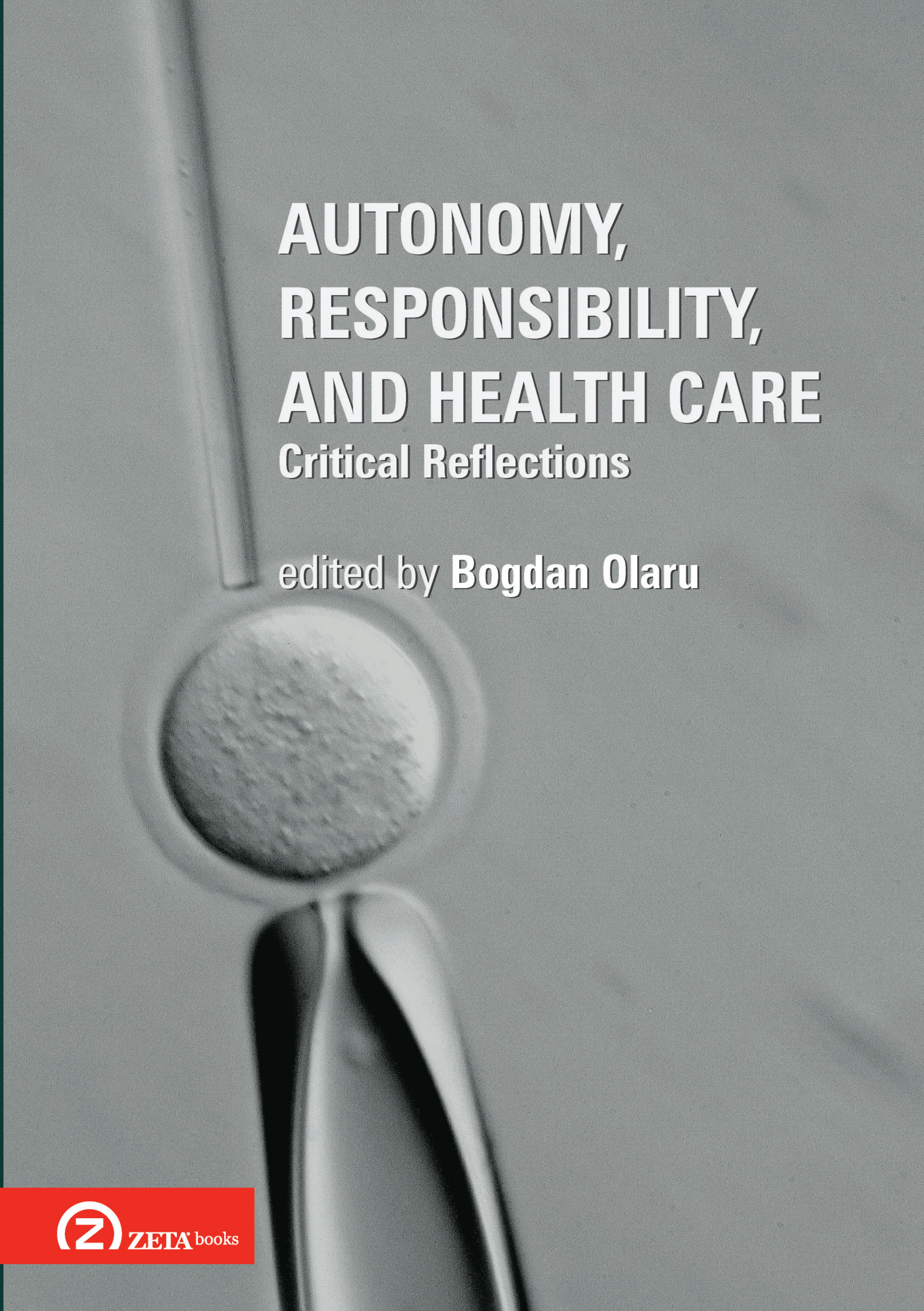

AUTONOMY, RESPONSIBILITY, AND HEALTH CARE

Critical Reflections

edited by **Bogdan Olaru**

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Volker Lipp is professor of civil law, law of civil procedure, and comparative law at the University of Göttingen (Germany), and was, inter alia, visiting fellow at the Institute of Advanced Legal Studies, University of London. He has written on subjects in bioethics, with specific interests in the legal and policy issues. His more recent books are *Patientenautonomie und Lebensschutz. Zur Diskussion um eine gesetzliche Regelung der 'Sterbehilfe'* (Göttingen, 2005) and *Familienrechtlicher Status und Solidarität* (co-authored with Anne Röthel and Peter A. Windel, Tübingen, 2008)

Karl-Wilhelm Merks is member of the Scientific Advice Council of the Centre for Intercultural Ethics at the University of Tilbug (Netherlands). He is author of *Verantwortung – Ende oder Wandlungen einer Vorstellung?: Orte und Funktionen der Ethik in unserer Gesellschaft* (Münster, 2001), *Gott und die Moral: Theologische Ethik heute* (Münster, 1998), and co-editor, with Frans Vosman, of *Aiming at Happiness: The Moral Teaching in the Catechism of the Catholic Church* (Kampen, 1996).

Nicolae Morar is a PhD student at Purdue University, USA. He received his Master degree in 2005 from Lyon III "Jean Moulin" University with a thesis entitled "Les enjeux de la médicine reproductive aux Etats-Unis: entre Ethique et Politique." He is interested in Continental Philosophy, especially Foucault, Deleuze, Agamben, and Sloterdijk and its connections with applied ethics (genetic testing/ bio-power). He is also the founder and the co-organizer of the Bioethics Seminar Lectures at Purdue University.

Bogdan Olaru has studied philosophy at Alexandru Ioan Cuza University of Jassy (Romania) and Humboldt University of Berlin. He worked for nine years as a researcher at the Jassy Institute for Economic and Social Research. His primary areas of interest currently include bioethics, ethical theory, and phenomenology. He has edited *Current Ethical Controversies in Biotechnology: Individual Autonomy and Social Responsibility* (Jassy, 2008), and his most recent publications address assisted reproductive technologies and stem-cell research.

Silke Schicktanz is professor at the University of Göttingen (Germany), where she teaches in the Department of Medical Ethics and History of Medicine. Her research and teaching interests include organ transplantation, xenotransplantation, and ethical and socio-cultural aspects of human reproduction and sexuality. She took part in the EU-Research Project "Challenges of Biomedicine—Socio-Cultural Contexts, European Governance and Bioethics" which focused on the socio-cultural background of modern biomedicine in different European countries. She has published numerous articles and co-edited several books on ethical and social issues in health care.

FOREWORD

This book brings before the readers' eyes the work of a group of dedicated researchers whose interest lies in moral philosophy and applied ethics. The contributors had the liberty to choose the application fields and the examples that best illustrate their arguments. Nevertheless, they all put the main stress on two issues which seems to be the key to understand many of the today's bioethical challenges: the autonomy claim and the question of moral responsibility arising in various fields of applied medical research.

The book addresses some classical questions such as: what is the meaning of autonomy? What justifies it? How come infringements against the autonomy claim make sense sometimes? How do we recognize overriding moral demands? Still, these questions are far from being fully answered here. The natural way to tackle these issues is to put the claim of personal autonomy in some kind of balance with other values, and to weigh the relative importance of different imperatives which (seem to) conflict with one another. Thus, we usually lose our aim in philosophical quarrels, because we face conceptual patterns which seem to be irreconcilable: autonomy and care, autonomy and justice, autonomy and solidarity, autonomy and trust, etc. Last in this series, for instance, constitutes the focus of a recent book by Onora O'Neill,[1] in which she describes in quite a straightforward manner, the conflict between autonomy, as precondition for individual liberty, on the one hand, and trust, as basis for social cooperation and solidarity, on the other. The other way to think about this is to see the clashing claims as moral demands which complement one another, and, if truth be told, this is what we expect and how things really work. We do justice only when and if, we really consider what people's wishes look

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[1] Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press, 2002).

like, and we show respect for their wishes especially when we take care of them. Or, to put it another way, to care about someone generally means to respect his or her wish to make decisions for him or herself. As a matter of fact, most of us expect the others to practice precisely this form of care, especially in matters such as reproductive issues or end-of-life decisions.

But this is not the end of the story. In most cases, we manage to recognize the individual responsibility that goes together with the exercise of free choice and autonomous action. Yet, there are times when we fail to do so. Let us consider this well-known example: We have an obligation not to make use of our environment as we please, that is, for instance, not to use the natural resources irrespective of what would benefit or harm the next generations. But it is difficult to point to a particular entity in charge of this form of ecological responsibility. Individuals as well as institutions, life-style as well as cultural habits, have a part to play in shaping this special form of responsibility. Let's take another example: active family planning and responsible parenthood. We usually think of the decision to have a child as the very expression of free choice and prize this as the genuine illustration of the autonomy claim. We should think so irrespective of how old the parents are, and we would never allow anyone to set the right time for parenthood on our behalf. Then why should we dismiss as weird or even 'abnormal' the wish to have a child when it comes from a sixty-year-old woman or even older? What makes such a decision look so peculiar? Is it not because we only point to her age over and over? But does her wish to have a child differ substantially from the same wish of other women, apart from the fact that the latter would eventually want the same at earlier ages? It seems that there are deeply rooted boundaries about these things and that most people find no difficulty in addressing them when it comes to actions which don't fit into traditional patterns. Perhaps these boundaries are not only cultural, but also anthropologically given, and therefore, we must include the anthropological dimension in a more comprehensive understanding of the autonomy concept. Only then, the charge of border-crossing could eventually make sense (if ever)—not because of some kind of incompatibility between one's age and what he or she wants to achieve in some circumstances, but because of the gap between the self-assumed decisions and the responsibility which follows from them.

One of the most difficult questions is, then, how to link human responsibility to those consequences of action which no one can fully foresee but, nevertheless, which no one can afford to neglect. Many biotechnological challenges are of the same nature. We just cannot foresee the complete range of virtual social and moral costs of genetic screening for reproductive purposes or of human germline engineering and gene therapy for humans or animals. This is why we must explore special obligations grasped under peculiar formulae like 'genetic responsibility'[2] or 'responsibility for the species integrity.'[3] In arguing about such new obligations, the big unknown variable is whether we really identify and describe genuine responsibilities or only inflate the field upon which we just want to extend our control. We see ourselves nowadays confronted with strong and even more unusual autonomy claims (the wish of a Finnish lesbian couple to have a child could be another such example), while the solution to conflicting demands becomes increasingly fuzzy and parochial. I believe we face here a circular, but non-vicious, legitimating process that any autonomy claim inevitably goes through: If autonomy makes up the necessary condition to take responsibility and if the latter functions as a factual limit for the former, we stand before a process of mutual justification and, possibly, of mutual limitation. I hope that this book will bring some insights into this process.

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[2] Thomas Lemke, *Veranlagung und Verantwortung. Genetische Diagnostik zwischen Selbstbestimmung und Schicksal* (Bielefeld: Transcript, 2004).

[3] Jürgen Habermas, *Die Zukunft der menschlichen Natur. Auf dem Weg zu einer liberalen Eugenik?* (Frankfurt/M.: Suhrkamp, 2001).

The first paper deals with some well-known and very popular assumptions about personal autonomy and human identity. The main line of the traditional approach identifies autonomy with the ability to recognize and pursue one's interests and preferences. To act autonomously means to act fully independent of external factors and exclusively dependent of internal influences. Regine Kather shows that this understanding of autonomy owes its popularity to the classical segregation between mind and body. Human essence and the very core of personal identity must lie in one's mind, not in one's body—this is what philosophy firmly teaches us, from Plato to Hume, and to (some trends of) the present-day bioethics. Regine Kather argues against the precarious reduction of personal identity to interests and to the mere ability to express them. If we embrace this reductionist approach, the first thing that we lose from sight is the significance of the human body to one's own biography. But the reduction would also lead to unacceptable treatments of borderline cases like haemophiliac newborns, dying patients, and people suffering from dementia, or lying in a state of irreversible coma. If we study the development of human identity from the physical and psychological point of view, we must acknowledge the significance of at least two aspects which contribute to a more comprehensive concept of personal identity: the relations with others and the reference to one's own body. The analysis underlines the various ways in which the body represents a medium of expressing intentions and meanings. The body is not only the genetic and physiological basis of personal identity, but it also contributes to the very biography of its owner through interpersonal mediation. If this is true, it is not the mind, but the living body, which "guarantees the singularity of a person even if it is not self-conscious." (p. 40) From this argument follows the priority of the living body as a medium of communication over the individual interests when it comes about defining personal identity. This 'shift in the anthropological premises' is based upon the concept of 'bodily autonomy', by which Wim Dekkers means the "combination of the biomedical notion of bodily automatisms and the phenomenological idea of the lived body." (p. 39) If the living body is a part of the biography, and if it participates in expressing at least some basic intentions, the argument turns into a plea for setting a higher valuation on the human body especially in those situations when the personal life is not yet fully developed or when it is irreversibly destroyed.

The next study deals also with the relationship between body and autonomy, and its significance for medical ethics. Silke Schicktanz argues that we must become aware of the anthropological and epistemic premises about the human body. She raises some objections to the way the traditional ethical theories have explained main ethical concepts without any relation to the body. Many of these concepts, like self-determination, personhood, preferences, or rationality must be considered as interwoven with anthropological facts. The anthropological and epistemic presuppositions about body and embodiment determine, for instance, the way we see ourselves as autonomous subjects. Autonomy is widely understood as the 'unavailability' of the body. A typical partisan of liberal self-determination would act according to the maxim: "My body belongs to me!" The insight that any living body is a suffering body, an entity that can be harmed and give rise to both pleasant and unpleasant feelings, provide the background for the bioethical principle of nonmaleficence. Other examples can easily follow this argumentation. This study focuses, however, on four normative perspectives on the relationship between embodiment and autonomy. The four concepts, which are rather alternative or even antagonistic, are viewed as complementary to one another, so no one could claim any sort of primacy. Four body-autonomy relationships are discussed: 1) Autonomy as the right to bodily self-determination; 2) Moral or relational autonomy, which includes the respect for another person's bodily integrity; 3) Autonomy as self-critical reflection, which focuses on the individual conception about what a good life means and includes a form of care for one's own body; 4) Autonomy expressed by means of specific forms of bodily interaction and of bodily-constituted communities. The latter is vital, when the body and bodily expressions are constitutive for specific social interactions (like parenthood, partnerships or friendship), and when the person's social identity develops by sharing bodily experience. The narrow relationship between embodiment and autonomy is illustrated further by applying the four perspectives to controversial issues like transplantation medicine, neuroprosthesis and cosmetic surgery. These are examples of 'transgressing body borders' with deep consequences over the bodily integrity. They bring into the limelight another three important fields in medical ethics, besides reproductive medicine and women's health, for which the way we consider and understand the body seems to be quite critical. It turns out that the body is not just a second level of reflection, but quite a decisive issue in dealing with bioethical questions.

Karl-Wilhelm Merks has also approached the moral sense of personal autonomy in medical ethics. For many theoreticians of modern biomedical ethics, the autonomy constitutes the core of the relationship between patients and physicians. This is one of the principles of biomedical ethics: autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress). It is probably impossible to establish a sharply delineated role for each of the four moral imperatives, given the tension between them, but some of the scholars tend to give autonomy preeminence. The common modern way of thinking about autonomy is related to the value of self-determination. This conception stresses upon the individual right to make a decision about having, pursuing or ending a medical treatment, when patients want to do this. It does not attempt to formulate arguments in favor of one of the available alternatives. Karl-Wilhelm Merks has no intention to argue against this view as he understands the importance attached to the concept of autonomy in modern society and also the tendency to value individuality and to preserve liberty while sharing different values. Merks only says that we must pay more attention to the context in which individuals manifest themselves as autonomous subjects. Different individuals involved in different contexts of one large and complicated medical care system have different needs and various interests. If we take these factors into account, medical ethics must rethink autonomy: the very logic of personal autonomy is not just bare self-determination, but rather doing what is morally required and refraining from doing what is morally wrong. The moral sense of personal autonomy has to do with the good will and with the pursuing of morality (p. 85). The respect of human dignity and the sense of moral responsibility are such moral goods, which give autonomy a moral sense. This is why autonomy cannot be conceived outside these moral requirements. The obligation to care about others and the feeling that others are caring about you is another feature that morally bounds autonomy in medical practice. We get a better picture about what autonomy means when we understand the moral demands, which mark the boundary of self-determination. Ethics of care and ethics of responsibility are such prospective approaches, which provide a notion of 'bounded' or 'relational' autonomy (p. 89). The reader will find in the last section of Merks' article an illustrative sample about the way in which care and autonomy are complementary to one another in the matter of end-of-life decision-making.

The next contribution assesses the question of pursuing or ending life-sustaining treatments seen from the viewpoint of the German legislation. Once again, the concept of autonomy is crucial for this topic. Volker Lipp begins by discussing the various legal forms of conceiving diminished or reduced autonomy, many of them occurring when patients enter the final stage of a lethal disease. One cannot prescribe the required action from the part of the physician in such cases before a close investigation of the patient's demands. Legal regulation must provide with instruments to mediate the wish of those patients even if, or precisely when, they cannot speak for themselves. Guardianship legislation and living wills are such instruments, meant to reestablish the proper conditions for end-of-life decision-making. The author shows that these legal instruments must be seen as elaborated forms of care, as essential complements of patient autonomy. The second point in Lipp's argumentation is to clarify the fundamental legal structure of the relation between patient and physician. The latter does not have unlimited decisional power. The right and duty to treat a patient is the result of a contractual relationship, which sets, on the patient's wish, the general legal frame for giving and receiving medical treatment. If a physician treats a patient against his will, the treatment must count from a legal point of view as physical injury. The same should be the case for life-supporting care and, in general, any treatment which is mainly intended for the prolongation of patient's life, in the light of strong evidence that the patient did not consent to this treatment. (p. 105) The third step applies the legal considerations about autonomy and patient-physician relationships to different forms of voluntary and/or active euthanasia. Volker Lipp argues that the withdrawal of life-prolonging treatment ('allowing to die') cannot be qualified as voluntary or active euthanasia, if the dying process occurred irreversibly, because there is no medical indication for that treatment. Only palliative care has to be provided. If the physician holds that the dying process has not yet occurred and the treatment is indicated from a medical point of view, but the patient refuses to undergo the treatment, the contractual nature of the patient-physician relationships forbids the continuation of any life-prolonging treatment. (p. 107)

The following two authors discuss some difficulties about conceiving responsibility for subjects that literally cannot speak for themselves. Various contributions of contemporary ethics aim at working out plausible moral obligations and related rights in the special case of an asymmetrical relationship such as, the one between existing and communicative subjects on the one hand, i.e. actual living humans, and nonhuman subjects or nonexistent, but potential moral subjects on the other. Nicolae Morar challenges the project of discursive ethics and shows that it is at least misleading in the way it deals with subjects that cannot perform a communicative action. He works out the basic lines of discursive ethics along the argumentation of Jürgen Habermas and K.O. Apel in order to evaluate the potential of their approach to integrate responsibilities with respect to nature, nonhuman animals, and future generations. The result is rather a negative one. Though discursive ethics takes a postconventional, postmetaphysical position, regarding normativity as the mere outcome of an achieved consensus among participants in a communicative action, both of the above mentioned philosophers fail to extend in a convincing manner the frame of ethical argumentation to 'anomalies' of discourse, now classical, such as animals or future people. They provide us, at best, with more or less artificial philosophical constructions like 'quasi-moral forms of responsibility' or 'analogous moral duties'. One central objection to discursive ethics is its inability to understand nature in a manner other than instrumental, that is, as an object of reification and scientific observation (Joel Whitebook). The consequence is, as Nicolae Morar puts it, that "the only moral attitude toward nature that communicative actors are able to perform is through a stance of compassion or, at most, an *analogous feeling to morality* with respect to animals." (p. 143) But this thinking and feeling 'by analogy' with normativity shows how difficult it is for discursive ethics to integrate non-linguistic entities in a normative situation, and in fact, it literally excludes a whole range of living creatures from any normative attempt. It proves how inadequate discursive ethics is when facing non-discursive ethical problems, like those generally related to environmental questions, experiments on animals, nutrition, etc. In the second part of his paper, Nicolae Morar explores, with scholars like Günther Patzig and Mark Bernstein, alternative ways to work out the moral stance humans should take toward nature and nonhuman animals. He also looks into Habermas' critical view that their argument fails the test of reciprocal universality.

