is, treating while allowing to die) would be more of an act of kindness than the second option would be.

Fourth, by displaying a *noblesse oblige* towards the pitiful, the physicians would not be a blessing for all involved. Their presence and action would not be an unctuous action that would affirm the wholeness of the patients and reveal the nimbus of kindness. They would primarily play a functional role with the imprimatur of the medical profession to validate the patients' assessment of their own lack of the value of life and their right to choose the manner of their dying. In such a role, physicians would not be kind souls. It may be that physicians believe it is not their role to be kind-souls, that their role is to provide a professional service and be the advocate for the patients' autonomous decisions about the importance and destiny of their lives. However, because such a belief primarily defines the physicians' role as providing a contractual service defined by transactional goals, the belief would argue against physicians seeing their roles as having the rare opportunities in people's lives to provide occasions to experience the powerful moments of being blessed to be alive.

References

1. The phrase physician-assisted dying has become the more recent name given for the procedure. For instance, in Beauchamp and Childress's 5th edition, 2001, of *Principles of Biomedical Ethics*, they call the procedure physician-assisted suicide. By the 2013 7th edition, they call it physician-assisted suicide, physician-assisted death, and physician-assisted hastening of death, and then in the 8th edition of 2019 they drop the phrase physician-assisted suicide all together and use physician-assisted hastening of death. They justify the change by saying "here [the Oregon law] the terms letting die and killing do not illuminate or help evaluate what happens when a physician helps a person escape the ravages of a fatal illness;" Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2019), 185. However,

the phrase “hastening death” could also explain a patient removing a life support device like a respirator or feeding tubes, whereas people utilizing a device or drinking a drug that kills themselves is more an act of suicide than a hastening to death. Their actions directly cause their deaths, rather than merely hastening their natural process of dying. Even though the recent names may try to avoid the difficulty of having to justify an act of suicide, the reality of the act is still an act of suicide.

2. Aristotle, *Poetics* 1450, 9:34–1451:8; in *The Basic Works of Aristotle*, ed. Richard McKeon (New York: Random House, 1941), 1463–1464.
3. Even though I look at our experiences to explicate kindness, I start by appealing to our aesthetic imagination by examining four aesthetic expressions, one painting, two novels, and one play. Whereas science utilizes the rigors of logical understanding to clarify the empirical and causal aspects of our experiences, art utilizes the imagination to suggest the moral possibilities of being human in the world. Both the understanding and imagination give us knowledge, and for this reason I agree with Albert William Levi, that aesthetic imagination informs us about the humanistic values, and I use the aesthetic imagination to inform us about kindness. See Albert William Levi, *Literature, Philosophy and the Imagination* (Bloomington: Indiana University Press, 1962), 2–3.
4. Ewert Collins, ed., *Bonaventure: The Soul’s Journey into God; The Tree of Life; The Life of St. Francis* (New York: Paulist Press, 1978), 190. Bonaventure wrote his biography in 1263, but the incident is also in the earlier biographies by Thomas of Celano (1229), Julian of Speyer (1232), and Henri d’Avranches (1232).
5. G. K. Chesterton, *Saint Thomas Aquinas and St. Francis of Assisi*, (San Francisco: Ignatius Press, 1986), 314.
6. William Hamrick mentions this assessment of Moore by Wittgenstein; see William Hamrick, “Kindness,” in *Phenomenology in Practice and Theory*, ed. William Hamrick (Boston: Springer, 1985), 211.
7. Immanuel Kant, *Groundwork of the Metaphysics of Morals* in *Practical Philosophy: The Cambridge Edition of the Works of Immanuel Kant*, translated and edited by Mary J. Gregor and general introduction by Allen Wood (Cambridge, England: Cambridge University Press, 1996), 69–73.
8. William Hamrick in his seminal book on kindness states this point in a similar way—“When I eventually come to perceive a previously undetermined act or omission as kind, I see the act or omission invested with a motivated freedom, purpose, and sensitivity to my welfare,” William Hamrick, *Kindness and the Good Society* (New York: The State University of New York Press, 2002), 21; also “Kindness thus actualizes what is most proper to human beings as such” (249). Hamrick perhaps has written the most and the best on kindness, and it would be tempting to reiterate his work. Suffice it to say that I endorse fully his work but seek to add my own contributions to the study of kindness (especially as it pertains to medical ethics).
9. Victor Hugo, *Les Misérables* (New York: Crowell & Co., 1887; Project Gutenberg, 1994), vol. 1, bk. 1, chap. 14, https://www.gutenberg.org/files/135/135-h/135-h.htm#link2HCH0014.
10. Because kindness suggests an ontological claim about the way the world ought to be, I differ with Marvin Kohl’s definition of kindness as not a natural or rational act—“Helpfulness towards someone in need, not in return for anything, nor for the advantage of the helper himself;” Marvin Kohl, “Kindliness: Some Classic Views,” *Journal of Medical Ethics* 5, no. 1 (1979): 35. Kohl’s definition is not complete enough. In trying to emphasize that kindness is not a natural survival response, he fails to recognize the ontological suggestions experienced in acts of kindness.
11. The role of the *summum bonum* permeates Kant’s ethical teaching; that is, the profound conviction generated by the experience of the moral law must believe that the moral life has a real goal and reward. My use of Kant’s idea of the *summum bonum* stems from the way he talks about it in *The Groundwork of the Metaphysics of Moral*. “For, all rational beings stand under the *law* that each of them is to treat himself and all others *never merely as means* but always *at the same time as ends in themselves*. . . . A rational being belongs as a *member* to the kingdom of ends when he gives universal law as in it but is also himself subject to these laws.” Kant, *Practical Philosophy: The Cambridge Edition of the Works of Immanuel Kant*, 83.