In my contribution to this volume, I hope to make a step further in exploring some atypical and intriguing questions of present-day bioethics. I begin with the question if we have a special responsibility to protect the integrity of living species, the human species included. This question might be seen as a classical issue of environmental ethics, but it also occurs more and more often in the debate about species hybridization through genetic engineering. It is also relevant for the debate on germline genetic modifications in humans, especially genetic enhancements via reproductive technologies. The most conservative view might be described as a position advocating a policy of preserving species ‘as they are’, i.e. in their ‘unaltered integrity’. The moral imperative of integrity says that “biological species in general and human species in particular have an intrinsic value, which is recognizable beyond the value of each individual. The respect of this intrinsic value requires protection of the species as they are, in their wholeness and intactness or, in other words, in their integrity.” (p. 160) Difficulties arise already in establishing a conceptual frame for the idea of integrity. The conservative position is undermined by ontological problems concerning species seen as abstract entities corresponding to a would-be fixed reality. The most plausible counterpart of the integrity protection position is to deny the existence of an intrinsic value, and to judge genetic manipulations only in the light of the estimated consequences. This position allows for rational arguments in favor of some carefully pursued genetic alterations of actual species or future beings as long as man’s intrusion can be measured in terms of well-being or increasing fitness. But this argument is not enough to support direct intervention in natural mechanisms. It makes not yet a case for ‘taking evolution in our hands’. In the first half of my paper I examine several arguments for and against the moral imperative about species integrity. The last section transposes the same question onto the ethics of human species and shifts the debate about biotechnologies applied on humans in a direction where considerations about our integrity as species are attached a higher significance. I argue by analogy: we cannot think of integrity of endangered species without pleading for the integrity of their habitat, and similarly, we cannot explore and protect human integrity regardless of what makes and secures the integrity of our life-world, that is the very possibility for moral interactions. I call this the argument of preserving the special language-game of moral discourse.

In the last contribution to this volume, Eugen Huzum approaches a subject related to the high costs of health care and the widespread of various but expensive methods of treatment and medical techniques. This is an intensely discussed, but difficult, question. Many physicians concede nowadays that rationing public health care is inevitable. Some of them admit that they are already practising various forms of rationing when patients compete for the same health care resources. They already use in their praxis more or less implicit criteria of rationing scarce medical resources (e.g. organ transplantations, blood transfusions, etc.), when they are forced to make decisions about how to optimize medical treatment in each individual case and for patients with different health improvement prospects. In their attempt to identify the right way to allocate these scarce medical resources, an increasing number of philosophers and physicians plea for different forms of rationalizing based on the principle of responsibility for illness. Basically, this principle says that patients responsible for causing their own diseases as a result of their health-threatening lifestyle (e.g. smoking, alcohol abuse, etc.) should cover the treatment costs from their own income and not from the health public insurance. A more lenient version holds that these individuals should have at least low priority in the distribution of scarce medical resources when they compete "against patients who are 'innocent victims' of a disease." (p. 194) The main argument for this position is based on the claim that the principle of responsibility for illness expresses a demand of distributive justice. Another argument says that responsibility for the lifestyle and its consequences over one's health is the price to pay for individual autonomy, precisely for the liberty each individual has in choosing how he or she wants to live. However, the principle of responsibility for illness is prone to strong criticism. Eugen Huzum presents a comprehensive review of the most discussed arguments for and against the principle of responsibility for illness in the allocation of health care. His position makes a case against this principle. The latter cannot be a demand of justice because it leads to several 'repugnant' consequences. Among these, the main problems are that this principle leaves room for discrimination against patients from underpriviledged social categories, that it cannot be applied without violating the fundamental right to privacy, and that it undermines the principle of equality of opportunities, i.e., equal access to medical services and equal treatment of medical needs.

Three articles originate in papers presented under the heading "Autonomy and Responsibility: How to determine the boundaries of self-determination", at the workshop organized by Forschungsinstitut für Philosophie Hanover, November 2006 (Regine Kather, Volker Lipp, Karl-Wilhelm Merks). Two papers worked out specific objectives of the research project "Biopolitics" funded by CNCSIS, one of the Romanian authorities for research, which has also provided financial support for the present publication (Bogdan Olaru, Eugen Huzum). Two other authors added their contribution as the main idea of this volume took a more defined shape (Silke Schicktanz, Nicolae Morar). I would like to thank Oana Maria Petrovici for her help in translation and style and Eugen Huzum for helpful comments.

Bogdan Olaru
Jassy, October 2008

1

AUTONOMY AND EMBODIMENT. THE WAY BACK TO THE UNAVAILABILITY OF THE BODY

AUTONOMY: AS SELF-DETERMINATION AGAINST, OR SELF-TRANSCENDENCE TO OTHERS?

Anthropological Reflections on the Background of Bioethics

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1. INTRODUCTION

Since the passage to modernity the concept of autonomy has been the leading idea in defining human identity. Following the tradition of empiricism, which is dominant in the scientific discourse and, in the meantime, in daily life, too, autonomy is based on self-consciousness, rationality, and the concept of time. Humans are autonomous if they are able to recognize their interests, to reflect on them, and to argue for them. If a human being does not have these basic capacities, it has no individual biography, though it belongs genetically to the human species. Without any intrinsic value, it has no right to the protection of its life. It may be killed, if it is the main interest of its family and the society to avoid care and responsibility. Therefore, the definition of human identity based exclusively on self-consciousness has far reaching implications for bioethics; they will be developed in the first part of this article. The anthropological premises determine strongly the ethical implications. But does the definition of human identity mentioned above really correspond to human life? Or do we have to correct and widen it? If so, the ethical implications will alter, too. In the second part of the article I will proceed to the thesis that human identity is based fundamentally on self-transcendence to fellow humans and to nature.[1] This thesis is by no means completely new. Though under different perspectives, it has been developed from Antiquity up to the Age of Enlightenment. For Aristotle and the Stoic philosophers humans have been an integral part of the social community and the cosmos. And beyond this, from Plato to Spinoza, human identity has been grounded in absolute being.

2. CAPACITIES AND PERSONAL INTERESTS AS BASIS OF HUMAN IDENTITY

On the background of empiricism, the German philosopher Michael Quante defines human identity as follows: "Eine Person ist genau dann authentisch, wenn sie alle ihre Wünsche und Überzeugungen durch Identifikation 'zu ihren eigenen' gemacht hat. Dieses Ideal fordert, dass es in der Persönlichkeit einer Person keine Elemente gibt, die nicht das Resultat eines Identifikationsprozesses sind."[2] Human identity is based neither on the unity of body and mind, nor on a spontaneous act which integrates the different types of experiences, but on a mere bundle of preferences, wishes, needs, and properties which can be recognized consciously and judged rationally. Humans can only develop an individual biography if they consciously identify themselves with their interests. Consequently, humans have no biography if they are not able to recognize wishes and feelings; though they belong genetically to the human species, they are not persons in the full sense of the word, and they are not entitled to social rights. Humans are singular and cannot be replaced by other members of the human species

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[1] Cf. Regine Kather, *Person. Die Begründung menschlicher Identität* (Darmstadt: Wissenschaftliche Buchgesellschaft, 2007).

[2] Michael Quante, *Personales Leben und menschlicher Tod. Personale Identität als Prinzip der biomedizinischen Ethik* (Frankfurt/M.: Suhrkamp, 2002), p. 193.

only during a limited span of time. Personal identity never embraces the whole span of life. Embryos, even newborns, schizophrenic persons, people with severe dementia and in an irreversible coma have no rational interests; consequently they are not able to articulate any interest in their life. Nevertheless, wishes and goals should not be caused by sudden moods only, by fear or desperation caused by extremely difficult situations. They should be fitting together for at least a certain span of time. But if they can be judged rationally and are an integral part of the biography, a person acts autonomously.[3]

Contrary to Kant, autonomy is not based on the capacity to judge one's interests in the light of fundamental ethical principles which are valid independently of the biography of an individual and which transcend the narrow horizon of its interests. Consequently, even the value of human life is not founded in human dignity which is inherent, as the authors of the German constitution and the Declaration of Human Rights of 1948 believed, essentially to every member of the 'human family'. The terminus 'family' indicates that humans are conceived both as biological and social beings. Both aspects are constitutive for the human identity. Therefore, dignity does not depend on certain capacities; it cannot get lost and does not rely on certain conditions. Humans can only behave adequately or inadequately to the dignity which they represent. For empiricism, humans have no intrinsic value which is independent of their state of consciousness and that means of their empirical situation. Their value is based on mental acts only, on their conscious will to live. "Personen sind zu einer wertenden *Identifikation mit* ihrer eigenen Existenz fähig. Eine leid- oder schmerzvolle Existenz kann als wertvoll angesehen werden. Ob dies der Fall ist, hängt davon ab, wie sich eine Person zu ihrer eigenen Existenz

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[3] M. Quante, 2002, p. 178: "Hinreichende Kohärenz plus Fähigkeit zur reflexiven Identifikation werden damit als notwendige Bedingungen für die Autonomie der Person gefordert."

verhält."[4] Following the logic of this argument, it would be inhuman to hinder a person to ask for assisted suicide or even active euthanasia in case of severe disease. If this decision fits into the current guiding frame of values, her will has to be respected by her family and the physician. She has the right to ask for the means necessary for this decision to be carried out. Assisted suicide and even active euthanasia has therefore to be offered by society as legal practice.

But why should fellow humans respect the conscious will of an individual, if he has no intrinsic value, and if his decision is not based on fundamental values which are valid regardless of his interests? Anthropology and ethics of empiricism are based on the basic assumption that the goal of life is to maximize happiness and to minimize suffering. As far as possible, suffering has to be excluded from life. But how can an external observer know if a person really suffers? Only a self-conscious individual can reflect on his feelings and talk about them with his fellows. Therefore, suffering does not mean the mere feeling of physical or psychological pain. It is caused by the frustration of conscious interests. Therefore, as Peter Singer argues explicitly, only persons, that is, beings which have conscious interests can suffer. But if so, how can we argue for animal liberation, as Singer does? If embryos and even newborn children have no rational interests, because they are not yet self-conscious, why should we protect pigs and cows since they will never become self-conscious? Either the concept of suffering must be widened and thus embrace also feelings of beings which are not self-conscious, that is, of embryos, newborns, and people with severe dementia, or animal liberation cannot be argued for convincingly. But let us return to persons. The suffering of a self-conscious individual would diminish the total sum of happiness of the social community. Therefore, at least those interests which do no harm to other persons or disturb social life have to be respected by the members of the community. Not ethical principles, but rules have to protect the individual's

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[4] M. Quante, 2002, p. 267.

right to a self-determined life. They guarantee that every individual can fulfill his interests as far as possible and most efficiently. Nevertheless, it is impossible that everybody follows his own interests only. At least to a certain degree, the interests of all members of a community have to be taken into account. Under these anthropological premises, the main task of interpersonal relations is to balance the interests of different persons. Personal interests have to be integrated at the social level. Identity, based on identification with interests, does not imply essential relations to fellow humans. They are not part of the individual biography, but means for the fulfillment of interests. Consequently, rationality is reduced to the capacity to analyze a situation and to find the means for the realization of one's goals. The instrumental function of intelligence is placed into the foreground; the sensorial, social, and emotional aspects of intelligence are not mentioned.[5]

If, as the constitution of the United States formulates explicitly, the pursuit of happiness is the main goal of a society, severe illness and death which are inextricably connected with suffering cannot be regarded as an integral part of life and as essential for the development of human identity. They seem to be mere faults of the physical constitution. Humans as self-conscious and social beings cannot profit from 'Grenzerfahrungen', as Karl Jaspers calls this special mode of experience.[6] On the contrary, life does no longer make any sense if severe illness and death hinder to realize one's own interests. A research project in the State of Oregon, USA, reveals that humans who decide to die by means of assisted suicide and active euthanasia often belong to a so-called 'control type'. They were accustomed to controlling their life in nearly every detail. But now severe illness enforces them to depend on the help of other persons, friends or members of their own family.

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[5] Cf. C. Meier-Seethaler, *Gefühl und Urteilskraft. Ein Plädoyer für die emotionale Vernunft* (München: C.H. Beck, 2001^3).

[6] Karl Jaspers, *Philosophie II: Existenzerhellung* (Berlin/Heidelberg: Springer, 1973) pp. 201-249.

Though they are completely self-conscious, they interpret the loss of the control over their bodily functions as a loss of dignity. Their wish to die is strongly motivated by their incapacity to accept help. This phase of their life which implies the breakdown of their social functions is not an opportunity for a very intense communication with beloved people, and they do not get into touch with the ground of being which transcends everything humans can create themselves. The last phase of life is a sign of weakness and decay only.

Yet another anthropological premise has to be taken into account: Fellow humans can only acknowledge their self-consciousness if they make their interests known to one another, and so ascribe a value to their life. But communication is inevitably bound to bodily functions, to speech, gestures, and look. Nevertheless, for empiricism the body is only the genetic and physiological basis of personal identity. It guarantees the continuity of physical life, without being an integral part of the biography and the medium for the expression of one's interests.[7] We can talk about individual biography without considering its biological basis only if the body is regarded as an empirical thing, as an object of scientific understanding. The body can be analysed completely by the laws of physics, chemistry, and physiology, and by means of the concept of causality used in these sciences; interests and goals exist only in the mind of the individual. Consequently, the concept of human identity is based on an epistemological asymmetry. For the explanation of self-consciousness, for qualified perceptions, interests, needs, and goals the perspective of the first person, of the individual itself is decisive. It cannot be explained causally by physiological or neuronal processes. But the body is regarded under the perspective of the third person, from the position of an external observer only. Its functions are

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[7] M. Quante, 2002, p. 56: "Damit werden die Persistenzbedingungen für menschliche Individuen von der biologischen Gesetzmäßigkeit festgelegt, die für Mitglieder der Spezies Mensch einschlägig sind."

objectified scientifically.[8] Self-consciousness is therefore invisible; it is completely hidden before the eyes of an external observer. It is enclosed in the body as in a box and can be recognized only under the perspective of the first person.[9] Fellow humans perceive a body which can be located in space and which functions in accordance with physical laws; only by analogy, because of the striking similarity with the own body, they ascribe self-consciousness to another body, too. Mediated by the body as an object of the empirical world, humans perceive one another under the perspective of the third person, as 'he', 'she' or 'it', but not as 'you' or 'we'.

At this point of argumentation, a severe problem which is intensely discussed in neuropsychology arises: If the physical world, as many philosophers and scientists argue, is causally closed, intentions, values, and interests can neither steer the motions of the body nor can they be expressed in gestures and physiognomy.[10] But how then is it possible that humans can communicate with one another by means of symbols,

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[8] M. Quante, 2002, p. 54: "Dabei wird der Begriff des Menschen in einem rein biologischen, d.h. auf die Biologie als Naturwissenschaft bezogenen Sinne gebraucht."

[9] G. Brüntrup, *Das Leib-Seele-Problem. Eine Einführung* (Stuttgart: Kohlhammer, 1996), p. 15: "Es ist für uns unmöglich, das mentale Innenleben eines anderen Menschen von außen direkt wahrzunehmen. Meine Gedanken, Gefühle und Stimmungen sind in diesem Sinne privat. Öffentlich sind hingegen alle beobachtbaren körperlichen Zustände einer anderen Person."

[10] G. Brüntrup, 1996, pp. 18-20: "Man kann dem oben beschriebenen Problem nicht dadurch entgehen, daß man unsere Körper aus den allgemeinen Gesetzen des Kosmos irgendwie 'herausnimmt' – wegen ihrer Universalität gelten die fundamentalen, strikten Gesetze überall. Wenn die Annahme, daß der physische Bereich kausal geschlossen ist, richtig ist, dann gibt es keine nichtphysikalischen Ursachen, die physische Ereignisse bewirken. Also kann das Mentale keine kausale Rolle in der physischen Welt einnehmen."

by the written and spoken language, and by gestures? How are symbols, which represent a meaning, expressed physically? Obviously, the privacy of human self-consciousness is transcended in actions, speech, and gestures. Intentions are expressed physically. Meaning is immanent in the bodily appearance of a person. Otherwise, communication and social life based on it would be impossible, and ethics would be deprived of its practical implication; it would be reduced to the mere feeling of values and motives in one's own mind. It would even be impossible to write scientific books which claim objectivity, and which address readers who can understand the meaning of the words.

Nevertheless, it is very popular to argue for the separation of body and mind. Michael Pauen develops the implications of this thesis in his book *Illusion Freiheit*. Though he takes into consideration the lived experience of one's own will, he argues that only science, especially neuropsychology, can explain human behaviour. The perspective of the living and feeling individual itself is no 'stable basis for philosophical argumentation'.[11] Though the feeling of acting free cannot be denied, an individual's behaviour is determined causally. Therefore, the argumentation of Pauen is by no means without any premise: It is based on the asymmetry between the perspective of the first and third person, of mind and body. As for Quante, for Pauen, too, the human 'self' can be specified by a 'set of personal preferences', of wishes, needs, and properties. An abrupt change of these preferences caused by neuronal manipulation or an accident does not imply the transformation of the same person; it leads to a completely new personal identity. Though the genetic structure of the body remains the same, we no longer communicate with Paul, but we do with Peter. The stream of consciousness between the first and the second person has been interrupted and this

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[11] Michael Pauen, *Illusion Freiheit? Mögliche und unmögliche Konsequenzen der Hirnforschung* (Frankfurt/M.: Suhrkamp, 2004), pp. 180f.

interruption leads to the constitution of a new identity.[12] As John Locke before him, Pauen argues that the body is no part of the personal biography. The person is not incarnated and its biography is not related with feelings and experiences which are not perceived consciously.

Consequently, there is only one way to think autonomy and the freedom of decision: an action is autonomous if it is independent of external influences and dependent of influences which are felt from within the human mind.[13] Freedom is interpreted as self-determination in the literal sense of the word. Though a person's special interests, properties, and capacities may be completely caused by genetic mech-

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[12] M. Pauen, 2004, pp. 158ff: "Eine solche radikale Persönlichkeitsveränderung schließt es aus, Handlungen, die nach einem manipulativen Eingriff vollzogen wurden, der Person zuzuschreiben, so wie sie vor diesem Eingriff existiert hat; tatsächlich kann man angesichts der Veränderungen durch diesen Eingriff nicht mehr davon sprechen, dass man es überhaupt noch mit derselben Person zu tun hat. Der hier vorgelegten Theorie zufolge wird das 'Selbst' eines rationalen Akteurs durch dessen personale Präferenzen definiert. Eine radikale Veränderung dieser Einstellungen führt ganz offenbar zu einer Persönlichkeitsveränderung, die es nicht mehr zulässt, die Person nach der Manipulation mit der Person vor diesem Eingriff gleichzusetzen. Wir hätten es hier also streng genommen mit zwei unterschiedlichen Personen zu tun, und nur einer dieser Personen könnten wir diese Handlung zuschreiben, nämlich Peter, so wie er aus dem Eingriff hervorgeht. Diese Behauptung mag zunächst nicht ganz überzeugend klingen, weil Peter auch nach der Manipulation die meisten alltagsweltlichen Identitätskriterien erfüllt: Er hat denselben Körper, dieselbe Stimme und bis zu dem Eingriff auch dieselbe individuelle Lebensgeschichte wie sein 'Vorgänger'."