12. George Eliot poignantly expresses in *Middlemarch* a similar point about the future ripple effects of good and kind deeds. "For the growing good of the world is partly dependent on unhistoric acts; and that things are not so ill with you and me as they might have been, is half owing to the number who lived faithfully a hidden life, and rest in unvisited tombs" (in Hamrick, *Kindness and the Good Society*, 160). In the biblical wisdom writings, *Ecclesiastes* poignantly expresses this sense of our actions creating conditions that lead to unknown and unforeseeable fulfillment as "Cast thy bread upon the waters: for thou shalt find it after many days" (*Ecclesiastes* 11:1 KJV).
13. See Marjorie Garber, *Shakespeare After All* (New York: Pantheon Books, 2004), 440–441.
14. Orlando does show kindness to Adam when he genuinely cares for him by carrying him on his back when Adam is too weak to continue. At that moment, it is easy to see they share a common destiny and bond as humans to each other, regardless of their social status.
15. Holley S. Faust, "Kindness, Not Compassion, in Healthcare," *Cambridge Quarterly of Healthcare Ethics* 18, no. 3 (2009): 298, https://doi.org/10.1017/s0963180109090458.
16. This distinction between predicative and attributive adjectives comes from Peter Geach. See P.T. Geach, "Good and Evil," *Analysis* 17, no. 2 (1956): 33–42.
17. Kenneth Strike is right to argue that liberalism (the view that all people are the same) and communitarianism (the view that only our community shapes our values) cannot account for the special impact of kindness upon us. "What I have claimed in the argument of this paper is that when we engage the stranger there is a voice we can hear which is neither the partisan voice of our own *Gemeinshaft* community [communitarianism] nor the voice from nowhere [liberalism]," Kenneth Strike, "Liberalism, Communitarianism and the Space Between: in Praise Kindness," *Journal of Medical Education* 29, no. 2 (2000): 140, https://doi.org/10.1080/713679340. Kindness has an ontological reference to the way the world ought to be.
18. Hamrick, *Kindness and the Good Society*, 242.
19. Joseph B. Soloveitchik makes a theological point that definitely undergirds this aspect of kindness—"The great ideal is *hesed* [which he defines as ethical kindness]. *Hesed* is the origin of the ethical norm. God's *hesed* refers to His over-abundant, all-inclusive existence, His all-inclusiveness that lets others share and be included in His existence," Joseph B. Soloveitchik, *Maimonides: Between Philosophy and Halakhah*, edited with an introduction by Lawrence J. Kaplan, foreword by Dov Schwartz (Jerusalem: Urim Publications, 2016), 196. Soloveitchik interprets Maimonides' *Guide for the Perplexed* as not only promulgating a scientific knowledge of the world, ordained by divinely instituted natural laws, but as also stressing the religious-ethical principle of *hesed* as the cornerstone and purpose of creation. Thus, an act of *hesed* is also a fulfillment of creation.
20. Fyodor Dostoevsky, *Crime and Punishment*, translated by Constance Garnett (2016, Project Gutenberg), https://www.gutenberg.org/files/2554/2554-h/2554-h.htm#link2HCH0024.
21. Hamrick, *Kindness and the Good Society*, 246.
22. There is clinical research attesting to the health benefits of kindness not only to those who receive kind acts but also who give them. See B.L. Fredrickson et al., "Open Hearts Build Lives: Positive Emotions, Induced through Loving-Kindness Meditation, Build Consequential Personal Resources," *Journal of Personality and Social Psychology* 95, no. 5 (2008): 1045–1062, https://dx.doi.org/10.1037%2Fa0013262; and Khoa D. Le Nguyen et al., "Corrigendum to 'Loving-Kindness Meditation Slows Biological Aging Innovices: Evidence from a 12-week Randomized Controlled Trial,'" *Psychoneuroendocrinology* 108 (October 2019): 20–27, https://doi.org/10.1016/j.psyneuen.2019.104440.
23. "Since the magnanimous person [that is, a great-souled person] is worthy of the greatest things, he is the best person. For in every case the better person is worthy of something greater, and the best person is worthy of the greatest things; and hence the truly magnanimous person must be good." Aristotle, *Nicomachean Ethics*, IV, 3, 14, translated with introduction, notes, and glossary by Terence Irwin (Indianapolis: Hackett, 1990), 57.
24. John Cottingham also argues that kindness is an ontological indicator, that it has a cosmic significance. He maintains the theistic view of divine love as the basis for creation gives confidence to our experiences of kindness. He admits we cannot metaphysically prove the reality that kindness indicates, but kindness is a compelling form of life, and hence, we are right "to be able to trust that the vision is valid;" John Cottingham, "Loving Kindness and Mercy:

Their Human and Cosmic Significance," *Philosophy* 94, no. 1 (2019): 42, https://doi.org/10.1017/S0031819118000487.

25. "As McTaggert once observed somewhere, providing refreshments in the intervals between tortures does nothing to prove the humanity of the torturer;" Hamrick, *Kindness and the Good Society*, 216.
26. Beauchamp and Childress, *Principles of Biomedical Ethics*, 8th ed., 189 and 192.
27. Gregory E. Pence, *Classic Cases in Medical Ethics: Accounts of Cases That Have Shaped Medical Ethics*, with Philosophical, Legal, and Historical Backgrounds, 3rd ed. (New York: The McGraw Hill, 2000), 112.
28. Timothy E. Quill, "Death and Dignity: A Case of Individualized Decision Making," in *Bioethics: Principles, Issues, and Cases*, 4th ed., edited by Lewis Vaughn (New York: Oxford University Press, 2020), 669.
29. Dan W. Brock, "Voluntary Active Euthanasia, in *Bioethics: Principles, Issues, and Cases*, 4th ed., edited by Lewis Vaughn (New York: Oxford University Press, 2020), 670.
30. Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson, "The Philosophers' Brief," in *Bioethics: Principles, Issues, and Cases*, 4th ed., edited by Lewis Vaughn (New York: Oxford University Press, 2020), 724.
31. Physicians must balance the demands of the patients' autonomy and what is the proper care. The rejection of the questionable procedure is not a denial of the patients' autonomy. In choosing the standard of care over the patients' demands, physicians are making what Beauchamp and Childress call a prima facie choice. "It is no objection to moral norms that, in some circumstances, they can be justifiably overridden by other norms with which they conflict," Beauchamp and Childress, *Principles of Biomedical Ethics*, 15.
32. Because the issue is often defined as the choice between living with indignity and dying with dignity, physicians' promotion of physician-assisted suicide probably exerts undue influence on vulnerable people to think of themselves as devoid of dignity and pitiful and hence would be better dead, I agree with Alan J. Wiesbard and Mark Siegler who argue that physicians and our society are too quickly justifying physician-assisted suicide. We may be encouraging some people to die who might have benefits in continuing to live; Alan J. Wiesbard and Mark Siegler, "Killing Patients with Kindness: An Appeal for Caution," in *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water*, ed. Joanne Lynne (Bloomington: Indiana University Press, 1986), 108.
33. Even though I am not using the phrase double effect to label what I am describing, my hypothetical case is close to such a designation. Typical to explanations of the doctrine of double effect, we must meet four conditions to qualify as double effect: 1) the act must be good and not bad, 2) the agent must not will the bad effect, 3) the bad effect must not be the cause of the good effect, and 4) the good effect must be proportionally desirable to compensate for allowing the bad effect. These conditions presume a moral difference between good intentions and unwelcomed foreseeable consequences, and also between the ethical permissibility between being the direct or indirect agency of a harmful and unwelcomed effect. Even though the doctrine is subject to the criticism that these distinctions are ambiguous, the doctrine is ethically significant because it recognizes the essential and important role of intentions to account for the morality of our actions. For a succinct but thorough explanation of the doctrine, see Allison McIntyre, "Doctrine of Double Effect," in The Stanford Encyclopedia of Philosophy (Spring 2019 edition), ed. Edward N. Zalta, December 24, 2018, https://plato.standford.edu/archives/spr2019/entries/double-effect/.
34. In describing these medical procedures, I refrain from citing the often-used illustration of double effect in which the physician, intending to alleviate the pain, uses an amount of morphine that causes the lungs to cease functioning. This illustration is often given as a clear case for double effect. For instance, Gilbert Meilander uses the illustration in *Bioethics: A Primer for Christians* (Grand Rapids: Eerdmans, 1996), 70. In 2001 Beauchamp and Childress give it in the 5th ed. of *Principles of Biomedical Ethics* (129); also, T. A. Cavanaugh uses it in *Double-Effect Reasoning: Doing Good and Avoiding Evi*l (Oxford: Clarendon Press 2006), xii; Lewis Vaughn uses it in *Bioethics: Principles, Issues, and Cases*, 4th ed. (Oxford University Press, 2010), 42; and in 2019 McIntyre mentions it as one of the four classic cases of double effect in "The Doctrine of Double Effect," *The Stanford Encyclopedia of Philosophy*. However, research has shown that physicians do not use morphine or opioid medication in this way and that morphine does not necessarily lead

to the cessation of lung function. Thus, the illustration is unfounded on actual medical practice. See Tatsuya Morita et al. "Effects of High Dose Opioids and Sedatives on Survival in Terminally Ill Cancer Patients," *Journal of Pain and Symptom Management* 21, no. 4 (2001): 282–289, https://doi.org/10.1016/s0885-3924(01)00258-5; and Russell Portenoy et al., "Opioid Use and Survival at the End of Life: A Survey of Hospice Population," *Journal of Pain and Symptom Management* 32, no. 6 (2006): 532–540, https://doi.org/10.1016/j.jpainsymman.2006.08.003. "In conclusion, opioids and sedatives used for symptom control in the last days are not associated with patient survival. They are safe and useful medications to palliate severe distress in the terminal stage of cancer when administered with a low initial dosage and adequate titration" (Morita et al., 282). "This analysis revealed that opioid dosing was associated with time till death, but this factor would explain very little of the variation in survival. In a hospice population, survival is influenced by complex factors, many of which may not be measurable. Based on these findings, concern about hastening death does not justify withholding opioid therapy" (Portenoy et al., 532).

However, there is the problematical practice called "terminal sedation" that can be used in which patients receive barbiturates, which also suppress their respiration and may cause asphyxiation.

35. Quote is from *The Ethics*, Benedict de Spinoza, *On the Improvement of the Understand, The Ethics, Correspondence*, trans. by R.H.M. Elwes (New York: Dover Publications, 1955), 221.
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CLIMATE CHANGE RELATED HEALTH HAZARDS AND THE ACADEMIC RESPONSIBILITY OF EVANGELICAL BIOETHICISTS

CRISTINA RICHIE, PHD

Abstract

This article will explore the academic responsibility of Evangelical bioethicists to address climate change related health hazards. First, it will provide evidence-based data on climate change related health hazards, which disproportionately affect the poor and vulnerable worldwide, and as such are a form of environmental racism. Second, it will look at responses to climate change. So-called "climate change deniers" in the United States—the majority of which are Evangelical—will be addressed and the argument will be put forth that, regardless of the causes of climate change, climate change bioethics is part of the Christian tradition of healing and justice. Focusing on climate health hazards builds consensus across partisan and denominational lines by addressing the result—not the cause—of climate change. Third, the article will confront the academic responsibility of Evangelical bioethicists in addressing climate change related health hazards using the paradigm of H. Richard Niebuhr's *homo dialectus*. It will, fourth, offer public theology and biblical scholarship as ways to engage this matter of moral significance. The conclusion will urge Evangelical bioethicists to develop a framework, such as Evangelical environmental bioethics, to effectively address climate change health hazards.

Keywords:

Climate change; human health; Evangelical theology; H. Richard Niebuhr; responsibility; sustainability; practical theology; theological bioethics

Introduction

Climate change is caused, in part, by greenhouse gas emissions such as carbon dioxide. Although some Evangelicals debate whether climate change is natural or anthropogenic, it is well documented that climate change causes health problems. Complications from climate change related health hazards cause an immense amount of human suffering and add to the burdens of the medical industry. This article will explore the academic responsibility of Evangelical bioethicists in light of this global issue.

"Evangelical" refers to a large number of Protestant denominations, which are often characterized by ecumenism, social justice, promotion of education, and involvement in "the World."[1] Evangelical bioethicists are trained scholars who teach and research in a university, college, seminary, or healthcare facility. They may also be independent scholars or work for a non-profit organization responsible for policymaking. Unlike other Evangelical academics who work in systematic theology, Old Testament, or New Testament studies, theological ethicists—under which theological bioethics falls—are oriented towards applied theology. Thus, they have the necessary position to write, speak, and teach others to live in a way that is impactful.

First, it will provide evidence-based data on climate change related health hazards, which disproportionately affect the poor and vulnerable worldwide, and as such are a form of environmental racism. Second, it will look at responses to climate change. So-called "climate change deniers" in the United States—the majority of which are Evangelical[2]— will be addressed and the argument will be put forth that, regardless of the causes of climate change, climate change bioethics is part of the Christian tradition of healing and justice. Third, the article will confront the academic responsibility of Evangelical bioethicists in addressing climate change related health hazards using the paradigm of H. Richard Niebuhr's *homo dialectus*. It will, fourth, offer public theology and biblical scholarship as ways to engage this matter of moral significance. The conclusion will urge Evangelical bioethicists to develop a framework, such as Evangelical environmental bioethics, to effectively address climate change health hazards.

I. Social Effects of Climate Change

In 1859, Irish physicist John Tyndall demonstrated that greenhouse gases such as methane, nitrous oxide, fluorinated gases, and carbon dioxide can become trapped in the Earth's atmosphere in a process later termed the "greenhouse effect." Since Tyndall's discovery, scientists have determined that human activities—specifically human population growth and resource consumption—have increased the amount of greenhouse gases in the atmosphere beyond any level in human history. Average global temperatures have increased by nearly one degree Celsius since tracking began. This climate change has produced geophysical consequences like glacial melt, drought, and altered disease vector habitats. It is well documented that climate change causes health problems.

Climate Change Related Health Hazards

According to the World Health Organization, "climatic change is estimated to cause over 150,000 deaths annually" and between 2030 and 2050 climate change related health hazards are "expected to cause approximately 250,000 additional deaths per year" due to thermal extremes and weather disasters, vector-borne diseases, a higher incidence of food-related and waterborne infections, photochemical air pollutants and conflict over depleted natural resources."[3] Temperature extremes cause higher morbidity and mortality as heat waves become more frequent, intense, and longer, while urbanization creates a "heat island" effect. Rising sea levels contribute to an increase in flooding and coastal erosion, storm surges, and damage to infrastructure. Some islands, and thus human habitats, will completely disappear.[4] While people are fleeing tsunamis and flooding, injuries occur.