[13] M. Pauen, 2004, pp. 17f: "Solange man Freiheit als Selbstbestimmung versteht und sich dabei an der Abgrenzung gegen Zwang und der Abgrenzung gegen Zufall [orientiert], kommt es nicht darauf an, ob eine Handlung determiniert ist, entscheidend ist vielmehr wodurch sie bestimmt ist: Ist sie durch den Handelnden selbst bestimmt, dann ist sie frei; hängt sie dagegen von äußeren Einflüssen oder von Zufällen ab, dann ist sie nicht selbstbestimmt und daher auch nicht frei."

anisms, education, social context, lifestyle, and habits, they are felt consciously. They belong, so the argument, to the human being itself. Every mentally sane human being is characterized by a set of personal capacities; in this respect, all humans are equal. Nevertheless, they differ with respect to their personal preferences which come as a result of identification with feelings and experiences; they constitute the individuality of a person.[14] In this respect, all individuals are unique. If a person makes use of these preferences consciously, her life is self-determined. Every action, every thought, and every wish is therefore determined by special preferences which have developed during the life of each individual.[15] Even though they are completely determined by genetic or social conditions, they are conceived as self-determined if the individual feels them consciously as part of his life.

What are the implications of this idea of autonomy? With Pauen, the concept of freedom and responsibility can be used if an action is not determined by external conditions. Nevertheless, the external conditions must not hinder the action of an individual; the action must be possible. Only then can the person follow her preferences and cause an action. Her action is autonomous because it is determined by personal preferences.[16] But a person can never act against her preferences.[17] Therefore, stronger preferences may top a set of current preferences. Actions not caused by internal or external influences, which are un-conditioned in the strong philosophical sense of the word, are impossible. With this argument, Pauen rejects explicitly a concept of causation which is, as Spinoza and Kant have argued, an immediate expression of the spontaneity of the human mind, and which cannot

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[14] M. Pauen, 2004, p. 67.

[15] M. Pauen, 2004, p. 75: “Handlungen, die durch diese Präferenzen bestimmt sind, müssen als selbstbestimmte Handlungen betrachtet werden.”

[16] M. Pauen, 2004, pp. 132, 153.

[17] M. Pauen, 2004, pp. 172f.

be proven empirically.[18] Therefore, it is impossible to correct an action by the insight in ethical reasons which do not correspond with one's own preferences.

The asymmetry of the perspective of the first and third person leads to the rejection of the naturalistic interpretation of the human being. The identity of a person cannot be explained by biological processes. In difference to physiological processes, mental acts have to be explained by means of the concept of intentionality which is bound to the perspective of the first person. An idea represents a meaning for the living and feeling individual. Consequently, it has to be described by a system of concepts and categories which differ from those applied to the body as object of the empirical world.[19] In this perspective, the body appears as a mechanism that does not reveal anything of the inner life of a person.[20] A person has a body, but she does not live in and

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[18] M. Pauen, 2004, p. 148.

[19] M. Quante, 2002, p. 105: "Aus den Voraussetzungen des biologischen Ansatzes ergibt sich unmittelbar, dass weder der Begriff der Person noch die Begriffe Personalität oder Persönlichkeit in seinem Rahmen verwendet werden können. Damit ist auch das Potenzial eines menschlichen Organismus, Personalität im Laufe seiner Entwicklung erlangen zu können, nicht direkt zu erfassen. Insgesamt kommen auf diese Weise nur die kausalen Ermöglichungsbedingungen in den Blick. Weil dies so ist, kann auch das Potenzial, sich zu einer Person zu entwickeln, mit den Mitteln des biologischen Ansatzes allein nicht erfasst werden."

[20] M. Quante, 2002, pp. 57f: "Der biologische Ansatz hat gegenüber anderen komplexen Theorien, die den Begriff Person verwenden, auch den Vorteil, nicht auf eine naturalistische Konzeption der für Personalität zentralen propositionalen Einstellungen (Erinnerungen, Intentionen etc.) angewiesen zu sein. Vielmehr reicht es im Rahmen dieser Konzeption aus, die für diese psychischen Episoden notwendige Basis im Rahmen einer an der Beobachterperspektive ausgerichteten Beschreibung biologischer Funktionen bereitzustellen. Weil es nicht darum geht, einen anspruchsvollen Begriff der Person mittels biologischer Begriffe zu rekonstruieren, reicht

with her body. Without any doubt, the body is a necessary condition of personal life and only in this perception it is an object of medical treatment. But the person herself is defined by self-consciousness and the capacities and properties derived from it.

But if we separate the personal identity from the body, the following question arises: What are we allowed to do with the body of a human being if the personal life has not yet developed or if it is destroyed irreversibly? Is it allowed to make use of the body as an object, if the nerve system and the capacity to feel pain and pleasure has been extinguished? Can we transplant organs if the brain functions, which are the necessary conditions for feelings and self-consciousness, are destroyed? At the beginning of life and in an irreversible coma humans have, in the same line with this argument, 'experiential interests' only. They can be reduced to a wish which remains completely unconscious: not to suffer physical pain. "Wenn X das Bewusstsein vollständig und dauerhaft verliert, während er noch am Leben ist, ist er nicht mehr das Subjekt von irgendwelchen Interessen."[21] If the capacity to feel pain is anaesthetized, then it is allowed to kill an individual.

This argument has far reaching consequences in bioethics. From the biological point of view, the development of a human being begins with the fusion of a sperm and an egg. A little bit later, the separation of the cell leads to the constitution of a new organism which already

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es aus, die biologischen Ermöglichungsbedingungen zu erfassen, die notwendig sind, damit menschliche Individuen Personalität haben können. Personalität und Persönlichkeit selbst aber lassen sich nicht im Rahmen einer naturalistischen Konzeption erfassen, sondern gehören der evaluativen Teilnehmerperspektive an. Da gemäß der Gesamtlage des hier vorgeschlagenen biologischen Ansatzes auf dieser Ebene keine Persistenzbedingungen zu ermitteln sind, kann dieser Bereich für Fragen der menschlichen Persistenz komplett ausgeblendet werden. Umgekehrt gilt dagegen, dass die faktische Beschaffenheit des biologischen Organismus als Realisationsbasis für Personalität und Persönlichkeit eine zentrale Rolle spielt."

[21] M. Quante, 2002, p. 272.

steers its own functions. This is the decisive step to a first form of physical autonomy of the organism.[22] Nevertheless, one should mention that the genetic code does not develop like a program without any interaction with its environment. This interaction determines which genetic sequences are activated or deactivated. But though the physical development continues without any rupture, for empiricism the first phases of human life do not yet belong to the biography. Biological persistence and personal biography are separated. Therefore, genetic manipulation ought not to be understood as an intervention into the biography of a person. The research with embryonic stem cells is permitted, and so is therapeutic cloning. Genetic manipulations are only allowed if they are not exclusively based on the interests of the parents or other individuals, but on normative standards accepted by the scientific and the social community. Why, so the argument, should biological mechanisms and accidental events which cause the recombination of the parental genetic material be valued higher than the goals of a social community which are based on rational and ethical argumentation? Is it not a genuine humanitarian attitude if people try to correct the nature's flaws and optimize the genetic potential of an individual? Nevertheless, this argument can only be accepted if the body is not regarded as an integral part of the personal biography from its very beginning. The genetic code can be manipulated without manipulating the person only if the bodily and the psychological development are separated from one another. Nobody will ever know how the individual person would have developed without the genetic intervention. That person did not exist, not even potentially.[23] The person which develops after the manipulation of some genetic sequences exists only on the basis of the new

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[22] M. Quante, 2002, p. 90.

[23] M. Quante, 2002, p. 116: "Damit lässt sich ein gentherapeutischer Eingriff, der die materielle Realisationsbasis des Organismus betrifft, verstehen als eine Art Umlenkmanöver: Es wird Einfluss genommen auf die bestimmte Entwicklung, die dieser Organismus durchlaufen wird."

combination of genes. The cells at the biological beginning of life can be treated physically. But there is no reason yet to speak of responsibility for a person.

Consequently, those members of the human species which are not persons have no right to the protection of their life by the social community. According to utilitarian principles, it does not cause any suffering when a living being is killed, if that being has no conscious interests, no expectations for future, and no individual biography. The amount of happiness in the world will not decrease. On the contrary, it may even increase, because those humans who had to take care for the killed individual will now feel better. And beyond this, the killed individual can be replaced quantitatively by another human being which normally will be sane. This argument is explicitly exemplified by Peter Singer. A bleeder newborn can be killed even several months after birth if the parents agree to that and if they can procreate another child which has a good chance to be healthy.[24] The question if the ill child may be happy and the physically healthy child may be mentally unstable and unhappy is not discussed. Beyond this, the organs of an individual which will never have conscious interests can be used. They, too, are a means to diminish the suffering of a person and, in this way, of society as a whole.

The problem of an argumentation which is based only on interests becomes visible if we take a brief look on the treatment of embryos and newborns in China and India. In both traditions a male child is more important for the social and religious status of the family. Consequently, many women get an abortion if the embryo is female. And even newborn girls are killed in accordance with a long lasting tradition, though it has been forbidden by law in the meantime. The social consequences of the strong interest to give birth to male children are already visible. A lot of young men have to stay unmarried because the biological equilibrium between male and female is lost. Beyond

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[24] Peter Singer, *Praktische Ethik* (Stuttgart: Reclam, 1994^2), pp. 237ff.

this, the practice of killing female babies for traditional and utilitarian reasons, because girls are too expensive, is regarded as anachronistic and incompatible with humanitarian ethics. Nevertheless, it is just this practice that Singer and other philosophers in the Western world are arguing for.

3. SELF-TRANSCENDENCE AS THE BASIS OF INNER AUTONOMY

Only a shift in the anthropological premises which dominate the Western culture today can alter the ethical implications. Therefore, the decisive question must be: Is it really sufficient to base human identity on personal interests only? Is it true that neither the body nor the relation to fellow humans is essential for the personal identity?

First, let us focus on some empirical details. The beginning of life, the act of procreation, is based on the union of two persons. Though already the single cell is genetically human life, the recombination of the genes of the parents is the starting point for the development of a new human individual. It is not just a biological organism, whose functions can be described physiologically. From the very beginning physical and psychological capacities develop together in a process of mutual feedback. The single cell has already a rudimentary sensitivity to stimuli. Being able to steer its motion, it can adapt to the environment. In complex organisms such as human embryos, the nervous system is developing quickly and this is the basis for complex sensations, sense-perceptions, and, finally, for feelings. Their quality influences in a process of feedback the development of the neuronal network in the brain. At the date of birth, the neuronal network has a basic structure already. Even without any conscious remembrance, the emotional and physical influences during pregnancy will influence the person's life as an adult. Beyond this, six-months-old embryos can hear, smell, and touch. With the growing sensitivity for their natural surroundings they begin to express their feelings in their physiognomy.

And they begin to move their feet, arms, and head intentionally. Recent studies show that already in the 8th month of pregnancy the embryo obviously can distinguish between two different forms of speech: the frequency of the heart differs significantly if the mother talks to it or to another person. Before birth, humans are not mere organisms which just react to stimuli. They feel their environment and explore themselves. Therefore, their individual biography begins already long before the date of birth.

Especially the newborn depends not only on food and protection. The physical and psychological development depends essentially both on the physical contact with humans and on the child's experience that we, humans, should respect in its individuality. The intuitive evidence of this insight has recently been proven empirically. "Kinder ohne feste, pflegende Bezugsperson in den ersten Lebensmonaten zeigten Auffälligkeiten in der Hirnstromkurve (EEG), wobei eine Messgröße betroffen war, die sich auf die synaptischen Verschaltungen bezieht und auf Veränderungen in neuronalen Netzwerken schließen lässt."[25] The deficiency in the mental development of a child which is emotionally neglected corresponds to deficiencies in the neuronal network of the brain that can be observed empirically. Though children have enough to eat, clothing, and shelter, they will even die if the social contact to other persons is missing. Obviously, the development of human identity from the physical and psychological point of view depends essentially on interpersonal relations.[26] They cannot be replaced by mere structures, functions, and systems. The development of self-consciousness is fundamentally based on the relation to other persons.

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[25] J. Bauer, *Das Gedächtnis des Körpers. Wie Beziehungen und Lebensstile unsere Gene steuern* (München/Zürich: Piper, 2005^4), p. 70.

[26] J. Bauer, 20054, p. 71: "Nicht nur unser seelisches Empfinden, sondern auch die Neurobiologie unseres Gehirns [ist] ein auf zwischenmenschliche Bindungen eingestelltes und von Bindungen abhängiges System."

Humans become conscious of their own individuality only through the experience they share with others. They are no longer enclosed immediately in their own feelings and interests. With the rise of self-consciousness, they learn to reflect on their feelings. They become self-conscious in the literal sense of the word. The rise of an inner distance to themselves enables them to recognise another human being as person. Only the perspective of the first person opens up the perspective of the second person. I and you, and not I and he, she or it, are corresponding to one another. A necessary condition of the development of self-consciousness is therefore the interaction with another person, as Jaspers puts it: "Ich bin nur in Kommunikation mit dem Anderen. Ein einziges isoliertes Bewusstsein wäre ohne Mitteilung, ohne Frage und Antwort, daher ohne *Selbst*bewusstsein. Es muss im anderen Ich sich wieder erkennen, um sich als Ich in der *Selbstkommunikation* gegenüberzustellen und um das Allgemeingültige zu erfassen."[27] The very basis of the constitution of personal identity lies not only in the individual, in its needs, feelings, and interests alone. "Er liegt nicht in seinem Bezogensein auf sich selbst," as Ferdinand Ebner puts it, "sondern in seinem Verhältnis zum Du."[28] The knowledge that fellow humans exist is not based on a conclusion derived from mere analogy;[29] and it is not based on utilitarian reasons, on the insight that we need other humans for the fulfillment of our own interests. It

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[27] Karl Jaspers, 1973^4, pp. 50, 55.

[28] F. Ebner, *Das Wort und die geistigen Realitäten: pneumatologische Fragmente*, ed. by M. Theunissen (Frankfurt/M.: Suhrkamp, 1980), p. 34.

[29] Helmuth Plessner, *Mit anderen Augen. Aspekte einer philosophischen Anthropologie* (Stuttgart: Reclam, 1982), p. 14: "Der Mensch sagt zu sich und zu anderen du, er, wir – nicht etwa aufgrund bloßer Analogieschlüsse oder einfühlender Akte, sondern kraft der Struktur der eigenen Seinsweise. Durch die exzentrische Positionsform seiner selbst ist dem Menschen die Realität der Mitwelt gewährleistet. Die Mitwelt umgibt nicht die Person. Die Mitwelt erfüllt auch nicht die Person. Die Mitwelt trägt die Person, indem sie zugleich von ihr getragen und gebildet wird."

is just the other way round: self-consciousness arises as a consequence of having relations to fellow humans. Along with self-consciousness, it also aquires the capacity to develop, articulate, and judge one's own interests. A human being can therefore never be regarded as an isolated entity who knows only indirectly and by means of complicated intellectual conclusions that she is not alone in the world. Humans are related essentially with one another, as persons from the beginning of their life to the end. A person, according to Macmurray, "exists only, if there are at least two persons."[30] Autonomy is not yet realized at the beginning of life; it has to be developed by means of communication with fellow humans. And even after it has been realized, it has to be trained and developed in an ongoing process during the whole span of conscious life.

Self-determination, which is based essentially on the relation to fellow humans, implies the capacity to accept limits to one's own wishes and actions. But these limits are not simply rooted in the interest to avoid to do harm to fellow humans, and that for utilitarian or purely moral reasons. The respect for one's own limits is based on the insight that fellow humans are an integral part of one's own identity. The respect and sympathy for other persons and for the measure of one's own actions can only develop through the fundamental relation to them. To be related to other persons essentially implies to have limits; but these limits are transcended by the relation to fellow humans. The narrow horizon of one's own interests widens by the participation in the life of other persons; and participation is far more than dependence on others in case of illness. Autonomy is based on self-transcendence to something which cannot be created by one's own activities, but which supports and carries one's own existence. Sympathy, compassion, confidence, friendship, and love are qualities of life for which humans are forever striving.

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[30] Citation in: J. Hick, *Religion. Die menschlichen Antworten auf die Frage nach Leben und Tod* (München: Diederichs, 1996), p. 162.

Consequently, the individual biography, too, is not based exclusively on conscious remembrances. Fellow humans can report on forgotten events, and they can witness behavior which remains completely unconscious. Conscious as well as unconscious feelings become part of the individual biography. The stream of consciousness does not break down when humans fall asleep or fall into a coma. Ethics, therefore, cannot be based on the mutual respect of interests only; it has to imply responsibility and care for fellow humans who are not yet or no more able to decide for themselves. Another person has to decide in their name, as their representative. Ethics ought to promote duties towards helpless individuals, but also empathy, tenderness, vigilance for their needs, and sensitivity for the bodily expression of their feelings and intentions.

But how can we recognize the continuity of personal identity, if a person cannot remember and articulate herself? Even under the premises of a dialogically founded anthropology, the external observer is unable to acknowledge another person's inner life at once. The inner life becomes visible for another person only through the human body. But this is possible only if we don't identify the body with an empirical object whose functions can be explained completely through science. The asymmetry between the perspective of the first and the third person which separates body and mind needs to be overcome. In difference to all material objects, it is impossible to regard one's own body as a mere object of recognition; at the same time, it is also the lived body. The separation of subject and object which was constitutive for the development of modern science and technology proves itself as incomplete at least with respect to the human body. As living beings, humans cannot ground their identity on mental acts only. Through their body, they are living in a complex environment which is made of nature and culture. Humans can survive only by interacting with their environment. They can survive only if they apply their knowledge to the surroundings. This is the way they can live a qualitatively and ethically good life. As living beings, humans feel their interests as well as the reaction of the environment to their actions. Therefore, they express their inner life, consciously and unconsciously, by gestures, motion, look, and sounds. The feeling of one's inner life and its expression through one's body are inseparable.[31] Therefore, the qualified feelings of the own body cannot be reduced to the privacy of the individual mind. The human body is not an instrument which can be put aside after use. It is not the means, but the medium for the expression of feelings and intentions. Already the immediate expression of emotions implies that an event has a meaning for a human individual. Beyond this, the body is not moved by physical stimuli devoid of goal and meaning. It is moved by an intention, an aim, a need or a wish. The meeting of a group of people who come together for a scientific lecture cannot be described by means of statistical probability. They meet intentionally at this place and at this time. Therefore, every motion which expresses the inner life of a human being must be understood by means of the concept of intentionality. Intentionality is not restricted to self-conscious acts, but embraces every form of behaviour which is steered by meaning, and that means by an aim. As the expression of the inner life of the mind, the body is the mediator to the world, to nature and to culture.[32] Intentionality is expressed by the physical appearance of the body. Therefore, it is in its physiological functions an integral part of the personal biography.

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[31] Helmuth Plessner, 1982, p. 50: "Jede Lebensregung der Person die in Tat, Sage oder Mimus faßlich wird, ist ausdruckshaft, bringt das Was eines Bestrebens irgendwie zum Ausdruck, ob sie den Ausdruck will oder nicht. Sie ist notwendig Verwirklichung, Objektivierung des Geistes."