Both flooding and drought impact food production through reduced crop yields, increased crop losses, and decreased nutritional content in food that is salvageable. Air quality is compromised through pollution and changes in the levels of pollutants.

Altered pollutant dispersal translates to previously immune communities now facing respiratory problems like asthma and lung cancer. The World Health Organization states "air pollution, which is linked to 7 million premature deaths annually, is "the world's largest single environmental health risk."[5]

Climate change related health hazards also include wildfires, tornadoes, and hurricanes. Survivors of these, and other, natural disasters show symptoms of post-traumatic stress disorders, anxiety, and depression.[6] Loss of access to basic elements of life, like clean water and food, cause war and conflict, forced migration, and population displacement. Climate change related health hazards are an international issue, with unique domestic contours.

Within the United States, six specific climate change related events caused more than 760,000 encounters with the healthcare system and over $740 million in health costs. These six events were national ozone air pollution from 2000–2002, the West Nile virus outbreak in Louisiana in 2002, the Southern California wildfires in 2003, the Florida Hurricane Season in 2004, the California Heat Wave in 2006, and the Red River flooding in North Dakota in 2009.[7]

In North Carolina, for example, residents—particularly the poor in rural areas—are subjected to Pfiesteria outbreaks and harmful algae blooms, injury from severe storms, hurricanes, tornadoes, lightning, and floods, contaminated drinking water supplies, upper respiratory problems, and gastrointestinal ailments linked to the flooding and overflow of hog waste facilities. All can be traced to erratic weather.[8]

The Poor and Climate Change

As with much ecological degradation, the poor are absorbing the brunt of the problem. For instance, "socioeconomic factors associated with heat related mortality. . . . include inadequate housing conditions, lack of access to air conditioning, social isolation, chronic illness, as well as psychological and behavioral factors . . . . Many of these factors are found disproportionately in urban areas, particularly among elderly, poor, and non-white individuals."[9] Climate change health hazards exacerbate health disparities.

After a climate event, those without financial means face additional health complications and life disruption because they may lack the economic resources to move and are confined to dilapidated, moldy, or uninhabitable homes.[10] The United States Catholic Bishops note in their statement *Climate Change: A Plea for Dialogue Prudence and the Common Good*, "Projected sea level rises could impact low-lying coastal areas in densely populated nations of the developing world. Storms are most likely to strain the fragile housing infrastructure of the poorest nations"[11] as well as the poorest people within countries. Climate change health hazards can be considered a form of environmental racism because of the effects on the poor within nations—who are mostly ethnic minorities—and on developing countries.

Environmental Racism

Environmental racism is present whenever people are forced to subsist in poverty; when the poor feel the effects—but infrequently the benefits—of an economic system that emits massive amounts of carbon. Environmental racism is just one among numerous, interlocking factors of structural racism. While "the economically well-off can choose to live amid acres of green…poor people are housed near factories, refineries, or waste-processing plants that heavily pollute the environment."[12] This leads to poor health outcomes, increased disease, and health burdens.

Environmental racism has been a theological concern since the mid 1980s, when "North American churches began turning their attention to environmental racism." [13]At that time, the United Church of Christ undertook a commission on Racial Justice, which led to the publication of the 1987, report *Toxic Wastes and Race in the United States: A National Report on the Racial and Socio-Economic Characteristics of Communities with Hazardous Waste Sites*.[14] The document found that environmental threats such as toxic waste sites, municipal dumping grounds, and hazardous waste facilities were clustered in low-income areas where racial and ethnic minorities dwell. Impoverished locations were deliberately chosen for environmental hazards since the poor generally lack the political resources to mobilize a constituency to lobby against policies that negatively affect their health. As former World Bank economist Lawrence Summer stated, toxic waste was put in places where poor people live because they "don't live long enough to feel the effects."[15] This disgraceful sentiment highlights the double burden of lack of access to healthcare for treatment and shorter lifespans, due in part to barriers to accessing healthcare like finances, geographical proximity, underemployment, and healthcare bias.

A follow-up report to the UCC *Toxic Waste Report* made twenty years later found that little had changed.[16] Linked with a history of colonialism and slavery, environmental racism in the United States is no less than, as Womanist theologian Emilie Townes describes, a "contemporary version of lynching a whole people."[17] Victims of environmental racism are subjected to an insidious and obfuscated form of prejudice, which denigrates human dignity. Instead of complacency, Christians are called to address environmental racism—and indeed, all forms of racism. Thus, a necessary, but not sufficient area for Evangelical bioethicists to address are the climate change health hazards.

II. Responses to Climate Change

In previous decades the term "global warming" was used to describe the increase in average global temperatures, when compared to previous centuries. Climate change is now the preferred term to describe the fluctuations in temperature—both hot and cold—in the globe. That is, there is both global warming and global cooling, with each being more severe. Not all people accept this data as true or relevant to social life. These people are known colloquially as "climate change deniers," but the implications of their beliefs are more nuanced than the label suggests. Understanding the basis for these positions opens dialogue, which can lead to places of consensus.

Climate Change Denial

Climate change denial usually hinges on two separate issues. The first is *if* the climate is changing. Fluctuations in temperature, from the ice age through the medieval warming period, to our current era, are scientifically established.[18] Even so, a fair number of self-identified Evangelicals in the United States are climate change deniers. When surveyed by the Pew Research Center, 31% of white Evangelicals answered "no" when asked, "Is there solid evidence the earth is warming?"[19] This type of climate change denial is due to scientific skepticism. Skepticism cannot always be addressed; however, it need not be. For theological bioethicists, denial in climate change can be circumvented to arrive at the more pressing issue of climate change health hazards.

The other issue of climate change denial—which is often conflated with, or confused with, the first issue—is the *cause* of these temperature changes. The same Pew survey found that 34% of white Evangelicals said that the earth was warming because of human activity, while 17% said it was warming because of natural patterns. 7% said it was warming, but that the cause was unknown.[20] Evangelicals, who do not believe that humans contribute to climate change, will be reluctant to change personal consumptive habits that contribute to carbon emissions. However, this epistemological barrier can be set aside to focus on consensus about wellbeing, health, and safety from health hazards related to climate and other forms of natural disasters.

Climate Change Bioethics

Evangelical bioethicists cannot be expected to allay the objections to climate data, as that is not usually within their expertise. However, a strategic focus on medicine and health is within the domain of bioethics. Rising sea levels, drought, hurricanes, heat waves, and pollution cause health harms. Moreover, alleviating the suffering of individuals affected by these health issues and preventing further medical problems are within the Christian tradition of healing (Luke 8:50; Jas 5:14-15) and justice (Prov 29:7; Isa 1:17). Discussion and action on healthcare can occur irrespective of what causes the changes in nature. Unlike other debates in theological bioethics, which may have a component of personal responsibility, such as HIV transmission from IV drug use, or health problems related to gluttony, health problems from natural disasters are generally seen as non-moral.[21]

In some cases, natural disasters are seen as directly from God in order to lead to repentance or as punishment for sin. Certainly, the Bible records such instances (e.g., the book of Jonah). Likewise, personal health issues may be seen as divinely caused (e.g., Zechariah's muteness, Paul's "thorn" in the side). Even so, theological bioethicists will still acknowledge the obligation to alleviate suffering and treat health conditions without reference to personal sin, while simultaneously refusing to endorse in activities that might increase personal harms or facilitate sin. For instance, a theological bioethicist would support cardiac care for obese patients while also taking a critical approach to overeating and sloth.

The role of responsibility and personal sin are important factors in climate change health hazards. Greed leads to overconsumption, which accelerates resource use and production of unnecessary goods.[22] These conversations should take place within theological ethics and practical theology, but they are less relevant for theological bioethics. With the current situation of climate change health hazards, the debates about the reality and causes of climate change can be set aside to confront the effects. It is the responsibility of Christians, and specifically theological bioethicists who reflect on the theological aspects of disease and wellbeing, to facilitate global health. This does not need to be argued, only re-stated. In addition to Scripture, the classic work of H. Richard Niebuhr on responsibility is an appropriate reminder that

Evangelical bioethicists have an obligation to address broad medical issues, such as climate change health hazards.

III. H. Richard Niebuhr's *The Responsible Self* and Evangelical Bioethicists

Responsibility is a major moral principle in both the scriptures and in theology. H. Richard Niebuhr identifies three archetypes of responsibility. His ideas presented in *The Responsible Self* are a compelling impetus for theological responsibility in addressing climate change health hazards. To appreciate how Niebuhr comes to the fullness of Christian responsibility, one must begin with the individual. One must begin with man-as-maker. The male pronoun will be retained when referencing Niebuhr's paradigms for translational integrity, however, the generic "man"-as-humankind, is the meaning that should be observed.

Homo faber

Homo faber is described in existential terms, where the human "constructs things according to an idea and for the sake of an end."[23] Niebuhr writes that man-as-maker is "the most common symbol" in moral theory and is teleological in nature.[24] Here the individual asks, "what is my good, ideal or *telos*?"[25] Under this paradigm, actions are deemed to be ethical when they are oriented towards the goal.

Teleological action as morality has been a feature of ethics throughout time. An example of teleological ethics is the Aristotelian view of the good. For Aristotle, all actions are oriented towards the good, which is *arête*. In Christian theology, a Thomistic view of morality is often teleological. Humans aim at the end they are created for—namely, fulfilling the natural law through relationship with God.[26] The agent's reference to the end, "the good,"[27] shapes human actions and determines morality. Likewise, in Niebuhr's *homo faber*, individuals are working towards a goal.

Although the teleological articulation of ethics is prevalent in philosophy and theology, ultimately the view is individualistic. The person moves towards a final outcome, but not evaluating her path—or how it will affect others. Since the end goal is the only motivation that matters—not the road on which the person gets there—the moral agent will "reject material which does not fit his purposes."[28]

With respect to climate change related health hazards, the *homo faber* paradigm might advocate for sustainable policies like widespread dissemination of contraception. As an individual, they might support recycling without recognizing the resource use required in production. Because the larger social context is not taken into account, *homo faber* is not a viable option for personal responsibility and is insufficient as a basis for Evangelical bioethicists to address change related health hazards. Niebuhr's next model of responsibility considers relationships within a community; the individual in a society.

Homo politicus

A person aware of her embeddedness within a society will have a different conception of responsibility than one only interested in his or her own moral path. In Niebuhr's description of *homo politicus*, or "man as citizen," the moral agent is recognized as existing in a milieu that both affects—and is affected by—individual actions. Here, the agent behaves and acts according to prescriptive and prohibitive laws. The individual's morality is primarily in relation to the legal or punitive system. In this juridical paradigm, the agent must primarily ask the questions, "to what law shall I consent, against what rebel?"[29] This paradigm is fundamentally deontological and morality is determined simply by following rules.

Deontological morality is reflected in Kantian philosophy where maxims, such as "never treat anyone only as a means, but as an end in themselves," dictate moral actions. The *Decalogue* is an example of Judeo-Christian deontological morality. In both Kantianism and the Ten Commandments, the person accepts that she is part of society, which has rules and boundaries for the good of all people. Morality is primarily in reference to the command: the right.[30]

Deontological morality can hinder responsibility because, for instance, it does not allow for circumstances that may arise which necessitate a breaking of the law, such as stealing food to feed oneself. Niebuhr assumes, "Those who view man this way seek to subordinate the good to the right; only right life is good and right life is no future ideal, but always a present demand."[31] Moreover, *homo politicus* offers little personal freedom by insisting on rote morality. Here, a person relies on institutions, such as the healthcare industry, to take care of all health harms, even those that are a result of human negligence. Consenting to the status quo—in this case the consumer approach to the medical industry—will not investigate the structure itself. For the reasons provided above, H. R. Niebuhr dismisses *homo politicus* as a paradigm of true responsibility. Likewise, Evangelical bioethicists will find *homo politicus* underequipped to respond to climate health hazards.

Given the limitations of both *homo faber* and *homo politicus*, a third paradigm is proposed, which corrects deficiencies and integrates strengths of the two. Niebuhr proposes *homo dialectus*, the "man-in-dialogue," as constitutive of authentic responsibility because the agent is neither a slave to a fixed end or goal—as in *homo faber*—nor uncritically obescient to an authority—as in *homo politicus*. Instead, the moral agent is actively engaged in dialogue with the world around her, in order to enact personal responsibility.[32] It is here, in *homo dialectus*, that Evangelical bioethicists can find the rationale to address climate change health hazards as a contemporary matter of moral significance.