[32] Helmuth Plessner, 1982, pp. 10f: "[Für den Menschen ist] der Umschlag vom Sein innerhalb des eigenen Leibes zum Sein außerhalb des Leibes ein unaufhebbarer Doppelaspekt der Existenz. Positional liegt ein Dreifaches vor: Das Lebendige ist Körper, im Körper (als Innenleben der Seele) und außer dem Körper als Blickpunkt, von dem aus es beides ist. Ein Individuum, welches positional derart dreifach charakterisiert ist, heißt Person."

But gestures do not express only spontaneous moods and intentions. Many movements have to be learnt consciously until humans are able to practice them without any reflection. Children have to learn to walk, to eat, to write, and to paint. These activities have to be trained systematically; it must be repeated again and again till it can finally be performed without any reflection and nearly automatically. It is incorporated and can be changed only through conscious will and new experiences. Nevertheless, the sensorimotor intelligence is not the first step to the rational understanding of the laws of motion. It has its own structure and develops earlier than the capacity of rational understanding. Long before children can describe their motions, they already know how to perform them. And even adults learn movements not by rational understanding, but by physical training. In extreme and complex situations, i.e. accident, skiing or dancing, the body 'knows' how to move itself without any conscious reflection. On the contrary, reflections would even disturb the dynamics of the motion. Though, without any doubt, mental training can help to perfect a motion, rational understanding and imagination can be helpful only before or after the actual performance. The physiologist Wim Dekkers writes: "The lived body possesses its own knowledge of the world, which implies the existence of a 'tacit knowledge', a silent knowledge that functions without conscious control. On a subconscious level, my body provides me with a lot of information about the world."[33] Every learnt motion represents the unity of physical processes and intentional acts. It is a mediator between consciously performed motions and physiologically steered functions of the body.[34] In this case, habits are not developed

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[33] Wim Dekkers, "Autonomy and the Lived Body in Cases of Severe Dementia," in: R. B. Purtilo & H. Ten Have (eds.), *Ethical Foundations of Palliative Care for Alzheimer Disease* (Baltimore/London: The Johns Hopkins University Press, 2004), p. 122.

[34] W. Dekkers, 2004, 123: "The body interprets not only itself but also everything in the outside world with which it is confronted via the senses.

by external stimuli, but by intentional acts. They change the repertoire of bodily motions. Even mere biological needs, hunger, shelter, and sex are interpreted by cultural schemes, by symbols and rites. They characterize humans as living beings which have to learn how to treat their body and their vitality. The way basic needs are satisfied is not innate; they are modes in which a person exists. Therefore, the human body is not just a part of nature, but of culture, too. It is a mediator between nature and culture. On the one hand, the biography of an individual is incarnated; on the other hand, the body becomes a part of the biography. A person's body is singular not only from the genetic and neuronal point of view, but as an expression of intentions and meanings, too. Humans are singular with respect to their mind and to their body.[35] The latter is not only the physiologically functioning organism of a member of the human species, but at the same time the lived body of a person. Consequently, the separation between the body, as a characteristic of the human species, and the biography of an individual must be overcome.

The bodily expression of feelings and intentions is the first step in a relation to fellow humans. They don't recognize mere physiological processes, but understand the meaning of gesture and look. Nevertheless, a scientist who tries to reduce mind to matter will still try to interpret gestures as reaction on neuronal and electrochemical processes. The experiment in which a person with a certain disease picks up a glass on a table and an intentional action are interpreted within

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The content of these bodily interpretations of the world does not necessarily need to be known by the person. The human body may be considered the author of a text (of bodily signs), but also the reader of the text that is constituted by what is happening in the outside world."

[35] E. Stein, *Der Aufbau der menschlichen Person* (Freiburg/Basel/Wien: Herder, 1994), pp. 110 f: "In der Einheit von Leib und Seele ist es begründet, daß die Gestaltung der Seele und die Gestaltung des Leibes in einem geschehen."

the same scheme of categories. Intentionality is reduced to causality and humans are read in the light of the metaphor of a machine. But this argument shortens the explanation of motion and of social communication decisively. Fellow humans can only react adequately if they understand the meaning of a gesture. The meaning is present in the sensorial aspect of life.[36]

Beyond the ability to express the inner life by means of movements, sounds and gestures, which all other primate species share already with one another, humans make use of symbols which have been developed in a historical process and which have to be learnt by tradition. Sounds, colors, stones or wood bear a certain meaning. But symbols are not bound to the object they represent. The same object can be represented by different symbols. They are contingent to the inner life and to biologically transmitted schemes of behavior. The forms of greeting vary, for instance, all over the world. And only those who are acquainted with them know how to behave. It is only by the bodily expression of an idea or intention that the privacy of the mind can be transcended and cause an effect in our daily life.[37] By speech and gestures, the body becomes the fundament for the relation to fellow humans.[38] As a medium of

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[36] Maurice Merleau-Ponty, *Phänomenologie der Wahrnehmung* (Berlin: de Gruyter, 1966), p. 219: "Der Sinn der Gebärden ist nicht einfach gegeben, er will verstanden, aktiv erfaßt werden. Die Kommunikation, das Verstehen von Gesten, gründet sich auf die wechselseitige Entsprechung meiner Intentionalität und der Gebärden des Anderen, meiner Gebärden und der im Verhalten des Anderen sich bekundenden Intentionen."

[37] Maurice Merleau-Ponty, 1966, p. 176: "[Nur so etwa kann sich] die musikalische Bedeutung einer Geste an einem bestimmten Ort niederschlagen, [so] daß der Organist, ganz der Musik hingegeben, gerade diejenigen Register und Pedale trifft, die sie zu verwirklichen vermögen."

[38] Wim Dekkers, 2004, p. 120: A person "communes with, and learns about, the world through her eyes and ears and touch and smell. She interacts with others through movement and words."

communication, the lived body is the basis for social life and, in a second step, it is the basis for balancing individual interests, too.

But what are the implications of this idea for bioethics, especially for those phases of life, in which persons are not self-conscious? If autonomy is restricted to mental properties, people with severe dementia ought not to be respected as persons. They have not the capacity to learn consciously, to judge their interests and to act out of free will. They are not able to express their interests rationally. But does the lack of self-consciousness allow the conclusion that there are no intentions and interests at all? If the lived body is part of the biography, at least certain intentions are expressed. It is well-known that people with severe dementia often refuse to eat and drink. Their movements are not mere physiological reflexes, but the expression of the unconscious will of a person.[39] The way an individual, a newborn or an ill person expresses emotions and feelings shows the strength of its will to live. Gestures show if it wants to live or to die.[40] They help to decide if those forms of

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[39] Wim Dekkers, 2004, p. 119: "Bodily defensive movements can be considered in two ways. First, they can be explained from a purely biomedical point of view, as automatic reflex movements. From this perspective, which leans heavily upon a Cartesian, mechanistic view of the human body, it is thought that these defensive movements must be considered as being totally separated from expressions of person or the self. Second, they can be interpreted as meaningful bodily expressions that tell us something about the person, the self, or the person's wishes."

[40] W. Dekkers, 2004, p. 119: "In this regard, another comparison forces itself upon us; namely, that between the person with severe dementia, for whom death is not far away, and the severely handicapped newborn, who fights for life. When caregivers in neonatal intensive care units have to decide whether or not to continue medical treatment, it appears that the newborn infant's energy and vigor contributes to the clinician's judgments about life expectancy and the continuation or termination of treatment. In ethical decision making in a neonatal intensive care unit, the phenomenon of vitality appears to have moral significance. The phenomenon of vitality appears to be interwoven in the medical signs and symptoms that are used in

medical treatment which lengthen the span of life should be continued or stopped short.[41] The physician Wim Dekkers therefore speaks explicitly of a 'bodily form of autonomy.'[42] "The meaning of *bodily autonomy* that I am putting forward is a combination of the biomedical notion of bodily automatisms and the phenomenological idea of the lived body. Considered from this (combined) perspective, the human body lives its own life, to a high degree being independent of higher brain functions and conscious deliberations and intentions."[43] The unity of physical and psychological processes which is the fundament of daily life can be observed already at the very beginning of life and it continues up to the end of life. Even after the irreversible breakdown of all rational capacities the body still recalls the former conscious life, of attitudes, habits and experiences. Bodily expressions bridge the gulf between self-conscious persons who can argue rationally and those humans who have not yet developed this capacity or who have lost it; they mediate between conscious and unconscious forms of life. The value of the life

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the prognostic and clinical evaluation of infants. Vitality was also described as temperament, personality, or the ability to react to pleasant or unpleasant stimulation. From this perspective, some of the newborn's bodily signs were interpreted as: 'I want to live' or 'Please, continue with the treatment.' These newborns tried, so to speak, to express their will and to execute their autonomy *in statu nascendi* just by demonstrating their vitality."

[41] W. Dekkers, 2004, p. 122: "From a nondualistic, phenomenological perspective, bodily defensive movements can be considered a meaningful answer to extreme circumstances from 'somebody' who once was a 'real' person."

[42] W. Dekkers, 2004, pp. 125f: "Tacit bodily knowledge is based on the sedimentation of life narratives. When the body's capability to learn gradually disappears, the body loses its capacity to build up a new repertoire of routine actions. However, though automatisms come to be lost in the course of the process of becoming demented, persons with dementia can still have routine actions 'stored' in their body. Bodily defensive movements of persons with severe dementia may be interpreted as a kind of 'bodily autonomy'—as a reminder of what once has been 'real' or 'rational' autonomy."

[43] W. Dekkers, 2004, p. 125.

does no longer depend only on rational acts; the body as expression of the inner will of a person becomes an object of moral decisions, too. Humans deserve respect not just for their mental qualities, but as a unity of body and mind. Though already the genetic code is the basis for biological individuality, the lived body guarantees the singularity of a person even if it is not self-conscious.[44] If a person has lost the capacity to act rationally, if the whole brain or most of it is dead, the body cannot automatically be used as organ donor. The patient's conscious consent is mandatory before the dying moment. If we take the unity of body and mind seriously for the whole span of life, even the foetus must not be the object of scientific research. The genetic manipulations at the beginning of life cannot be separated from the emergent personal life. Therapeutic interventions may only be allowed in case of severe genetic diseases.

If interpersonal relations are an integral part of the identity, the meaning of 'Grenzerfahrungen', of suffering and death changes, too. 'Grenzerfahrungen' belong inevitably to the *conditio humana*, and can never be abolished completely by technological means. They can be ignored or taken as an opportunity for a more intense form of self-consciousness and communication with beloved persons. The main characteristic of 'Grenzerfahrungen' is that the strategies which help to master daily life break down. Without any possibility to find an orientation in social rules and functions, humans are confronted with themselves. But this painful experience should not lead to depression or even suicide. On the contrary, beyond philosophical reflections concerning the 'memento mori', especially those of the Stoics and Karl Jaspers, we know from empirical research in hospitals that the acceptance of suffering and even death can lead to a more intense form of

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[44] W. Dekkers, 2004, p. 123: "However, if this unity of a mind and an animated body is considered an ontological characteristic of human beings, it cannot (entirely) disappear. In other words, though the body of a person with severe dementia increasingly functions as an 'automaton', it still remains a lived body."

life. Humans gain a new form of inner autonomy which helps them to live more consciously. In a sort of 'jump', ethical values and the relation to fellow humans suddenly become the centre of life, and the consciousness of one's own responsibility increases, too. The existential meaning of suffering and death influences therefore the ethical orientation of an individual and the society as a whole fundamentally. Life has now an intrinsic value and must not be thrown away; it ought to be lived with respect and responsibility. Though 'Grenzerfahrungen' are painful, they open the horizon for fundamental ethical values which transcend utilitarian principles. Therefore, society should not legalize any form of active euthanasia. It should remain the very special solution for those patients which really cannot bear their suffering any longer. But each society should support institutions which help people to deal with 'Grenzerfahrungen', as for example the 'Hospiz-Bewegung' does.

Especially the existential confrontation with death leads to the question if there is an eternal being which transcends the finiteness of life and which is its everlasting ground. The breakdown of all relations which support a person's social identity may lead, according to William James, Simone Weil, and Karls Jaspers, to a completely new form of experience: human consciousness opens to transcendence. The latter is created neither by humans, nor by a mere projection caused by fear and blind hope. Beyond religious confessions and cultural diversities, many people report that in 'Grenzerfahrungen' they had the clear feeling that there is a something which transcends time and space, and which therefore is normally hidden in daily life.

4. HUMANS WITHIN NATURE

Another aspect of human identity has to be taken into consideration: As living beings, humans cannot found their identity only on mental and social acts. Through their body, they participate in nature, too. They have to organize their life in the midst of a complex environment. Though the cultural conditions may vary broadly, the ecological conditions which allow physical survival and well-being must not change too much. The interpretation of nature therefore cannot be mere construction. Humans have to apply their knowledge to their environment. The success of their actions depends on their intergration in the world.[45] But nature, too, is more than an object for recognition and the fulfillment of human interests. Through evolution, humans relate to all other living beings, both from a genetic and psychological point of view. Therefore, they can, at least to a certain degree, communicate with them. As Max Scheler argues, humans are the most complex living beings on this planet. They have the capacity to understand the feelings of other living beings and to take care of their needs.[46] Though these beings have no responsibility for us, humans should feel responsible for them. To ignore this capacity does not only disturb nature; it implies a deficiency in personal identity and interpersonal relations, too. Human autonomy is therefore based essentially on self-transcendence to fellow humans and to nature.

5. SUMMARY

Human identity cannot be based on identification with one's own interests, but must be grounded essentially on self-transcendence. Firstly, fellow humans are not only 'useful', from an utilitarian point of view. They are an essential part of one's own identity, from both the physical and psychological point of view. The respect for them implies not only duties, but care and responsibility, too. Secondly, humans are part of nature by physiological processes as well as by qualified sensorial perceptions and feelings, mediated by the lived body. Thirdly, humans may even open to transcendence in so-called 'Grenzerfahrungen'. A

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[45] Maurice Merleau-Ponty, 1966, pp. 166-168.

[46] Max Scheler, *Wesen und Formen der Sympathie* (Bern: Francke, 1973), pp. 112–114. Cf. R. F. Nash, *The Rights of Nature*. A History of Environmental Ethics (Madison/London: University of Wisconsin Press, 1989).

human must no longer be conceived as ‘homo curvatus in seipso’, whose horizon is closed around his interests. Humans have learnt to open to the world in the multitude of its dimensions. Therefore, the concept of autonomy needs to be rethought. Humans ought to be respected as an inseparable unity of body and mind from the beginning up to the end of their life, and ethics has to deal with interpersonal relations and with nature for their own sake, too.

WHY THE WAY WE CONSIDER THE BODY MATTERS
Reflections on four Bioethical Perspectives on the Human Body[1]

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1. INTRODUCTION

During the 1970s, a number of performance artists shocked the public by making their bodies the subject of artistic performances. By being thus displayed, the body itself becomes both the medium of the artistic work and the scene on which it takes place. In the performance *Zerreißprobe* (1970) the Austrian artist Günter Brus injured himself by cutting his head and thigh with a razor blade. The vulnerability of the flesh was to be shown by means of the extreme display of a body disfigured by pain and by interventions from the outside. Brus' perfomance at the same time was intended to demonstrate limits and extremes. The American artist Chris Burden had his left arm shot by a friend in the course of the performance 'Shoot' (1971), though the focus here was less on the vulnerability of the body than on the examination of ideals of masculinity and insensitiveness to pain as a test of courage. The French artist Orlan has been causing sensation since the 1990s by describing her body as 'software' and declaring surgical operations on her face to be 'art made of flesh and blood'. In the course of these operations she regards herself as a living sculpture and "takes the liberty to experiment with her own body."[2]

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[1] An earlier version of this paper has been published online in *Philosophy, Ethics, and Humanities in Medicine* (4 December 2007).

[2] M. Schneede, *Mit Haut und Haaren. Der Körper in der zeitgenössischen Kunst* (Köln: Dumont, 2002).

In the 1970s, the liberty to be in charge of one's own body was discussed in another, quite different context as well: under the slogan 'My body belongs to me!', thousands of women took to the streets in Germany, Britain, and the United States to demand a liberalization of the then existing abortion laws. These concerns and procedures—different as they may appear at first glance—point to the same important problem, namely the unclear or questionable relationships between the body, the self-determination of one and the same person, and its public articulation: What am I allowed to do with my own body, and to what extent can I permit others to do 'whatever they like' with their bodies?

Emerging from these public discussions of the 1970s, we may ask whether these concerns and questions are still relevant for recent bioethical debates. Both examples, modern performance art and political demonstrations, have pointed to the political and social dimension of these questions, as especially 'external' power over the body was criticized. However, in the early 1970s many people did not understand these primarily as ethical *questions*. It was for many deemed as self-evident that the body is an object of self-determination and action. Bioethics itself, understood as the systematic consideration of ethical problems and ethical judgments on the basis of rational argumentation, was in its infancy at this time.[3] It was only in the 1990s that many scholars started to criticize the neglect of the body in academic bioethics.[4] Additionally, in recent years, a 'body boom' in media studies, history and social science

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[3] A. R. Jonsen, "A history of bioethics as discipline and discourse," in: *Bioethics: An Introduction to the History, Methods, and Practice*, 2nd edition, edited by N. S. Jecker, A. R. Jonsen, R. A. Pearlman (Sudbury/Boston/London/Singapore: Jones and Bartlett Publishers, 2007), pp. 3-16.

[4] See for e.g. T. Lysaught, "Social theories of the body," in: *Encyclopedia of Bioethics* 1996, vol. 1, pp. 300-305; R. M. Zaner, "Embodiment: The phenomenological tradition," in: *Encyclopedia of Bioethics* 1996, vol. 1, pp. 293-300; D. Leder, *The Absent Body* (Chicago/London: University of Chicago Press, 1990).

has occurred. According to Anne Witz[5] the 'corporeal turn' in sociology and feminism has emerged from a critique of the exclusion of certain bodies (such as women, disabled persons or elderly people) from the academic discourse. These should now no longer be neglected.

Additionally, one can call into question the tendencies of both analytical metaethics and also moral philosophy, as both center around notions of 'personhood', 'rationality', 'preferences' and 'self-determination' which are mainly conceptualized without any relation to the body, although bioethics often deals with problematic cases in which entities lack rationality and specific mental capacities, for example embryos, brain-dead patients, animals and so on. Thus, Margrit Shildrick[6] critically remarks that "bioethics is out of touch … with bodies themselves, in the phenomenological sense in which the being, or rather the becoming, of the self is always intricately interwoven with the fabric of the body."[7]

Of course, international academic bioethics has itself developed into a multifaceted discipline, with mutual relationships between moral philosophy, sociology of science and clinical ethics. Thus, generalizations are always problematic. Nevertheless, I think it is not totally wrong to state that many scholars in applied ethics and bioethics still tend toward—as Shildrick calls them—'conventional' positions which stress "fixed standards of judgment."[8] One of these standards is the value of autonomy and self-determination. Another common strand often favored by partisans of liberal self-determination sees the human body as an 'object' and as 'property' subject to personal, self-determined

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[5] A. Witz, "Whose Body matters? Feminist sociology and the corporeal turn in sociology and feminism," *Body & Society* 6(2000), pp. 1-24.

[6] M. Shildrick, "Beyond the body of bioethics. Challenging the conventions," in: *Ethics of the Body. Postconventional Challenges*, edited by M. Shildrick & R. Mykitiuk (Cambridge, Mass/London: The MIT Press, 2005), pp. 1-28.

[7] M. Shildrick, "Beyond the body of bioethics. Challenging the conventions," 2005, pp. 1 f.