Homo dialectus

The definitive standard of responsibility for H. Richard Niebuhr is a response to a situation, in line with social solidarity—*homo dialectus*. Because Niebuhr is writing as a theologian, response is "not merely to be accountable; it is to answer a vocation."[33] That is, the vocation of being a disciple of Christ. This cosmological commitment distinguishes Niebuhr's articulation of responsibility from other secular models. This high calling, this vocation of the person-in-dialogue, is only possible through the grace of God, indeed the paradigmatic Responsible one—Jesus Christ. "For Niebuhr, the dominant structure of moral experience is the structure of responsibility."[34] The term "responsibility" is a synecdoche for four dialogical phases which comprise *homo dialectus*. For simplicity, James W. Fowler describes these as "response, interpretation, accountability, and community."[35]

Niebuhr begins his description of *homo dialectus* by stating, "the first element in the theory of responsibility is the idea of response."[36] The potential for response assumes that the person is morally free and unconstrained by a prior goal or law. A free response places the agent in a position to act instead of remaining passive. In academia, this requires free speech. For Christians, it requires liberty. Freedom should not be taken for granted, as many scholars are constrained by institutional norms and Christians may suffer reproach from their denomination for speaking on a topic. Climate change is often seen as a "liberal" concern, but it need not be polemical. Focusing on climate health hazards builds consensus across partisan and denominational lines by addressing the result—not the cause—of climate change. Hence, for Niebuhr, "freedom is prerequisite for responsibility."[37]

Once the potential to respond in freedom is established, the second part of responsibility can occur. Niebuhr writes, "we respond as we interpret the meaning of actions upon us."[38] In the second part of responsibility, interpretation plays a vital role since responsible action is not a spontaneous reaction, but rather a prudential judgment. Upon encountering a particular situation, action is forestalled as responsible agents seek "not only our responsive action but responsive in accordance with our interpretation of the question."[39] For Evangelical bioethicists, the question of interpretation aligns with broader biomedical principles of justice, fairness, and stewardship. Millions of our global neighbors are suffering the complications of severe weather. The situation must be interpreted as a plea to act.

Following the interpretation of the situation, the third element of responsibility emerges as "the anticipation of reaction to our reaction."[40] That is, the responsible agent does not merely decide what she will do, but also considers how others in society will react to her anticipated action, to gauge the collective implications of the decision. In theology, this may be called "reading the signs of the times." In a Rawlsian paradigm, the concept of "reflective equilibrium" is similar.[41] The objective is not to succumb to the complacent ways of the world, but rather recognize oneself accountable within a community of other moral agents.

Major worldwide organizations such as the United Nations, the World Health Organization, and numerous academic research centers across the world have made statements and taken actions to reduce carbon emissions and attend to climate change health hazards. There is international support—and in some pockets of the United States domestic support—for being accountable for the effects of climate change on the wellbeing of citizens.

The fourth aspect of responsibility in *homo dialectus* is not necessarily a prescriptive action, since the agent in dialogue must act uniquely in each situation. In this final stage of responsibility, the agent responds within the community. Niebuhr argues, "the responsible self is driven by the moments of the social process to respond and be accountable in nothing less than a universal community."[42] A non-anthropocentric universal community is, by some estimations, the fullest articulation of Christian theology. The Scriptures start with creation of the natural world and in the New Testament declare, “For in him all things were created: things in heaven and on earth, visible and invisible, . . . all things were created through him and for him. He is before all things, and in him all things hold together” (Col 1:16-17, NIV). Not all Evangelical bioethicists will assent to this vision of community. Action on climate health is more important than agreement on theological matters tangential to that action.

In sum, *homo dialectus* is characterized both as an individual and as a person in a relationship with society, in ongoing dialogue. The moral objective of the person is neither to construct a morality of her own, nor to follow social commands, but rather to discern the correct action for a particular situation, which then results in an obligation to act with reference to “the fitting.”[43] Due to the ever-evolving nature of social conditions, “the ‘fitting’ thing to do is not determined in advance, but rather discovered in the process of deciding ‘what is going on.’”[44] This facilitates the highest form of morality, which includes an active involvement in decision-making.

Authentic morality entails responsible actions in response to, and with the approbation of, the entire community. With regards to ecology and human health, it is well known that people are impacted by climate change health hazards. The United States Conference of Catholic Bishops poignantly state, “In facing climate change, what we already know requires a response.”[45] Thus, the question put forth to Evangelical bioethicists is, “How will they respond?”

IV. Evangelical Bioethicists in Public Theology and Biblical Scholarship

Higher education, both through disciplines and within institutions, is responsible to society, students, and its historical profession. Christians are endowed with a supernatural calling imposed over an ordinary, social obligation. In theological education, instructors “must hold firmly to the trustworthy message as it has been taught, so that we can encourage others by sound doctrine and refute those who oppose it” (Titus 1.9, NIV). Christians are advised, “Not many of you should become teachers, . . . because you know that we who teach will be judged more strictly” (Jas 3:1, NIV). Teachers—as individuals—naturally work within a discipline. The academic discipline of theological bioethicists has a particular responsibility to address climate change related health hazards, since human health is the content of bioethics.[46] There are many avenues for Evangelical bioethicists to discharge the responsibility of making others aware of climate change health hazards. Here two are offered: public theology and biblical scholarship. Both fall under the already existing competencies of theological bioethicists.

Public Theology

In public theology, personal religious commitments are not disregarded, but rather form a tapestry of dialogue in which true consensus occurs. Jacques Maritain believed to speak as a Christian and to speak in the name of Christianity are two very different things.[47] Maritain identified two approaches to engaging the responsibility of being a Christian in a secular world. Public theology, at its core, is a translatable gospel. Christian bioethics particularly is adept at public theology, and is naturally suited to articulate a biblical position in the larger society. In this way, ethics as an area of specialization is advantaged for conversation and transformation on an assortment of topics that are relevant to secular society.[48]

Public theology can take a variety of shapes. Dissemination of ideas through writing and speech—aimed the general public—can be effective. Public theology includes engagement with secular and religious organizations to address the clinical side of climate change health hazards. At its core, public theology allows theological bioethicists to fully engage the world on issues of high importance and urgency.

Biblical Scholarship

Like public theology, biblical scholarship comes in a variety of forms. Academic theologians can draw on numerous resources[49] to construct original curriculum, courses, and class sessions to educate Christians about climate change health hazards. From curriculum comes publications. Written engagement can take shape in policy papers for churches[50] and religious organizations,[51] peer-reviewed articles, monographs, books, and blogs. To complete the loop of responsibility, written work can form the basis for oral dissemination.

Conferences are one obvious place for engagement. On university campuses, invited lectures, grand rounds, student group meetings, and faculty workshops provide opportunities to articulate the health problems associated with climate change. However, the local community should not be overlooked in favor of academia. Speaking to secular interest groups, at bookstores, coffee shops, and pub events reach socially engaged audiences outside the ivory tower. Homiletics and guest preaching remains an undertapped avenue for prophetic speaking on the topic, as well.

The academic profession depends on students to teach in the classroom, peers to engage in the academy, and transmission of ideas. The Bible is not a laminated relic. It is “living and active” (Heb 4:12) and thus able to provide guidance on contemporary issues. It would be negligent to sit idly by while people suffer from climate change health hazards. For Niebuhr, and indeed all engaged in theological bioethics, “the capacity to respond is central to . . . the moral life.”[52] Climate change health hazards are a global issue. Even if not individually affected, Evangelical bioethicists are obligated to focus work on those who suffer.