[8] M. Shildrick, p. 3.

disposal. For example, the moral claim that "Every individual should decide for himself whether he wants to donate his organs" is built upon the assumption that organ donation should be decided on by the donors themselves, seeing the body as 'property' or as 'material object'. In contrast, postmodernism, or as Shildrick puts it, postconventional ethics, sees the body as "leaky, uncontained, and uncontainable."[9] From this vantage, the body is neither separable from the self nor from other embodied selves.[10] Many postmodernists also criticize the idea of thinking about the body as property, as an economic value, or as an instrument.[11]

We observe a double clash of perspectives precisely in the field of body modification and bioethics. In the first place, there is a serious difference in the normative way of ethical judgment; secondly, there is a difference in how the body and embodiment are addressed. This distinction between mainstream bioethics and postconventional sociology and ethics could be difficult to overcome as long as both insist upon their 'rightness'.

However, in order to understand bioethics in a broader sense, as an academic discipline, sweeping aside for a moment the part that the social and political power plays in the academic world, it should be a basic interest for each and everyone to listen and understand what the others are saying. This could be partly achieved by choosing a method of ethical reasoning which is open for the various and sometimes conflicting views. This paper is a first attempt at presenting such a method. It is hereby necessary to state that according to my understanding, normative bioethics is a *systematic, processual* method of ethical judg-

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[9] M. Shildrick, p. 7.

[10] M. Shildrick, p. 6.

[11] See for e.g. C. Waldby, R. Mitchell, *Tissue Economies: Blood, Organs and Cell Lines in Late Capitalism* (Durham: Duke University Press, 2006); M. Shildrick & R. Mykitiuk (eds.) *Ethics of the Body*, (Cambridge, Mass/ London: The MIT Press, 2005).

ment.[12] It includes the description of an ethical problem, the analysis of underlying terms and opinions in the light of theory and practical experience, and finally an ethical evaluation or a recommendation on how to act. (Whether this is only true for problem-solving ethics or also for moral philosophy, in a general sense, I cannot discuss here). In this paper, I focus mainly on the issue of 'problem definition'; an issue that is necessarily crucial for all kinds of moral analyses and for final evaluation. This understanding of bioethics is applicable to 'conventional' deontological, utilitarian and postconventional (such as care-ethics) perspectives. (What matters for each distinct position are the following decisions: Who do we identify as the relevant actors? What are the relevant values? And finally: What is our justification for them?) Thus, the aim of this paper is not to discuss postmodernism itself. Instead, I intend to critically reflect on mainstream medical ethics (which I see myself as a part of) and I want to show why and where some of the postmodernist observations are very important and helpful.

In the first section, I will show that the socio-historical and phenomenological approach, on the one hand, and 'conventional' bioethics, on the other, cross each other (not only, but most prominently) in the debate about 'bodily limits' and 'transgressing body borders'. Conventional bioethics especially could profit from socio-historical and empirical-phenomenological investigations of these phenomena because they help clarify descriptive or anthropological premises about the 'body'. Hence, I argue that—irrespective of the way in which the body is described in bioethics, whether as material and distinct from mind or as dynamic and socially interconnected—we always deal with a value-laden phenomenon. Instead of seeking to avoid hidden moral assumptions, I suggest a methodological approach of making them explicit. By relating the opposite positions to one another dialectically, it can be made heuristic use of the recent dichotomies in bioethics. I have chosen for this purpose 'autonomy', one of the central conceptions

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[12] See A. Edel, *Ethical Judgement. The Use of Science in Ethics* (New York: The Free Press, 1955).

of contemporary U.S. American and Mid-European bioethics. A 'conception' means here an abstract notion or system of thoughts which is bundled in a term. However, such a term could be conceptualized in various ways. Thus, 'autonomy' covers several aspects of self-determination, such as the opportunity for free decision, but also the capacity of voluntary self-limitation.[13] I develop four different normative perspectives of how autonomy and embodiment could be interlinked. I suggest that these recent conceptions of bodily autonomy could complement one another, instead of our presupposing that only 'one' view is right. This allows, in my understanding, an improvement to bioethical normative reasoning, and also helps ethicists interested in concrete problem-solving to start right from the beginning with a critical sensitivity to their own premises about the 'meaning' of autonomy and the body. In a third step, I will provide a short account about how my method broadens our way of *asking* ethical questions by discussing briefly three examples: transplantation medicine, neuroprosthesis and cosmetic surgery. These examples should also show that the way we consider the body in bioethics is not only an issue relevant for women's health or reproductive medicine,[14] but for all topics in bioethics. The aim of this approach is to be open to multi-dimensional categories in order to identify and describe bioethical problems.

2. THE BODY IN ETHICAL, SOCIAL AND HISTORICAL CONSIDERATIONS OF MEDICINE

2.1 The body is more than the locus

Of course, the body has always been and will always be the physical object of medical interventions and biomedical innovations, and it is

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[13] M. Merleau-Ponty M, *Phenomenology of Perception* (New Jersey: The Humanities Pres, 1981).

[14] R. Diprose, *The Bodies of Women: Ethics, Embodiment and Sexual Difference* (London: Routledge, 1994).

therefore already present in bioethical thought.[15] Within the medico-ethical canon of nonmaleficence, of risk avoidance, of healing and care, the body as soma—the body as physicality—is always involved as a 'locus' where the intervention or the action takes place. Eventually, the focus on the body is obvious in the context of the veto right to bodily integrity or as moral concerns about 'suffering', often understood as a physical state. Both foci feature a predominantly instrumental relation to the body, because the body is regarded as a carrier of, or as a vehicle for the decisive wishes, preferences or interests of a person. The understanding of the body as socially and culturally constructed or negotiated element plays no role, that is neither for the justification of veto rights nor for the case of physical suffering. For example, in the case of 'suffering', the search for physiological parameters and quasi-objective criteria to measure it—a hot topic in animal ethics—refers to the 'natural', materialistically-conceived body. This conception, which has been described as the 'absent body',[16] is based on the assumption that the generation and validity of wishes and interests can be analyzed on the basis of the physical body alone without reference to the body in its social and phenomenological meaning. According to Leder,[17] this is due to the after-effects of Cartesian dualism and its materialist conception of the body as a machine. The human being and its personality were located exclusively within the bodiless spirit. But further contexts are also important. On the one hand, many writers mention the individual "constitutions of meaning qua the body."[18] Embodiment is regarded as

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[15] T. Lysaught, "Social theories of the body," in: *Encyclopedia of Bioethics*, 1996, vol. 1, pp. 300-305.

[16] D. Leder, *The Absent Body* (Chicago/London: University of Chicago Press, 1990).

[17] *Idem*.

[18] V. Schürmann, "Die Bedeutung der Körper. Literatur zur Körper-Debatte – eine Auswahl in systematischer Absicht," *Allgemeine Zeitschrift für Philosophie* 28(2003), pp. 51-69.

experienced body sensation, whereby the body is understood as the scene of the immediate, of the pre-reflexive or of life's taking place. The whole context is that of the individual actions, perceptions and experiences, seen in their role for human self-understanding.[19] (The idea of embodiment must not be used interchangeably with the idea of naturalness, as long as the boundaries between nature and culture remain unclear with respect to the body.) According to the early phenomenological tradition of Max Scheler[20] (1913), the German language allows for a distinction between 'Körper' and 'Leib', which relates to the difference between 'thing body' (or 'flesh') and 'lived body'. This distinction highlights some Cartesian presumptions, but is not identical with the body-mind-distinction. Later, Merleau-Ponty[21] pointed rather to the ambiguity of the lived body as 'corps propre'—an intermediate between flesh and the body as it is subjectively experienced by the mind.

On the other hand, scholars from history and social science stress the 'historicity of the body'. In this stance, we should pay more attention to the social and historical contingency and flexibility of the localization of perception, and of the description and disciplining of the body. The understanding of the body as socially constructed 'corporality' is interpreted as a historically and culturally relative variable.[22] Following Donna Haraway,[23] body images are of linguistic nature and do not

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[19] D. Leder, *The Absent Body*, 1990; H.A. Fielding, "Body measures: Phenomenological considerations of corporeal ethics," *Journal of Medicine and Philosophy* 23(1998), pp. 533-545.

[20] M. Scheler, *Der Formalismus in der Ethik und die materiale Wertethik: neuer Versuch der Grundlegung eines ethischen Personalismus* (Bonn: Bouvier, 2005).

[21] M. Merleau-Ponty M, *Phenomenology of Perception*, 1981.

[22] M. Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (New York: Vintage Books, 1974); B. Turner, *The Body and Society. Explorations in Social Theory* (New York: Basil Blackwell, 1984).

[23] D. Haraway, "The biopolitics of postmodern bodies: Determinations of self in immune system discourse," *Differences: A Journal of Feminist*

represent the real body but are in fact 'objects of knowledge'. However, a very radical socio-constructivist approach would eliminate this perspective on the body as well. The conception of a (totally) flexible and ambivalent body reduces the body to nothing, or to a mere space for projection. In postmodern transhumanism the body is often not ascribed a value of its own. Within the phenomenological approach, embodiment, as an entity in its own right, is seen as giving immediacy and materiality to individuals and societies. Embodiment is thus constitutive for human self-understanding. With this approach, the precarious nature of conceptualizing the body becomes obvious. Phenomenology points to the already implicit normative significance of the body and to the discussions about what should be done with, and made of it.[24] Although one could fear that the loss of certainty concerning our body may result in a new form of absence of the body, the socio-cultural and poststructural criticism allows us to open our reasoning in further directions. We can now reflect on the phenomenological perspective of perception and experience of embodiment, on the one hand, and on the conception about body as corporality, as something shaped by culture, socialization or in the history of science, on the other.

Since the goal of this article is to develop an approach which is open for different premises and perspectives regarding the body, I don't want to restrict my definition to one theoretical strand. Therefore, I suggest using the term 'embodiment' to encompass the different perspectives.

2.2 Body limits as moral and epistemic uncertainties

What is here at stake is that both of the last mentioned approaches question the certainty of the claim that the body is only the physical locus of medical interventions. They question that on a theoretical level, while medicine and biotechnology question this certainty on a practical, everyday level. I suggest that the 'body boom' continues because the time

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Cultural Studies 1(1989), pp. 3-43.

[24] V. Schürmann, "Die Bedeutung der Körper," 2003.

we live in confronts us with transgressions between bodies and categories (in the sense of playing with limits), a fact which makes the main focus for technical innovations and social designs of life.[25] The body boom is a result of the experienced and conscious play with the limits of the body.

However, the reactions to this phenomenon are quite ambivalent. Whereas some want to liberate such transgressions from taboos by describing them as logical consequences of technological development,[26] or even demand them, as the so-called transhumanists do, others express concerns about the (often hidden) increasing danger for both society and individuals, a danger which comes with the new technical domination of the body and its perfection towards the elimination of finiteness.[27]

From an ethical point of view, it remains to be analyzed whether, for instance, our intuition that certain forms of utilization of the body should not be permitted is morally sound, and whether certain practices must necessarily be judged as instrumentalizations of the body. It is my thesis, though, that such an ethical analysis has to consider the anthropological and epistemological premises that form the basis for the relationships between embodiment and normative values. The following three observations shall serve as an introduction to my considerations of the intertwining of ethical, anthropological and epistemological dimensions:

1. Certain biomedical procedures (e.g. transplantations and implantations) activate moral intuitions or discomfort more strongly than

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[25] See also M. Shildrick, “Beyond the body of bioethics. Challenging the conventions,” 2005.

[26] P. Sloterdijk, *Regeln für den Menschenpark* (Frankfurt/M.: Suhrkamp, 1999).

[27] E. List, “Selbst-Verortungen. Zur Resituierung des Subjektes in den Diskursen um den Körper,” in: *Grenzverläufe. Der Körper als Schnittstelle*, edited by A. Barkhaus & A. Fleig, (München: Wilhelm Fink Verlag, 2002), pp. 185-210.

others do, and thus raise questions concerning the normative relevance of the body;

2. At the same time, technologies that transgress both borders and 'limits' question the traditional categories of order of the Western culture (influenced by the Judeo-Christian tradition, the Enlightenment and scientific ideas since the nineteenth century).[28] This pertains above all to the following binary categories:

Nature – culture: this basic distinction, based on Aristotelian thinking, is blurred for example in the case of the cultivation of cells or artificially produced organisms.

Human person – machine: this distinction is challenged by manipulation of the mind through brain-implanted chips and brain-computer interfaces.

Human being – animal: this Aristotelian and also Judeo-Christian distinction between humans and animals is questioned by, for example, the creation of human-animal chimeras.

Internal – external: the nineteenth century idea of physical and political boundaries is challenged for instance by questioning the ownership of an explanted organ or of an embryo created in vitro.

Body – mind: the Cartesian distinction between the body as a machine and the mind as the ratio is challenged for instance through the transplantations of brain tissue.

3. There are different reactions to the questioning of these conventional orders:

There is the naturalist argument, where the body is understood in a materialist way and judged as irrelevant for the formation of norms. The 'value' of the body can only be established by referring to the interests or values of the 'users' of this particular body;

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[28] See e.g. L. Otis, *Membranes: Metaphors of Invasion in Nineteenth-Century Literature, Science, and Politics* (Baltimore/London: John Hopkins University Press, 1999).

There is a constructivist-relativist discussion about the variety of body conceptions, which either refuses all universally applicable truth claims or denies, in a radical form, the body's materiality;

Another approach asserts the normative, prescriptive relevance of the body and makes of it something resistant and unavailable, with a value of its own—an end in itself.

Let us consider the first observation. Research in the history of medicine and culture suggests that the development of modern medicine (starting with anatomy, physiology, cellular pathology, bacteriology and hygiene, and human genetics) has successively turned the human body into an object, and then dissected, regionalized, localized and standardized it.[29] As a consequence, the body and its parts tend to be regarded through a view known as "empiricist materialism."[30] Body and its part are therefore seen as exchangeable and open to modification.

Transplantation medicine, for instance, is historically clearly based on the localization theory of illness which dates from the mid-nineteenth century.[31] However, the practice of transplantation medicine could only be established on the basis of insights resulting from systemic immunology in the second half of the twentieth century, including the knowledge of how to understand and manipulate several pathways of immunological rejection. For a long time, the ethical discussion of transplantation medicine neglected the consideration of the transfer of organs with respect to the organ's integration into the body image and the union of body and spirit, although there were many sociological

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[29] R. v. Dülmen (ed.), *Die Erfindung des Menschen* (Wien: Böhlau, 1998); R. Winau, "Medikalisierung und Hygienisierung von Leib und Leben in der Neuzeit," in: *Der Mensch und sein Körper von der Antike bis heute*, edited by A.E. Imhof (München: CH Beck, 1983), pp. 209-225.

[30] T. Lysaught, "Social theories of the body," in: *Encyclopedia of Bioethics*, 1996, vol. 1, pp. 300.

[31] T. Schlich, *Die Erfindung der Organtransplantation* (Frankfurt/M./New York: Campus Verlag, 1998).

and anthropological publications on these issues.[32] The premise of interchangeability in its relationship with physicality and personal identity was only questioned in ethics against the background of discussions about the transplantation of neuronal tissue or even entire heads,[33] whereas other body parts were not regarded as constitutive of identity. Such scientific and technological objectivation and fragmentation has been criticized as "de-bodiment of reality" and "ousting from perception the body itself,"[34] and opposed as an attitude that exclusively focuses on control over the body. This criticism appears to contain the vague (and predominantly implicit) assumption that there is a right or authentic perspective on the body-identity-relationship which one just needs to capture differently, in a new way. Even if one cannot fully agree with this criticism, it nevertheless hints at a situation that I would classify as paradoxical: the mutual relationship between, on the one hand, still very prominent theoretical premises of objectification, fragmentation and blindness towards the (lived) body within everyday medical practice; and, on the other hand, socially and politically powerful critiques of increasingly dominating biotechnologies, which stress that the body is unique, must be perceived subjectively, and has independence and resistance.

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[32] See e.g. D. Joralemon, "Organ wars: The battle for body parts," *Medical Anthropology Quarterly* 9(1995), pp. 335-356; L.A. Sharp, "Organ transplantation as a transformative experience: Anthropological insights into the restructuring of the self," *Medical Anthropology Quarterly, New Series* 9(1995), pp. 357-389.

[33] P. McCullah, *Brain Dead, Brain Absent, Brain Donors: Human Subjects or Human Objects?* (Chichester: Wiley, 1993); D. Linke, *Hirnverpflanzungen. Die erste Unsterblichkeit auf Erden* (Reinbeck bei Hamburg: Rowohlt, 1993).

[34] A. Barkhaus & A. Fleig, "Körperdimensionen oder die unmögliche Rede vom Unverfügbaren," in: *Grenzverläufe. Der Körper als Schnittstelle*, edited by A. Barkhaus & A. Fleig (München: Wilhelm Fink Verlag, 2002), pp. 9-23.

The second observation concerns the ways in which such paradoxes or ambivalences are triggered. Traditional Western Occidental culture distinguishes very clearly between human being and machine. It characterizes the human being as a hybrid being that can be located between the two poles of 'nature' and 'culture'. This hybrid aims at the separation of the 'own' from the 'other' through individuation. According to my thesis, these poles not only become blurred in the course of the biotechnological revolution, but they increasingly disappear. Certainly, the mechanization, the rationalization and the instrumentalization of the body or of other living things increasingly move the balance of the traditional order in one particular direction, predominantly towards *materialization*.[35] According to the sociologist Gesa Lindemann,[36] certain medical technologies massively shake the hitherto common distinctions of relationships, namely the difference between the social interaction of two human agents on the one hand, and the relationship between a personal agent and a non-personal object on the other. Lindemann demonstrates this by reference to her anthropological investigation of the ambivalent and sometimes contradictory attitudes of doctors, nurses and relatives to brain-dead patients in intensive care. Many bioethical problems result from this kind of situation: the question of how to treat and care for a brain-dead person in the clinical setting, whether it is permissible to remove organs (which will result in heart death) or whether others should care for months for a brain-dead pregnant woman so that the baby may grow and be brought to term. Conceptual difficulties about identifying and evaluating the distinction between two human agents or between a personal agent and a non-personal object became obvious in discussions about

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[35] A. Barkhaus & A. Fleig, 2002, pp. 9-23.

[36] G. Lindemann, "Der lebendige Körper – ein ou-topische Objekt der szientifischen Wißbegierde," in: *Grenzverläufe. Der Körper als Schnittstelle*, edited by A. Barkhaus & A. Fleig (München: Wilhelm Fink Verlag, 2002), pp. 211-232.

the moral status of entities that transgress borders, for instance hybrid beings such as so-called chimeras. Such transitions from loss of order towards normative evaluations lead to the third observation concerning reactions to such kind of loss. The philosopher Hilge Landweer[37] has asserted that there are three very different and partly opposing strategies to place basic anthropological assumptions within contemporary images of the world:

Through the naturalist approach, the human being is reduced to a body and understood as a creature that is determined by physicochemical processes beyond its control. Consequently, a person's self-relation would be nothing more than a complex neurophysiological process which could be changed and manipulated accordingly.

In the constructivist or postconventionalist approach, the essence of the human being can only be explained through historical and cultural discourses and contexts. Objective descriptions of the 'body' are no longer possible. There are only provisional 'truths'.[38] And their analysis is reduced to the description of a series of conflicting and dispersed discourses. The materiality of the body could eventually be understood as a discourse, depending itself on narrations of the 'body'.

In the 'transformation'-approach, the materiality of the body is assumed, yet embodiment is seen as inaccessible for and through science. The body (as the sensory access/interface to the world) is understood as a precondition of all experience and knowledge. The body's independence and autonomy are defended. Despite all historical and cultural qualifications, this approach does not entirely neglect universally applicable statements. However, the ways in which the body precedes all experience and knowledge cannot be captured by the terms 'nature' or 'biology', but escape any direct analysis.

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[37] H. Landweer, "Konstruktion und begrenzte Verfügbarkeit des Körpers," in: *Grenzverläufe. Der Körper als Schnittstelle*, 2002, pp. 47-64.

[38] See M. Shildrick, "Beyond the body of bioethics. Challenging the conventions," 2005, p. 5.

My first interim conclusion is that all three positions are needed to explain how the normative relevance of the body (e.g. seeing body parts as ‘mechanistic spare parts’) is related to other values (e.g. liberty, justice, and self-development). I hereby distinguish between normativity (which is prescriptive, as rational ethical justification) and morality (which is descriptive and entails an analysis of the values and the socio-cultural attitudes within a group of people or society related to what is right and wrong).[39]

Within the naturalist and constructivist positions, the modification of the body relates to the normative framework of personal interests, social obligations or reciprocal relational structures as determined for instance by postconventional or feminist views. Of all three, the ‘transformation’-position is most supportive of the independent development of the idea of the body as an essentially ‘unavailable’ entity with a specific inherent value. The terms ‘unavailable entity’ and ‘unavailability’ are used as *termini technici* to characterize normative limitations with respect to the body. The body must not be objectified and is never totally disposable for instrumentalization. This value in its own right nevertheless needs to enter into some kind of relation with other norms and values, in order for positions to be taken from a bioethical perspective and related to various forms of modification of the body. According to a rather common point of view, whether an intervention into bodily intactness is morally permissible depends on the agreement of the person having to undergo such an operation, be it the removal of a kidney or an artistic act, as described in the introduction.

In the next section, I will focus on the relation between autonomy (as one prominent value in bioethics) and embodiment. This relationship is, in my opinion, a crucial issue, precisely because one cannot understand the various positions about the body and its meaning for the self without considering liberalism, social conformism and the question of when a human act or decision is authentic, free and autonomous.

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[39] B. Gert, “The definition of morality,” *Stanford Encyclopedia of Philosophy*, 2005.

3. MORE THAN ONE RELATION: EMBODIMENT AND AUTONOMY

Let me give a short overview of two philosophers who have specifically investigated the relationship between embodiment and autonomy, by criticizing (radical) liberal tendencies in bioethics.

According to Richard Shusterman,[40] recent forms of conformism as well as individualism encourage 'somatization', that is, the special attention paid to the body (through, for instance, cosmetic surgery, body building, medical operations, and piercing). There is an explanation for the positive co-existence of both the cult and the negation of the body: Both trends are rooted in a sort of disrespect for the body, as long as by focusing on the mere exterior materiality of the body, one cannot acknowledge the body's independence. The body is no longer perceived as a given fate, but as raw material at the disposal of individual creativity. There are, however, some indications about the dialectics of these practices: at least in their beginnings, many aesthetic body techniques such as tattooing or piercing can be seen as an individual's expression of resistance against standards and societal body norms. Similar to sports, they can also represent a positive body experience which is obtained through pain. Modifications of the body apparently promise liberties, yet at the same time there is a fear of the enslavement of the body. Shusterman makes the distinction between the 'somatic of presentation' (a manipulation of outward appearance) and the 'somatic of experience' (new breathing techniques, psychotherapy, etc.). With Shusterman, especially the former is criticized. This was due to a critical attitude which interprets attention paid to the body as an already alienated interest in an outward representation, which would therefore inevitably serve the corrupt aims of advertising and propaganda.[41] In

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[40] R. Shusterman, *Performing Life* (Ithaca, NY: Cornell University Press, 2000).

[41] *Idem*.

contrast, Shusterman recognizes the somatic of the experience as an option that may have constitutive potential for identity and harmony.

In libertarian ethics, 'autonomy' is, as already shown, the normative touchstone for many kinds of body modification. However, as Christman has shown in depth, there are various conceptions and interpretations of autonomy.[42] In general terms, autonomy is seen as a basic condition for liberty.[43] Following Carter, the crucial question is—in order to distinguish between 'negative' and 'positive' liberty—whether someone is primarily interested in the degree of external interferences and controls (such as the state, other persons; here is meant the negative liberty) or whether someone advocates the importance of internal factors (such as self-commitments or shared social opinions, that is, the positive liberty). Both ideas of liberty focus attention on the way desires and interest are formed and put into practice,[44] while the *content* is not considered.[45] This observation points precisely to the debate over 'bodily autonomy', a term coined by Catriona Mackenzie.[46] Mackenzie develops an account of the theoretical relationships between choice, bodily capacities and autonomy in order to discuss the arguments concerning wishes and acts that interfere with embodiment and body modifica-

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[42] J. Christman (ed.), *The Inner Citadel. Essays on Individual Autonomy* (New York/Oxford: Oxford University Press, 1989); J. Christman, "Relational autonomy, liberal individualism, and the social constitution of selves," *Philosophical Studies* 117(2004), pp. 143-164; I. Carter, "Positive and negative liberty," in: *The Stanford Encyclopedia of Philosophy* (Zalta EN ed., October 2007 edition: The Metaphysics Research Lab, Center for the Study of Language and Information, Stanford University, Stanford CA, 2007).

[43] I. Carter, "Positive and negative liberty," 2007.

[44] J. Christman, "Liberalism and individual positive freedom," *Ethics* 101(1991)/2, pp. 343-359.

[45] See also I. Carter, 2007.

[46] C. Mackenzie, "On bodily autonomy," in: *Handbook of Phenomenology and Medicine*, edited by S.K. Toombs (Waco: Kluwer Academic Publishers, 2001), pp. 417-439.

tions. She criticizes the notion of maximal libertarian autonomy that underpins the expansion of available body modifications, the right for body property and the instrumentalization of the body for personal autonomy,[47] because she rejects the idea that maximizing choices automatically increases a person's autonomy. In addition, she rejects the straight liberal maximal choice conception because it provides no normative criteria to assess which choices are autonomy-enhancing and which are impairing. Here, Mackenzie seems to refer to a radical libertarian interpretation of 'liberal ethics', while other liberal ethicists, most prominently John Rawls,[48] see self-restriction, fairness and paternalism as parts of a reasonable social morality and as protecting us from unreasonable first-order wishes which endanger our second-order wishes. Referring to a 'relational conception of autonomy', and following Ricoeur's phenomenological approach, namely that human corporeality is the invariant condition of human selfhood, Mackenzie suggests a view about body as part of our identity. Her favored notion of bodily autonomy—also as a normative theory—always implies critical reflection on changes of bodily integrity and accepting the "givens of human embodiment."[49]

The attraction of Mackenzie's idea lies in its productive critique of the 'radical' libertarian conception of bodily autonomy, as described above. It helps to detect the weak point of under-complex premises regarding the meaning and condition of the human body as an instrumental means. But again, her ambitious conception of bodily autonomy is itself built upon normative and anthropological premises which are taken for granted. Instead of the phenomenological position which she seems to take it as given, I would suggest that normative reflections on bodily autonomy should be grounded on more premises, including

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[47] *Idem.*

[48] J. Rawls, *A Theory of Justice* (Cambridge MA: Harvard University Press, 1971).

[49] C. Mackenzie, "On bodily autonomy," p. 433.

non-phenomenological positions, as they are also prominent in medical practice or radical postmodern thinking.

What follows for my argumentation? Not only conventional liberal bioethics, but also the critiques of this and related positions are in need of clarification and justification of their premises about embodiment. I understand this critique as a fruitful starting point for re-thinking our initial problem about how we interpret and conceptualize the body in bioethics. And further, the current international discourse in bioethics has to acknowledge its own diversity in its use of 'body conceptions'. It is scientifically unsatisfactory to 'stick' to some views and reject others as 'ideologies'. The several, conflicting assumptions of what the human body 'is' may result in conflicting ethical judgments. The aim is not so much to overcome all conflicts, but rather to have an explicit account of what the body means to bioethics and not only in theoretical papers but also in applied problem-solving ethics. Therefore, I suggest an analytical matrix which allows a self-critical test of various premises by way of dialectical composition of the various views. It is built upon the idea of a critical reflection of normative and anthropological premises by contrasting them with alternative or even antagonistic conceptions of body-autonomy-relationships. This multidimensional approach functions as a heuristic tool to 'identify and test' bioethical assumptions, that is, the various epistemic and anthropological premises about the body. At the same time, the approach sustains the tension between different notions of autonomy.

To achieve this goal, I start from a summary of the two polarized main lines concerning the interpretation of 'autonomy'. According to Christman,[50] 'autonomy' refers, on the one hand, to the potential or actual capability of a person to act and decide independently of external influence and power. This avenue is often stressed in liberal argumenta-

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[50] J. Christman (ed.), *The Inner Citadel. Essays on Individual Autonomy*, 1989; J. Christman, "Relational autonomy, liberal individualism, and the social constitution of selves," 2004, pp. 143-164.

tion, where self-determination is conceptualized without considering the social influence on norms and preferences. Its main pursuit would be 'negative liberty' (see above). I prefer to talk of self-determination in this understanding of autonomy, because the term stresses the 'self', instead of external determination. On the other hand, 'autonomy' means also the moral ideal of developing values and normative standpoints through role distance, self-limitation and universalization. This avenue leads in the direction of the above mentioned 'relational autonomy' in which social responsibility and social relationships are the main entrance into understanding autonomy. I call it here 'moral autonomy' to stress the capacity for moral self-reflection, as Mackenzie does.[51] Moral (bodily) autonomy connects to the imagining of the good life through critical and creative self-reflection and the integration of biological, socio-cultural and biographical dimensions of bodily self-representation. This notion of autonomy also appears to be linked to the idea of a successful establishment of a coherent identity, despite fashionable trends and socio-cultural conformity. Both conceptions of autonomy do not necessarily preclude each other from a normative point of view. While the liberal minimalist conception understands autonomy as the capability to develop and formulate individual preferences despite, or precisely because of social influences, the second maximalist one understands autonomy as the capability to question and prioritize one's own preferences and to use them for orientation with respect to others' interests and needs.

According to my analysis in part 1, there are also at least two main polarized perspectives on the body. These also enrich the bioethical debate. There is the phenomenological perspective which combines both the perception of the individual's material and the anthropological limitations (the physical dimension) on the one hand, and the lived-body phenomena such as sensory perceptions or pain on the other. The second perspective understands embodiment as a textually or culturally inscribed 'exterior' (such as categorization into specific

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[51] C. Mackenzie, p. 429.

aesthetic, social, gender or medical-scientific 'classes' would be). As a result, we now have four different specific perspectives for the relationship between embodiment and autonomy. The four perspectives are not hierarchically understood; one could start reading the matrix from the conventional, 'liberal-materialistic' perspective and end at the 'communitarian-deconstructivist' position, but also vice versa (I will illustrate this for concrete cases in the next section). But in order to avoid misunderstandings, I choose more adequate labels to describe these four perspectives:

3.1 Bodily self-determination

Autonomy as the right to bodily self-determination refers in this view to the defense of one's own body against direct and indirect interventions by third parties. The body represents the immediate access to one's own personality (i.e. to 'express' one's own opinion by a body modification), and at the same time can be regarded materialistically as a transformable entity. Autonomy remains fixed to the somatic/bodily- conveyed capabilities of personal identity (i.e. to communication, to coping with pain, to the conscious realization of personal characteristics). However, this view does not have to lead to the conclusion that an instrumentalization of the body always means an instrumentalization of the person, provided that the interventions in question are agreed to by this person, and the natural basis for this person's identity remains intact.

3.2 Respect for the bodily unavailability of the other

Moral autonomy, as part of the self-restriction, includes the respect for another person's bodily integrity, even if it conflicts with one's own preferences and aims. This calls for a critical reflection on the ways in which one deals with the body of others and with one's own body within the given social and cultural context. This respect is more than a negative right to reject claims of others. It is the respect for others as reciprocity for the wish to be respected. First and foremost, this respect for the bodily unavailability of others allows critical reflection of own needs for other bodies. But it also includes considerations about one's own body images, bodily integrity and desires for body modifications. Can one rightfully deduce certain demands to maintain or form bodily integrity on this basis, particularly when this has implications for third parties? A self-critical view on body images and ideals could be required if one cannot be fully sure of avoiding implicit or explicit discrimination of those who diverge from this ideal. In addition, moral autonomy can involve taking political-normative initiative for the bodily integrity of others even if one is not affected directly. This could be done through advocacy, especially for those who cannot articulate their own interests and views. This includes also the commitment to political discussions about the unavailability of the body of third parties.

3.3 Care for bodily individuality

Autonomy as self-critical reflection includes the fulfillment of individual interpretations about what a good life is for me, including a form of care and concern for my body. Therefore, the way I see my body can be regarded as part of a conception of the good life: one's own interests and desires are linked to bodily perceptions and expressions, and to bodily-mediated actions such as communication, love and sensations. Visions of the good life include the striving for aesthetic values, and the development and stabilization of an identity as conveyed through sexuality, appearance as bodily characteristic and bodily techniques (such as in the act of eating or moving etc.). Such bodily features are always situated within a complex understanding of individual normality, of political and social standardization, and of historical and cultural difference. Embodiment is critically investigated as socially constructed and discursively negotiable. This emphasizes the role of individual care for bodily characteristics: the central normative element of this kind of care may well be the recognition of a difference rather than of a norm or normality. The care for bodily individuality goes far beyond having a maximal choice for body modifications: It also includes the idea that the self and personhood are built upon individual appearance and individual body language and styling. Care includes the protection of bodily individuality by maintaining one's own identity even if one's body appears different and ‘strange’ to others. Recognition of bodily individuality could be understood as recognition of being different. Therefore, this shouldn’t lead to an exclusion of the others. This form of recognition can support the fortification of one’s own self-determination through dialogue with others and by coming closer together. The background is the idea that there are several ways of dealing with embodiment (and its weaknesses) which provide orientation in life and thus with a conception about what a good life means.

3.4 Recognition of bodily cooperation

Autonomy as the opportunity and capacity to develop a self as an autonomous person may at the very least require the right to one’s own social identity within the framework of group membership. This group is assumed to express itself by means of specific forms of embodiment, of bodily interaction, and of bodily-constituted communities. This builds up a well-balanced cooperation, here called ‘bodily cooperation’. This recognition is built upon the care for bodily individuality, but refers to forms of bodily expression in which the body is constitutive for specific social interactions. The building of stable social relationship such as parenthood, partnerships or friendship could not easily be thought without having bodily contact through touching or sharing bodily experience. For instance, most forms of sexuality are constitutively bodily social interactions. The same is true for maternity or the social handling of dead human beings. Recognition of such bodily interactions leads to political and social recognition of those communities which are different in sexual preferences, e.g. homosexual communities.

4. DISCUSSION: INCREASING SENSITIVITY FOR VARIOUS NORMATIVE PERSPECTIVES OF THE BODY

What conclusions can be drawn once we open up these four perspectives instead of narrowing us to only one view? In this section, I will use the approach developed in part 2 for an improved, premise-critical description of ethical problems in recent biomedicine. The chosen examples—transplantation medicine, neuroprosthesis, and cosmetic surgery—present serious cases of 'transgressing borders'. Because of limitations of space, I will only refer to the increased sensitivity to the various perspectives of normative judgments through different ways of formulating the starting problem.

I therefore start again from the liberal conception in which the argument of *bodily self-determination* is vehemently used to justify the right to body modifications, provided that the affected person has given her informed consent. As long as biomedical technologies are perceived as means to achieve emancipation from bodily limitations (that is, illness, pain or death), their legitimacy won't to be in doubt. But it is decisive whether new options secure, impair or increase a person's interests and autonomy through body modifications. For instance, in the case of the transplantation of organs, how manifests itself the freedom of a patient to choose between options available inside of a particular medical system and safeguarded within the framework of information and agreement procedures? A special case is the possible commercialization of the donation of organs. The argument of bodily self-determination seems to support a liberalization of the trade in organs, as long as it is guaranteed that possible medical risks are reliably assessed and made clear to the agent, and that injustice through possible exploitation is avoided.[52] But in the same field, we have to consider the understanding of what constitutes a person, as exemplified by the question whether self-determination continues beyond a person's heart death or beyond totally or partially brain death. Here, the anticipated relationship of self-determination and embodiment (in the sense of an understanding of the body that has to be interpreted individually) is decisive. Is it a genuine personal matter to decide on what should happen to one's dead body, or should one respect the piety of relatives and, therefore, accept certain limits? The former distinction between human being

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[52] S. Wilkinson, "Commodification arguments for the legal prohibition of organ sale," *Health Care Analysis* 8(2000), pp. 89-201.

and machine, mind and body, is blurred by the technology itself (as 'dead' persons are kept 'quasi-alive' by heart-lung-machines). If a person's autonomy is linked only to current bodily self-determination and if we see the body as a physical instrument, further-reaching claims will eventually succeed, such as the social obligation to help other patients with organs, even if the dead person refused the explantation of organs whilst alive.

But further interesting perspectives appear when bodily self-determination must confront concerns about the respect for the bodily unavailability of another person. The constructed case of an individual decision-making process often cuts out medical and social reality. This includes questions about the person who serves as an organ donor or who carries out an operation, i.e. a doctor. For example, in the case of a living donation one needs to raise the question as to whether the living donor of a kidney considers the act of donation as a voluntary, autonomous decision, but also whether the potential organ receiver has a right to ask for the donation. The transgression of the internal-external-borders ('My kidney in your body?') opens the new field for the moral assessment of identity and bodily integrity. Taking seriously the *moral respect for others' bodily integrity* opens as such a new perspective. Doctors, as well as any potential recipient of the organ, have to acknowledge the moral dimension of their decision (to conduct the operation and to receive the organ). They have to take responsibility for their respective roles within the decision-making process.

The critical reflection on the respect for the bodily integrity of the other allows us to evaluate the impact of modern biomedicine on people who are not directly affected, in terms of a possible discrimination. While the focus on bodily self-determination neglects the dimension of future social developments, the respect for bodily unavailability makes us sensitive for critical social changes, even if they are indirect and only a future possibility. Such problems could be approached by considering slippery-slope arguments. Cosmetic surgery could hereby be seen as a challenge to the border between what is seen as natural and what is artificial. While this ‘border’ is not said to be a distinction between morally right and morally wrong, its transgression puts some questions about authenticity and cultural standards. For instance, cosmetic surgery on an adult woman very often seems to be justified by pointing to her bodily self-determination. Taking influential pop cultural shifts in body images as possible and likely, this may result in a successive, implicit social compulsion for next generations to undergo similar modifications. The moral dimension of such individually legitimated decisions unveils ethical problems for those who are rather dependent on cultural standards (such as adolescents).

The conception of self-determination is related to a conception of the good life insofar as the fulfilling of personal preferences and second-order interests could be seen as embedded in the ‘whole’ perspective of what a person should be, of what is part of his/her self and identity. The stabilizing effect of the exclusion of and separation from others on personal identity should not be underestimated.[53] This new idea of individual care leads to a positive effect that stabilizes identity. The role of *care for bodily individuality and its characteristics*, for the development of identity and thus for self-determination is further supported by the process of individualization and the deconstruction of fixed socially constructed categories such as ‘healthy’ and ‘ill’, ‘ugly’ and ‘beautiful’, ‘natural’ and ‘artificial’. For instance, it allows a more open discussion of how to assess neuroprosthesis and brain implants to cope with certain disabilities (such as deafness), Parkinson disease (e.g. treated with xenotransplants) or patients with the Tourette-syndrom (a disorder, which is characterized by uncontrollable vocalizations

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[53] H. Joas, “Kreativität und Autonomie. Die soziologische Identitätskonzeption und ihre postmoderne Herausforderung,” in: *Identität, Leiblichkeit, Normativität: Neue Horizonte anthropologischen Denkens*, vol. 1, edited by A. Barkhaus, M. Mayer, N. Roughley, D. Thürnau (Frankfurt/M.: Suhrkamp, 1996), pp. 357-369.

and movements and treated with deep brain stimulation).[54] These biomedical technologies could challenge the 'border' between human being and machine or animal. If the body is seen only as raw material or as depending on individual perception, the bioethical discourse is then poised on the (empirical) question of whether the prostheses or xenotransplants are able to change 'personal identity'. Instead, realizing that the border itself is questionable, on the one hand, and that the normative recognition of bodily cooperation may also count, on the other hand, alternative solutions such as the improvement of care and the reduction of barriers on the social, structural or town-planning for elderly or mentally ill people will be seriously discussed. Additionally, this opens up issues of distributive justice: We have to face the problem that excessive use of biomedical solutions could lead us to ignore all those disabled people and patients who—for personal or structural reasons—do not have access to biomedicine.