V. Conclusion: Evangelical Environmental Bioethics

In 1976, James Gustafson connected ecology, the common good, theology, and medicine in healthcare,[53] but his work has been largely overlooked by Evangelical bioethicists. Richard O. Randolph rightly linked human health and environmental health as ethical concerns for Christians, but did not make use of the Scripture, nor foundational concepts such as stewardship and creation care for his arguments. [55]Those working within Catholic hospitals have been leading the way in religious environmental bioethics for decades, but Evangelicals do not have the same ties to healthcare administration. Other Protestants working towards sustainability in healthcare tend to separate their faith from clinical settings and may retain a denominational name of a hospital (e.g., Presbyterian Hospital; Baptist Hospital) out of tradition rather than live commitment to that dimension of their faith.[56] These fragmented approaches are an opportunity for Evangelical bioethicists to develop a coherent Evangelical environmental bioethic.

In order to be effective, there ought to be an established framework with which to place the responsibility of Evangelical bioethicists to address climate change health hazards. Evangelical environmental bioethicists can align themselves with other forms of secular[57] and Catholic[58] environmental bioethics and Green Bioethics and could place an environmental ethic in many areas relevant to theological bioethics. Evangelical environmental bioethicists can address broad, societal issues of climate change, justice, and health as a part of public health. Evangelical bioethicists can engage clinical ethics by advocating for resource conservation within health care and hospitals. This would link public health and clinical ethics in a circle of virtue, whereby conservation decreases pollution, which mitigates climate change, and related climate change health hazards are reduced. Taking personal responsibility for health, disease prevention, and climate readiness could also be a form of critical engagement.

Evangelical environmental bioethics itself may be non-anthropocentric or anthropocentric. This article has presented the latter by focusing on climate change health hazards that affect humans. However, as the discipline of Evangelical environmental bioethics emerges,[60] it may also address the impact of human healthcare on the planet, animals, and ecosystems.[61] These two paths highlight the multiple, non-exclusive tactics to discharge the responsibility that Evangelical bioethicists have to respond to climate change health hazards and participate in the healing ministry of Christ.

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BOOK REVIEWS

The Death of Expertise: The Campaign against Established Knowledge and Why It Matters

Tom Nichols. New York: Oxford University Press, 2017.

ISBN: 9780190469412, 272 Pages, Hardcover, $24.95

I recently saw a satirical video advertising doctors as the solution to confusion surrounding the coronavirus pandemic. The video made the point that doctors, people who have dedicated close to a decade of education to understanding disease processes, have been some of the most ignored voices in the Covid-19 crisis. Tom Nichols, Professor of National Security Affairs at the Naval War College, would argue that this assessment is true not only of medicine, but also of expert fields in general. Nichols, in this book diagnoses the death of expertise as a disregard for experts by the lay public. Nichols argues that the American lay person no longer considers the expert's opinion to have extraordinary weight, and the expert subsequently withdraws from conversations where their knowledge is not valued (Nichols 2017, 4–5).

Nichols acknowledges that people have always remained skeptical of experts but writes that this new death of expertise highlights an active hostility to expert knowledge and a concurrent embracing of misinformation (Nichols 2017, 20). He argues that this "rejection of science and dispassionate rationality" spells doom for modern democracy (Nichols 2017, 5). Nichols describes the primary characteristics of this phenomenon as the illusion of intellectual egalitarianism and the commodification of higher education and journalism, both of which are accelerated by the inundation of information from the Internet.

One of Nichols's strongest points regards the devolution of higher education. Nichols lambasts the American higher education system, arguing that mass college attendance, the proliferation of professorships and colleges marketed as universities, and the ubiquity of bachelor's degrees has bankrupted the value of undergraduate education (Nichols 2017, 72–76). The pervasiveness of an undergraduate education devalues college and, to his argument for the death of expertise, gives people an illusion of expertise or credibility. An example he gives from the medical field is the finding that low childhood vaccine compliance in a population generally correlates with educated parents rather than parents with less schooling (Nichols 2017, 21). Although counterintuitive, Nichols argues that these individuals' education leads to an unwarranted confidence in rejecting expert knowledge.

Nichols superbly highlights the psychological basis for the death of expertise. He explains how psychological defense mechanisms incline people against expert opinions that contradict their deeply held values (Nichols 2017, Ch.2). The connection of these mechanisms to the swaths of information on the Internet arms any skeptic with a response to expert claims (Nichols 2017, Ch.4). Nichols's ultimate impact is stated gravely in the conclusion. For the sake of democracy, people must purposefully inform themselves. A Google search will not suffice this time. Democratic governments require experts to help shape sound policy, and experts must be valued for the sake of the nation (Nichols 2017, 230–31). With this impact, Nichols expands the scope of the death of expertise from individual cases to whole societies. For the medical professional, mistrust in experts means more than serving as the second opinion to Dr. Google. This mistrust can jeopardize effective responses to public health crises when both policy responses and the general populace choose to forgo expert advice, risking lives and livelihoods.

Although Nichols's book is well-crafted in its narrative of the death of expertise, there remain a few areas where his argument could have been strengthened. First, Nichols primarily relies on anecdotes rather than thorough empirical evidence. This would make sense were Nichols to describe his own experience, but the lack of statistical evidence makes it difficult to prove a systematic problem regarding hostility towards experts. Furthermore, Nichols hints in his chapters on journalism and higher education that commodification has ruined the integrity of these institutions. These bigger concepts—commodification and a populist distrust in elites—seem to comprise the foundation of Nichols's argument, but without an in-depth analysis of the systemic problem, his ability to analyze these social shifts is limited.

Second, Nichols does not address situations in which experts disagree. In transiently mentioning this issue, Nichols quotes Bertrand Russell as saying, "when [experts] are not agreed, no opinion can be regarded as certain by a non-expert." (Nichols 2017, 207) However, there are times when decisions must be made, even if there is expert disagreement. Deeper than mere disagreement, Nichols also leaves unaddressed the issue of ideological polarization, when expert disagreement stems not from good faith differences of interpretation but from differences in ideological agenda. While not deadly to Nichols's argument, these conflicts must be clarified if his advice can be practiced.

Finally, Nichols seems to frame society as comprised of the experts and the lay people without providing for a middle ground. A middle ground of the "lay expert" is implied—he states that there is no excuse for people to be uninformed about a relevant issue—yet uncertainty remains as to the significance of the lay expert in relation to the expert (Nichols 2017, 206–7). Nichols crafts a tension between listening to the experts and seeking to inform oneself. Nichols may be simply arguing that people should better understand the limits of their knowledge. However, being informed is only useful if it aligns with the expert's view, in which case it seems easier to just allow the expert their field without bothering to understand it. Again, this argument does not deny the death of expertise, but it creates ambiguity in applying Nichols's ideas.