Finally, the consideration of the *recognition of bodily-constituted communities and bodily cooperation* allows us to question whether some biomedical practices could destroy cultural identities, for instance, as signified by a loss of sign language due to the use of cochlea implants,[55] or whether it contributes to the gestation of new ones (through the development of new collectives of patients, for instance). The normative tension between bodily self-determination and care for one's bodily individuality gives rise to a discourse over the extent to which the acceptance or refusal of an intervention into the body is rooted in a comprehensible insecurity or desired unavailability with respect to one's own body. The perspective of the possible value of bodily-

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[54] See e.g. J.L. Houeto, C. Karachi, L. Mallet et al., "Tourette's syndrome and deep brain stimulation," *Journal of Neurology Neurosurgery and Psychiatry* 2005, pp. 992-995.

[55] J.L. Scully, C. Rehmann-Sutter, "Ethics/Legal/Regulatory. When norms normalize: The case of genetic enhancement," *Human Gene Therapy* 12(2001), pp. 87-95.

constituted communities allows new forms of assessing social actions and communication. Since the debate about race, sexuality, ethnicity and disability, we have seen by way of negative effects the crucial role that embodiment plays in the perception of other ‘cultural’ identities. For instance, the social and political dimension of patients’ self-help groups could be better discussed as part of a socio-political dimension in the medical system than by focusing on individual decision-making. Patients support and advise each other; they share something which not only separates them from others, but also strengthens them: the existential experience of illness or the experience of a long process of therapy and recovery.[56]

5. CONCLUSIONS:
THE LOSS OF SELF-EVIDENT TRUTHS

The receptivity for various relationships between autonomy and embodiment provides a central interface for the ethical reflection about who decide and how about one’s own body. What elements of a person can be regarded as available or unavailable, at which moments in time during a person’s life? Some liberal ethicists criticize the ‘body boom’ in ethics as a “neo-heathen body cult,”[57] because they don’t consider that body is morally relevant. However, as I argued above, this assumption could be self-contradictory if proponents of the liberal conception of self-determination recognize the principle of nonmaleficence as a moral duty to act in a responsible way, as many scholars do. Nonmaleficence and the obligation to reduce suffering are linked to a specific

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[56] S. Schicktanz, M. Schweda, M. Franzen, “ ‘In a completely different light’? The role of ‘being affected’ for epistemic perspectives and moral attitudes of patients, relatives and lay people,” *Journal of Medicine, Health Care and Philosophy*, 11(2008):1, pp. 57-72.

[57] U. Steinvorth, “Kritik der Kritik des Klonens,” in: *Hello Dolly? Über das Klonen*, edited by J.S. Ach, G. Brudermüller, C. Runtenberg (Frankfurt/M.: Suhrkamp, 1998), pp. 90-122.

concept of the body, a body which is able to ‘suffer’, ‘feel pain’, and can be ‘harmed’. Instead of neglecting one’s own anthropological and epistemic premises about this suffering body, I suggest to be aware of them. I conclude therefore that the bioethical procedure of detecting and describing ethical dilemmas should also take into account the ways and limits of perceiving one’s own body and those of others. From here, it should not be concluded that any kind of biotechnology is morally problematic just because it annihilates the ‘difference’ (by making an ‘ill’ person ‘healthy’). Neither is any biotechnology justified just because patients gave their ‘free’ informed consent.

The body is a challenge for bioethics, because moral values such as autonomy, and ‘unavailability’ of the body, rely on various premises regarding the manner in which cultural and personal identity is built upon bodily practices, bodily constitutions and body images. Within the liberal bioethical context, bodily self-determination is often understood as a minimal moral consensus based on a legitimate resistance against medical (or state) paternalism. But as I showed so far, bioethics provides more than just a way to stress the importance of this minimal consensus; ethical reflection also serves a fruitful idea of a reflective self-relation of the moral agent. This reflection makes it necessary to think about the normative meaning of specific bodily related interactions with others and about the respect and the care for others’ bodily integrity.

However, the categories for the cultural and natural order of the body as described above are not regarded as having a moral value on their own, but as being very value-laden. Thus, the suggested matrix is open to various interpretations and offers both linguistic and argumentative access to critical inquiry and to the different ways of being a lived body or a thing body.[58] One should also note that the loss of order, as I described the moral and epistemic uncertainties towards human

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[58] A. Barkhaus & A. Fleig, “Körperdimensionen oder die unmögliche Rede vom Unverfügbaren,” 2002, pp. 9-23.

bodies in Part 1, is constantly discussed within the bioethical debate, but is labeled in a different way: as the conflict about the so-called ‘moral status’ of various entities, e.g. of human embryos, animals, or brain-dead persons.

The loss of self-evident truths may often be regarded as a specifically modern phenomenon or even as the tragedy of modernity. Particularly the wider bioethical perspective shows to which extent epistemological and normative views are intertwined. However, in the course of self-reflection this loss can also be seen as something positive: as an opportunity for self-reinterpretations.

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[59] E. List, 2002, pp. 185-210.

2

AUTONOMY AND CARE FROM THE PERSPECTIVE OF END-OF-LIFE DECISION-MAKING

AUTONOMIE ALS SELBSTBESTIMMUNG UND FÜRSORGE

Aufgezeigt am Beispiel der Sterbehilfe [1]

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Wie kaum eine andere Disziplin hat sich die Medizinethik, aufgrund der rasanten wissenschaftlichen und technischen Entwicklungen, gewandelt von einer Disziplin mit relativ stabilen normativen Vorstellungen über das zu Tuende und zu Unterlassende hin zu einer Disziplin, die sich stets stärker auf eine Reihe grundlegender Prinzipien bezieht, Prinzipien, die lediglich normative Rahmenbestimmungen bieten, deren Berücksichtigung in konkreten Entscheidungen gewährleistet sein muss.

Medizinische, wissenschaftliche und technische Möglichkeiten, mit ihren Chancen und Gefahren, zeigen immer wieder, dass frühere konkrete Regeln und Normen nicht mehr passend sind, sondern immer wieder das Zurückgreifen auf allgemeinere Prinzipien zur Rechtfertigung eines bestimmten Handelns oder Unterlassens erforderlich ist. So stellte sich z. B. nicht das Problem, über Organtransplantation positiv oder negativ urteilen zu müssen, solange es die Möglichkeit hierfür gar nicht gab. Darüber hinaus aber haben sich nicht allein die technischen Möglichkeiten verändert. Viel eingreifender ist: Auch das gesellschaftliche Bewusstsein ist durch Entwicklungen gekennzeichnet, die uns an

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[1] Der vorliegende Beitrag ist eine bearbeitete und gekürzte Fassung von: *K.-W. Merks*, „Autonomie: Selbstbestimmung und Fürsorge“, in: *A.T. May*, *R. Charbonnier* (Hg.), Patientenverfügungen. Unterschiedliche Regelungsmöglichkeiten zwischen Selbstbestimmung und Fürsorge, Münster 2005, S. 19-35.

einem Modell festgestellter allgemeiner konkreter Normen zweifeln lassen. Vorstellungen über ein glückliches Leben, über das Können des Menschen, über die Machbarkeit des Lebens, über den Fortschritt, über Gesundheit, Leiden, Tod, dies und vieles andere mehr prägen unsere Wertungen, tragen zu ihrem Wandel bei.

Eine wichtige Rolle in der Entwicklung solcher allgemeiner Prinzipien spielt das beinah klassische Quartett der vier durch Engelhardt, Beauchamp und Childress und andere entwickelten „Principles of Biomedical Ethics“ als leitende Kriterien medizinischen Handelns: *autonomy*, *nonmaleficence*, *beneficence*, und *justice*, zu übersetzen etwa als Selbstbestimmung des Patienten, Schadensvermeidung, Fürsorgepflicht und soziale Gerechtigkeit.[2]

Im weiteren konzentrieren wir uns auf das erste dieser vier Prinzipien, *autonomy*, d.h. Autonomie und Selbstbestimmung von Patient oder Patientin. Unter diesen Grundprinzipien medizinischer Ethik nimmt Autonomie im Bewusstsein unserer Zeitgenossen, aber auch in den Diskussionen über medizinethische wie juristische und politische Entscheidungen ganz offensichtlich nicht allein den ersten Platz, sondern auch einen unvergleichlichen Platz ein. Es ist das *principium sine qua non*, ohne das nichts läuft, nichts laufen darf.

Autonomie, so konstatiert Andrea Arz de Falco in einem vor einiger Zeit erschienenen Band zum Thema sittlicher Autonomie[3] zu Recht, ist der „Kernbegriff moderner Medizinethik“.[4] Wer die engagierten öffentlichen Debatten über die sittliche Zulässigkeit, die moralischen

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[2] Vgl. *G. Rager*, „Medizinische Ethik“, in: Lexikon für Theologie und Kirche, Bd. 7, 3. Auflage, 1998, S. 59-61.

[3] A. Arz de Falco, „Reproduktive Autonomie. Kritische Anfragen an die Fortpflanzungsmedizin am Beispiel der Präimplantationsdiagnostik“, in: *A. Autiero*, *S. Goertz*, *M. Striet* (Hg.), Endliche Autonomie. Interdisziplinäre Perspektiven auf ein theologisch-ethisches Programm, Münster 2004, S. 283-303.

[4] Ebd., 287.

Bedenken, die Wünschbarkeit bzw. Unerwünschtheit in verschiedenen medizinischen Bereichen, bei der Abtreibungsfrage, der Fortpflanzungsmedizin oder der Präimplantationsdiagnostik ein wenig verfolgt, kann konstatieren, dass hier in der Tat und beinah unmittelbar die Diskussion um Recht und Reichweite der Autonomieforderung eine dominante Rolle spielt. Auch bei den neueren Debatten über Sterbehilfe und Patientenverfügung spielen Begriff und Bewertung von Autonomie und Selbstbestimmung diese zentrale Rolle. Ein durch das Bundesjustizministerium nicht weiter verfolgter Referentenentwurf zur Patientenverfügung formuliert das in der Begründung so: „Für die Rechtmäßigkeit eines ärztlichen Eingriffs ist … die Einwilligung des Patienten erforderlich. Dabei kommt es nicht darauf an, ob die Entscheidung des Patienten aus medizinischer Sicht als vernünftig oder unvernünftig anzusehen ist. Es entspricht der ständigen Rechtsprechung …, dass die Wahrung der persönlichen Entscheidungsfreiheit des Patienten nicht durch das begrenzt werden darf, was aus ärztlicher oder objektiver Sicht erforderlich oder sinnvoll wäre.“[5]

Mit meinen folgenden Überlegungen will ich keine unmittelbare Antwort auf die konkreten Probleme der Patientenverfügung geben, sondern lediglich einige allgemeine Gesichtspunkte vortragen, die vielleicht hilfreich sein können für eine nähere Einschätzung von Wert und Grenzen von Autonomie und Selbstbestimmung im sensiblen Bereich menschlichen Lebens und Zusammenlebens am Lebensende.

In drei Schritten werde ich auf die tatsächliche und die moralisch wünschbare Wertschätzung von Autonomie (a) eingehen, sodann ihre Begrenzung durch andere Werte sowie durch menschliche Beschränktheiten (b) kurz beleuchten, um abschließend zu einigen Folgerungen

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[5] Entwurf eines 3. Gesetzes zur Änderung des Betreuungsrechts vom 1.11.2004, S. 7; online unter http://www.aem-online.de; siehe dazu die Pressemeldung vom 5.11.2004, online unter: http://www.bmj.bund.de/media/archive/791.pdf

für die einander geschuldete zwischenmenschliche Fürsorglichkeit (c) gerade von autonomen Subjekten zu kommen.

1. WERTSCHÄTZUNG DER AUTONOMIE: AUTONOMIE ALS SELBSTBESTIMMUNG UND ALS VERANTWORTLICHKEIT

Autonomie ist, wie gesagt, nicht eines unter anderen Prinzipien medizinischer Ethik, sondern nimmt hierin einen ganz eigenen Platz ein. Sie ist „zentrales Element heutiger Medizinethik“.[6] Damit wird in der Medizinethik ein Begriff zur tragenden Kategorie, der für das gesellschaftliche Bewusstsein der Moderne ganz allgemein bestimmend ist, die Freiheit als zentraler und allgemeiner Wert, die eine ihrer wesentlichen Ausdrucksformen in der Autonomie findet, im Recht und der Möglichkeit von Menschen, ihr Leben und ihre Lebensordnungen selbst zu bestimmen.

Es ist gewiss nicht falsch, einen wichtigen Grund für das Autonomiestreben in der allgemeinen Tendenz zum Individualismus und der damit einhergehenden Pluralisierung ethischer Wertungsmuster zu sehen. Viele verstehen denn auch unter Autonomie und Individualisierung unmittelbar eine Antastung der sittlichen Ordnung. Hierbei gehen sie aus von einem Verständnis von Moral, das sich wesentlich in Normen und gesellschaftlichen Ordnungen äußert, in Normen, die unabhängig von den Normsubjekten, den Menschen also, je schon vorgegeben sind. Die Folgerung der Aufweichung von Moral und moralischer Ordnung durch den Autonomiewillen der Subjekte liegt dann auf der Hand. Diese Folgerung aber ist keineswegs selbstverständlich.

Denkbar ist auch, und dafür spricht vieles, dass wir es hier in erster Linie, zunächst einmal, mit einer radikalen Veränderung der Gesellschaftsstruktur zu tun haben, in der die Dominanz der gesell-

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[6] A. Arz de Falco, a.a.O., S. 287.

schaftlichen Ordnungen und Strukturen zumindest teilweise für die Priorität der Subjekte Platz hat machen müssen.

Es ist nicht zu übersehen, dass das Insistieren auf Autonomie und Selbstbestimmung in der Tat stark bestimmt ist vom Gesichtspunkt der Verteidigung und Selbstbehauptung gegen Fremdbestimmung durch die Gesellschaft oder durch die Macht und die Position von Gruppen oder Personen, in unserm Falle etwa der Ärzte, denen gegenüber wir abhängig sind. Diese Idee der Selbstbehauptung spielt zweifelsohne auch in der Diskussion der Patientenautonomie eine große Rolle.

Im übrigen zielt Autonomie nicht lediglich auf das Verhindern unerwünschter Handlungen. Häufig hat sie auch den Charakter eines Wunsches bzw. einer Forderung bestimmter Be-Handlungen. Beides geht bisweilen ineinander über. So kann etwa die Grenze zwischen dem Wunsch nach Euthanasie und dem Wunsch des Unterlassens von medizinischen Handlungen zum Lebenserhalt äußerst dünn sein. Wie wir wissen, entstehen dann Situationen, in denen auch noch andere Fragen als die der einfachen Entscheidungsbefugtheit wichtig sind.

Autonomie der Selbstbestimmung kann z.B. dann mit Berufspflichten kollidieren, oder mit gesetzlichen Regelungen, mit gesellschaftlichen oder ökonomischen Erfordernissen, oder auch mit anderen moralischen Auffassungen. Derartige Komplikationen sind nicht ganz neu, aber sie gewinnen durch die Autonomieforderung als Basisprinzip an Schärfe.

Schon hier zeigt sich ganz allgemein, dass die Frage der Patientenautonomie, wo sie als reines Recht der Selbstbestimmung verstanden wird, sich nicht allein an der gleichen Freiheitssphäre anderer stößt, sondern dass sie auch die Frage nach weiteren Kriterien nicht erübrigt. Um diese Frage kommt daher eine moralische Wertung der Patientenautonomie, aber auch eine Rechtsordnung, die natürlich nochmals ihre eigenen Regeln kennt, nicht herum. Bevor wir aber über die Grenzen von Autonomie sprechen, ist es wichtig, ihre moralische Bedeutung zu sehen: Sie steht in engstem Zusammenhang mit der menschlichen Würde. Autonomie hat zu tun mit moralischer Verantwortlichkeit. Das ist jedenfalls das, was die moderne Moraltheologie unter Autonomie versteht.[7]

Im Zuge der modernen Entwicklungen wird sichtbar, wie weitgehend unsere Lebenswelt Menschenwerk und darum Gegenstand menschlicher Verantwortung ist. Die traditionellen Grenzen zwischen dem, was als Domäne Gottes und dem, was als Domäne des Menschen betrachtet wurde, sind fließend geworden (vgl. Vaticanum II, Gaudium et spes 33). Wo würde das deutlicher als z.B. in der modernen Medizin? Die in jüngerer Zeit, bisweilen nicht zu Unrecht geäußerte Kritik an der modernen Zivilisation kann allerdings nicht darüber hinwegtäuschen, dass es nicht mehr um einen Rückzug des Menschen aus seiner dominanten Stellung in der Welt gehen kann, sondern lediglich um die Frage nach der Menschlichkeit einer Menschen-bestimmten Welt und Gesellschaft. Es geht um die „Macht über die Macht“ (R. Guardini). Das heißt: Wir wollen und können nicht auf Wissenschaft und Technik, auf eine durch uns selbst (mit-)gemachte Welt verzichten, sehen uns aber herausgefordert, immer wieder die Frage zu stellen nach dem Menschenwürdigen, nach dem was wirklich gut ist und gut tut, uns selbst, den andern, der Gesellschaft und der Welt insgesamt. In einer solchen Moral steht einerseits das Subjekt, und das heißt, jedes Individuum, jede Person mit ihrem Gewissen, zentral. Freilich, wenn hier von Gewissen gesprochen wird, ist das etwas anderes als allein mein eigenes Wollen: Von Gewissen ist erst Sprache, wo es um die Frage von gut und böse geht, und um die Suche nach dem wirklich Guten, natürlich in den Strukturen der Wirklichkeit, mit den Möglichkeiten, die diese bieten, aber auch den Schwierigkeiten und Beschränkungen,

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[7] Vgl. zum Folgenden ausführlicher: *K.-W. Merks*, „Sittliche Autonomie. Wissenssoziologische Studie zu Genese und Bedeutsamkeit eines Begriffs“, In: A. Autiero, S. Goertz, M. Striet (Hg.), Endliche Autonomie. Interdisziplinäre Perspektiven auf ein theologisch-ethisches Programm, Münster 2004, S. 34-42; ferner insgesamt: *K.-W. Merks*, Gott und die Moral. Theologische Ethik heute, Münster 1998.

die die Wirklichkeit unserm Wollen und Wünschen, unserm Tun und Lassen auferlegt. Autonomie und Selbstbestimmung können daher eigentlich erst dort moralisch genannt werden, wo sie das Gute wollen und nach dem wirklich Guten suchen.

Bei Autonomie und Selbstbestimmung in diesem Sinne geht es daher nicht um die einfache Frage, ob i*ch* bestimme oder *andere*, auch nicht um die Frage, was mir am besten auskommt, wie ich am ungeschorensten davonkomme, sondern worin wirklich und letztlich das *Gute* in dieser jeweiligen Handlungssituation zu sehen ist, für das ich verantwortlich eintreten soll.