A comprehensive Christian response to such societal rifts does not come easily. However, important elements of a Christian response to the death of expertise should involve being critically informed while remaining humbly mindful of one's biases and knowledge limitations. A humble evaluation of perspectives may reveal that people's passionate stances often rest on underlying values that they want to protect, rather than an actual disagreement with the action. In the current Covid-19 pandemic, for example, those who choose not to wear masks may be concerned with infringements on personal freedoms rather than convinced that masks are inefficacious. Evaluating what values are godly and worthy of defense can help to remove unnecessary barriers to civil communication with experts and those with whom we disagree. Understanding that the church recognizes an internal hierarchy of authority, prideful ignorance toward authority is no more foolish in the secular sphere than in the church (cf. Hebrew 13:7, 17).

The Death of Expertise offers a compelling yet incomplete picture of the fragmentation between experts and the lay public in society. Social shifts towards populism and commodification, combined with the Internet's information monopoly, have sown distrust of expert knowledge. Published as the 45th U.S. president was beginning his term, Nichols's predictions and warnings appear almost prophetic, no less so than in the current Covid-19 crisis. With Covid-19, the medical community has seen public health politicized and experts ignored. While not easily bridged, the gap between experts and the public can begin to narrow if the populace chooses to inform itself and critically seek the truth amid the overwhelming untruths. Experts must likewise seek to understand and connect with the public despite the radical polarization that often induces divisive tribalism. Such a task is not easy, but it is vital to the healthy functioning of society.

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What it Means to be Human: The Case for the Body in Public Bioethics

O. Carter Snead, Harvard University Press, 2020.

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The purpose of laws is to protect people's rights and freedoms, thus promoting human flourishing. Because they reflect societal values, laws are based on society's anthropology—its concept of what it means to be human, and the goods, virtues, and practices that ensure prosperity for its citizens. Therefore, for human beings to flourish, laws should be grounded in an understanding of the human condition as it is actually lived. In *What It Means to Be Human: The Case for the Body in Public Bioethics*, O. Carter Snead delivers a devastating critique of the anthropological foundations of current laws and policies in public bioethics. His goal is not to propose specific changes, but to defend a more robust vision of the human experience and to offer an alternative to the contemporary paradigm.

Drawing on the work of Robert Bellah and Alasdair McIntyre, Snead identifies today's reigning anthropology as *expressive individualism*. On this view, human flourishing is best envisioned as an individual person, untethered from social and familial connections, expressing his core beliefs and desires. He does this by following a destiny based on his personal values and preferences. Personhood, by this definition, is simply the capacity to choose, giving preeminence to the mind and will. The body is important only as an instrument to pursue life goals, and other human beings are either collaborators or adversaries in that pursuit.

Expressive individualism is severely flawed, Snead argues, because it does not account for the "whole truth of who we are and how we stand in relation to one another as vulnerable, mutually dependent, finite, and embodied beings" (p. 4). From the moment of conception, and at various times throughout our lives, we are limited and vulnerable, dependent on the unconditional and self-sacrificial giving of others for life and growth. To deal with this flaw, writes Snead, we must apply an "anthropological corrective" that acknowledges the limitations we face as embodied beings, our dependence throughout life on the beneficence of others, and the need to inculcate virtues and practices that will ensure the flourishing of human beings beyond our lifetimes.

Snead begins his argument by describing the rise of public bioethics in this country in the early 1970s as a reaction to the abuses occurring in human subjects research. Shocked by reports of reprehensible treatment of human subjects, the US Congress, supported by the courts and the public, created laws, protocols, and regulatory agencies to govern research and define public bioethics today. The prevailing arguments that inspired these efforts focused on promoting autonomy and informed consent. But this approach only offers protection to a select group of individuals who are free of the incapacitating effects of disability, pain and suffering, immaturity, cognitive deficits, or low intelligence. The lived reality for most people, however, is a struggle with the weakness, vulnerability, and dependence that characterizes embodied persons. So the current framework to address public bioethics is inadequate and ineffective to truly resolve current bioethical dilemmas.

Snead applies his critique of the current anthropology to an exploration of three major bioethical issues: abortion, assisted reproduction, and end-of-life decision making. First, he shows how the past fifty years of abortion law assume that individual rights are primary, even if that requires destroying unborn life. The courts do not recognize the special nature of the mother and child relationship or the common experience of every person as a newly-conceived, absolutely dependent human being who needs support from others. Instead, mother and child appear as isolated entities pitted against each other as strangers and enemies. The developing human being is a non-person, and the woman is left to fight her battles alone.

Second, Snead tackles the complex issue of assisted reproduction, noting the surprising absence of laws to regulate and monitor the technologies involved. According to expressive individualism, a person has an almost unlimited right to pursue procreation, and the government should not interfere. The law does not protect gamete donors, gestating mothers, surrogates, developing children, or the millions of embryos destined for destruction. Nor does the law promote the expression of virtues such as just generosity, hospitality, "openness to the unbidden," and compassion necessary for the flourishing of children. The law exists, almost exclusively, to support the choices of individuals who desire to reproduce.

Third, regarding end-of-life decision making, the law appropriately supports the rights of competent individuals, but fails to consider the unique experiences of those who have lost decision-making capacity. The law assumes that those incapacitated by disease and disability still desire to assert their wills. But Snead points out that many people at the end of life prefer to allow loved ones to make their decisions. For those with a diminished quality of life, the law should encourage compassion and empathy and protect against abuse and abandonment. Instead, many states are adopting legislation that promotes suicide with the aid of physicians and other clinicians. Summarizing he notes, "At a time when the person is most fragile and dependent on the care of others for basic needs, the law elevates freedom and self-determination as its animating goods" (p. 248).

In each of these arenas, Snead demonstrates that expressive individualism fails as an adequate description of our anthropology. In fact, we are not atomized wills, but interdependent, vulnerable, and embodied beings, indebted to others for the self-sacrificial and uncalculated care extended to us from the very beginning. The strength of this thesis is that it resonates with our actual lived experience. Even those who disagree with Snead's positions on abortion, assisted reproduction, and end-of-life decision-making will find it hard to challenge his call for a new paradigm for resolving bioethics controversies.

Each of us knows that we have not made it on our own. We cannot flourish in a society where life has degenerated into a competition between isolated, self-interested individuals. Snead reminds us that "human flourishing is most profoundly achieved through love and friendship" (p. 222). In gratitude to those who cared for us in our deepest need, we must follow their example of unconditional beneficence. Only by inculcating the virtues of generosity, hospitality, compassion, and humility will we nurture and protect the "robust and expansive networks of uncalculated giving and receiving" (p. 269) necessary for creating a humane, wise, and just society.

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