Die Hinwendung zur sittlichen Autonomie und zu einer autonomen Moral kann man zurecht als einen Paradigmenwechsel,[8] ein radikal anderes Moralmodell bezeichnen. Gegenüber einer Ethik unter dem Primat der Gemeinschaft und ihrer Normen führt der unhintergehbare individuelle Subjektcharakter der entscheidenden und handelnden Person zu einem fundamental andern Typus von Ethik. Es ist ein Typus, der im dezidierten Sinne Verantwortungsethik heißen darf.

Diese Verantwortungsethik plädiert nicht einfach hin für Individualität und Subjektivität moralischer Entscheidungen. Sie bringt wohl zum Ausdruck, dass moralische Optionen immer Stellungnahmen von Subjekten sind, die sich mit ihrer Freiheit und Macht verantwortlich für ein gutes, sinnvolles Leben engagieren (oder dies nicht tun). Diese unsere Verantwortung betrifft nicht nur die individuelle Situation. Auch das soziale und politische Leben ist Objekt unserer Verantwortung. Auch unsere Ordnungen – die juridische, ökonomische, wissenschaftliche, soziale und selbst moralische Ordnung (als Phänomen des sozialen Lebens) – hängen von den Subjekten (d.h. der Gemeinschaft von Subjekten) selbst ab, die verantwortlich sind für

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[8] Ausführlich: *K.-W. Merks*, „Natuur-persoon-cultuur. De moraaltheologische paradigmawisseling“, in: *J. Jans* (Hg.), Bewogen theologie - theologie in beweging, Tilburg 1996, S. 64-72.

das, was sich wohl und was sich nicht verwirklicht von einer wirklich menschlichen und gerechten Welt und Gesellschaft.

Eine solche Umorientierung zum sittlichen Subjekt ist zu unterscheiden von Subjektivismus (dass *ich* werte, bedeutet nicht, dass es mir nur um mich zu tun ist). Wirklich wahrgenommene Verantwortung bezieht die anderen mit ein, und sie sieht sich zugleich mit den objektiven Dimensionen der Wirklichkeit in ihrer Bedeutung für die sittlichen Entscheidungen konfrontiert. Das Ethos der Subjektivität verweist selbst auf ein Ethos der Sachlichkeit und Sachgerechtigkeit.

2. BEGRENZUNG UND EINBETTUNG VON AUTONOMIE

Aus dem Vorhergehenden wird schon deutlich, dass Autonomie sich nicht einsam an einem im Übrigen leeren Wertehorizont bewegt, sondern je schon in Beziehung steht zu andern für das menschliche Leben und Zusammenleben wichtigen Werten und Gütern.

Das zeigt sich etwa auch bei einer auch nur oberflächlichen Betrachtung der Rechtsordnung.

Ich erwähne die mit unserer Rechtsauffassung selbst aufs engste zusammenhängenden Fragen von Rechtsgleichheit und Rechtssicherheit, demokratische Verfahren, Toleranz, liberale, politische, soziale und kulturelle Grundrechte. Ich nenne all das, was wir selbst als zu einem würdigen Menschenleben normal dazugehörend betrachten: Leben, Gesundheit, Nahrung, Bildung, Freizeit usw. usw. Es sind dies alles Rechte und Güter, die mit der Entscheidungsfreiheit abgewogen werden müssen.

Die eigentliche Frage ist also nicht die der andern Güter und Werte, sondern die nach ihrer Zuordnung zur Freiheit und untereinander. Damit aber konkurrieren nicht allein Freiheit und Freiheit, Autonomie und Autonomie, sondern auch meine Freiheit mit meinem Wohlergehen, mit dem Wohlergehen anderer und der Gesellschaft, in vielerlei Hinsichten.

Ergeben sich so schon Probleme für die Selbstbestimmung aus ihrer Beziehung zu andern Werten, so ist mindestens ebenso wichtig ein anderes Problem, das man bezeichnen könnte als *innere* Brüchigkeit der vermeintlichen Selbstbestimmung selbst.

Wie frei sind wir überhaupt bei unseren so genannten freien Entscheidungen?

Dieses Problem stellt sich insbesondere bei den Fragen, die mit der Sterbehilfe zusammenhängen.

Freiheit der eigenen Entscheidung ist ja offensichtlich eines der Schlüsselwörter, unter denen in unserer Gesellschaft die Frage nach Sterbehilfe angesprochen wird. Niemand brauche ja darum zu ersuchen, aber niemand solle auch daran gehindert werden können, wenn er oder sie es möchte, das Recht auf den eigenen Tod, einen „menschenwürdigen“ Tod, wie man sagt, in Anspruch zu nehmen und hierbei eventuell auch die Hilfe von Mitmenschen zu bekommen.

Freilich, gerade Sterbehilfe unter dem Stichwort Freiheit zu fordern, hat etwas abgründig Doppeldeutiges: Wie frei sind wir eigentlich in dieser Freiheit hin zum Sterben, und hin zur Sterbehilfe?

„Freitod“ hat man die Selbsttötung genannt. Dabei ist bekannt, wie schmal und eng oft der Freiheitsraum geworden ist, wo der Entschluss zum eigenen Tod, zur Selbsttötung genommen wird. Und wie zwanghaft dieser Entschluss meist ist. Fachleute, die mit Menschen in Suizid-Situationen zu tun haben, sagen uns, dass ein solcher frei gewählter Tod recht selten ist. Der Mensch hat eine natürliche Neigung zum Leben, er strebt von Natur zum Selbsterhalt, sagten, vielleicht etwas naiv und kurz, aber damit doch einen evidenten Sachverhalt ausdrückend, mittelalterliche Theologen.

Es mag ja sein, dass bisweilen der Freitod nicht die einzig verbliebene Möglichkeit ist, dass er in diesem Sinne frei gegen andere Möglichkeiten abgewogen und gewählt wird. Doch meist und selbst in solchen Fällen bleibt (mir) die Frage, ob sich nicht hier ganz andere Abgründe von Unfreiheit auftun, eine Bindung und Fesselung durch das eigene, oft kranke Ego zum Beispiel, für das Freiheit nur noch in einer abgrundtiefen Selbstisolation gelebt wird, in einer im Grunde nicht mehr zu Kommunikation offenen Einsamkeit, wo Selbstbestimmung der einzige Erfahrungsraum von Freiheit geworden ist.

Auf das Thema der Sterbehilfe oder Patientenverfügung angewandt: Welche Freiheit ist eigentlich im Spiel, wenn es um die Forderung nach dem Respekt vor der eigenen Entscheidung über Behandlungsgrenzen, doch wohl meist im Zusammenhang mit dem eigenen Sterben-Dürfen, geht?

Natürlich ist damit nicht gemeint die Freiheit anderer, die gegen unsern Willen unsern Tod herbeiführen. Dass dies nicht sein darf, ist eine Errungenschaft unserer Moral- und Rechtskultur, die auch durch diejenigen, die der Sterbehilfe das Wort reden, nicht in Frage gestellt wird.

Haben wir *selbst* das Recht auf eine solche Freiheit, haben wir die Freiheit, andern dieses Recht zu gewähren? Hier beginnen dann für mich die eigentlichen, schwierigen Fragen. Verengen wir nicht unsern Blickhorizont, wenn wir nur auf diese Freiheit der Selbstbestimmung achten und, gebannt durch das moderne Ideal von Freiheit und Selbstbestimmung, übersehen, dass mit der Entscheidung über den eigenen Tod immer schon mehr als nur die Frage nach der Ausübung unserer Entscheidungsfreiheit gestellt ist? Was ist der Sinn unserer Freiheit, wie, wozu wollen, ja vielleicht auch: sollen wir sie gebrauchen?

Tod und Sterben stellen uns so die Frage nach den Möglichkeiten unserer Freiheit, aber auch nach den frei akzeptierten Grenzen unserer eigenen Freiheit.

Die Antworten von Menschen auf diese existenzielle Frage nach dem Sinn unserer eigenen verantwortlichen Freiheit sind verschieden. Aber das ist nun einmal das Wesen der Freiheit. Und das scheint uns nun wichtig: Wir sind keine Schiedsrichter, die über Wahrheit und Falschheit dieser Antworten das gültige Regelbüchlein hätten. Auch nicht als Theologen. Was wir aber wohl können und müssen, ist, uns einzuschalten in diese Fragen nach Sinn und Ziel des menschlichen Lebens und Sterbens, ist, uns einzumischen, wenn uns gegebene Antworten dürftig, löcherig, hoffnungslos erscheinen, wenn sie zu Unrecht und Unmenschlichkeit im Umgang miteinander führen. Das, denke ich, sind wir einander in Solidarität schuldig.

Aber auch dann nicht mit einem Regelbüchlein, sondern im respektvollen Umgang mit andern Sichtweisen, um in gemeinsamem Sprechen und Nachdenken unsere Alternativen auszulegen, in ihrer Sinnhaftigkeit sichtbar zu machen, als Möglichkeit anzubieten, sie miteinander zu versuchen zu verwirklichen. Damit komme ich zu meinem letzten Punkt.

3. AUTONOMIE UND FÜRSORGLICHKEIT

Menschen leben nicht für sich allein. Autonomie kann Ausdruck gesellschaftlicher Anerkennung sein, sie kann aber auch Ausdruck gegenseitigen Desinteresses sein. Unter dem Deckmantel der zugestandenen Selbstbestimmung verbirgt sich dann allzu leicht die Verabschiedung aus der Sorge füreinander. Es erscheint mir darum wichtig, den Gedanken der Autonomie einzubetten in den Gedanken der gemeinschaftlichen Fürsorge füreinander. Gegenüber einer Autonomie der Einsamkeit ist eine Autonomie- in- Beziehungen, eine *relationale Autonomie*, zu entwickeln. Namentlich von feministischen Überlegungen her wird versucht, gegenüber einer abstrakt verstandenen Ethik der Gerechtigkeit eine Sorge- oder Fürsorgeethik (*ethics of care*) zu entwickeln, oder, so würde ich lieber sagen, ihr zur Seite zu stellen.

Mit diesem Versuch werden Grundeinstellungen unseres gesellschaftlichen Zusammenlebens zur Sprache gebracht und in Frage gestellt. Vor allem ein dominantes individualistisches Verständnis der Gesellschaft von den Rechten und Pflichten her, die einem jeden und einer jeden zukommen.

Erst in einer Grundhaltung des Offenstehens für die andern und der sich daraus nährenden Idee des Füreinander- Verantwortlichseins entsteht die Sensibilität dafür, welche Hilfe wir voneinander erwarten können und einander geben können oder gar geschuldet sind, aber auch, was wir einander zumuten können und wo die Grenzen unserer Ansprüche liegen, welche Entscheidungen wir einander überlassen, und wie wir andere in die verantwortungsvolle Pflicht nehmen können, ohne sie zu überfordern, und schließlich, wie sich solche Einsichten in rechtlichen Regelungen niederschlagen oder für diese nicht mehr zugänglich sind.[9] Dies gilt auch gegenüber einer allzu formalen Betrachtung der Patientenautonomie.

Einige Folgerungen für unsere aktuelle Frage will ich kurz nennen. Wie hängen Autonomie und Fürsorglichkeit zusammen? Drei kurze Gedanken hierzu.

3.1 Fürsorglichkeit kann nicht bestehen in einer Ablehnung oder Relativierung von Patientenautonomie, sondern sollte sich eher verstehen als Beitrag zu einem reiferen Verständnis von Autonomie

Dies setzt zunächst einmal eine große Bereitschaft zur Anerkennung des Rechtes auf Eigenentscheidung voraus.

Nicht gegen Autonomie, sondern im Bunde mit Autonomie müssen Entscheidungen über Leben und Tod entstehen.

Vom Gedanken der durch Gott geschenkten und gewollten Würde des Menschen her darf, ja muss auch die theologische Ethik die Autonomie der Person verteidigen und zugleich versuchen, sie vor Verengungen zu schützen, Verengungen nicht nur durch Egozentrik,[10] sondern auch durch Missachtung der Freiheit und Eigenverantwortung, die der Person zukommen, vonseiten anderer. Verengungen aber auch durch eine abstrakt zwar verteidigte Selbstbestimmung, die aber konkret durch die Umstände, durch Armut, Schmerz, Mangel an Pflege und Zuwendung abgewürgt wird, so dass Selbstbestimmung eigentlich nicht mehr ist, als die verzweifelte Wahl des als kleiner erachteten Übels.

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[9] Vgl. hierzu und zum Folgenden meine Überlegungen „Perspektiven der klinischen Sterbehilfe aus der Sicht des katholischen Moraltheologen“, in: *V. Schumpelick* (Hg.), Klinische Sterbehilfe und Menschenwürde. Ein deutsch-niederländischer Dialog, Freiburg 2003, S. 327-353.

[10] Vgl. die Ausführungen über Autonomie als „relationale Autonomie“ bei *Chr. Gastmans*, Zorg voor een menswaardig levenseinde in het christelijk ziekenhuis. Ethische oriëntaties bij de euthanasiewet, in: *Collationes* 32 (2002), S. 227-242.

Fürsorglichkeit beweist sich daher z.B. auch keineswegs darin, einem früher getroffenen Wunsch auf Verzicht von Weiterbehandlung sozusagen zunächst einmal prinzipiell den Zweifel entgegen zu setzen. Dies ist eine durchaus doppeldeutige Wohlmeinendheit. Wichtig ist, dass Menschen nicht mit der Angst leben müssen, dass ihre Willenserklärung nicht im Maße des Möglichen respektiert wird. Hierdurch würde der Wunsch nach dem Recht auf Sterbehilfe ja geradezu gefördert statt gemindert.

Fürsorglichkeit braucht sich allerdings umgekehrt auch nicht darin zu erschöpfen, sich ein isolierendes Verständnis von Autonomie zu eigen zu machen und ihre Grenzen ausschließlich im Respekt vor einmal getroffenen Patientenentscheidungen zu sehen. Vom Gedanken der Fürsorglichkeit ergibt sich durchaus auch die Pflicht des Abwägens der Relevanz einer solchen Verfügung.

Fürsorglichkeit bedeutet schließlich auch nicht den Verzicht auf deutliche Rechtsregelungen. Auch das Recht ist Fürsorge füreinander. Wohl muss man sich gegen die Versuchung allzu großer Eindeutigkeit wenden, wo diese nicht gegeben ist. Die juristisch sauberste Lösung ist eben längst nicht immer die beste; oft ist sie lediglich die simpelste. Was daher auch wohl zur Fürsorglichkeit gehört, ist das Bewusstsein von der Begrenztheit des Rechtes. Von daher plädiere ich für eine nähere und immer wieder neu aufzugreifende Ausgestaltung der Grundsätze, nach denen einem Patienten, einer Patientin billigerweise Unerträglichkeit des Leidens, oder der Situation zugestanden werden sollte und deshalb eventuell auch auf mögliche Behandlungen verzichtet werden darf.

3.2 Fürsorglichkeit bedeutet nicht nur, Menschen zum Leben zu helfen, sondern auch, wenn es an der Zeit ist, ihr Sterben zu begleiten

Ein wichtiger Aspekt einer fürsorglichen Einstellung bleibt es allerdings, wie schon im Kontext der Euthanasiedebatte immer wieder gefordert wurde, bereits im weiten Vorfeld von Patientenverfügungen die Gewissheit entstehen zu lassen, dass zwischen Abbruch jeder Behandlung und dem wenig sinnvollen medizinischen Einsatz aller

Mittel Alternativen bereit stehen und dass auch Menschen bereit sind, nach diesen Alternativen verantwortlich zu handeln.

Hierhin gehören sowohl die Fragen von Palliativmedizin und Hospizwesen, wie anderseits aber auch ein erneutes Überlegen der alten, leider nicht mehr so seriös genommenen Unterscheidungen zwischen Tun und Lassen, aktiv und passiv, direkt und indirekt in der Begleitung von Menschen in ihrer letzten Lebensphase, und a fortiori, wenn es sich nicht um diese letzte Phase handelt. Man muss zugeben, dass die Grenzen zwischen aktiv und passiv unscharf geworden sind. Angesichts dieser Entwicklungen bedarf es eines gewissen juristischen Spielraumes für Entscheidungen (des Arztes, aber vielmehr noch aller Betroffenen), die als vertretbar durch die Rechtsgemeinschaft akzeptiert werden, ohne dass man sie stets in universellen Regeln verallgemeinern könnte.

Eine scharfe Grenzziehung ist nicht immer möglich. Aber auch eine unscharfe Abgrenzung kann davor bewahren, falsche Konsequenzen zu ziehen, sei es die Konsequenz, im Grunde seien alle Handlungen mit gleichem Effekt gleich; oder sei es die Konsequenz, dass man alles unterlässt, was die Grenze vom passiven Geschehenlassen zum aktiven Tun hin eventuell zu überschreiten droht. Zum Beispiel: Man vermeidet Unterlassungen medizinischer Behandlung, weil dies als verweigerte Hilfeleistung interpretiert werden könnte.

Vor allem in Deutschland scheint diese Furcht sehr lange das ärztliche Berufsethos mit beeinflusst zu haben. Eine deutliche Änderung zeichnet sich m.E. ab mit den jüngeren Richtlinien der Bundesärztekammer zur ärztlichen Sterbebegleitung (1998; 2004).

In derartigen Überlegungen zeigt sich ein Wandel im ärztlichen Berufsethos an, der übereinstimmt mit der Sichtweise weiter Kreise der Gesellschaft: Die ärztliche Begleitung und Hilfe endet nicht vor der Grenze des Sterbens, sondern gehört auch in den Sterbensprozess hinein. Sie ist nicht allein dem Lebenserhalt gewidmet, sondern kann ihre aktive Aufgabe auch haben im „Sterbenlassen“. Auch das ist eine Frage der Fürsorglichkeit.

3.3 Fürsorglichkeit gilt auch gegenüber Arzt und Ärztin, dem Pflegepersonal, sowie Betreuern und Bevollmächtigten

Man darf von diesen nicht erwarten, dass sie aufgrund eines formalisierten Verfahrens überfordert werden, gegen ihr Berufsethos bzw. gegen ihre eigene Einschätzung der Situation zu entscheiden. Ärzte haben neben dem Respekt vor dem Patientenwillen auch ein medizinisches Berufsethos zu vertreten, das von ihnen verlangt, die ärztliche Kunst nach Möglichkeit lebensermöglichend und lebenserhaltend einzusetzen, wofern dadurch Chancen der Besserung wahrgenommen werden, sich die Frage nach Verlängerung unerträglichen Leidens nicht stellt und jedenfalls nicht ein „natürlich" sich anbahnendes Ende unnötig hinausgezögert wird. Lebensverlängerung als solche ist nicht in jedem Falle Aufgabe der Ärzte.

Umgekehrt: Die Autonomie des Patienten oder der Patientin kann nicht so weit gehen, dass ihr gegenüber die normale ärztliche Pflicht immer nur den kürzeren ziehen würde.

Wenn aber derartige Konflikte auftreten, dann soll eine Handlungsentscheidung breiter getragen werden und nicht den Schultern von einigen wenigen Berufsverantwortlichen aufgelastet werden.[11]

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[11] Diese Fürsorglichkeit betrifft z.B. auch die Ärztinnen und Ärzte, denen die Gesellschaft gleichsam die Verantwortung für Leben und Tod zuschiebt. In einem sehr nachdenklich stimmenden Vortrag über „unerträgliches Leiden" hat die Tilburger Kollegin A. van Heijst auf die Ambivalenz einer vielleicht „rational"-ethischen Akzeptanz der durch das niederländische Gesetz ermöglichten Euthanasie bei einem gleichzeitigen ethisch relevanten spontanen „Gefühl" der Zumutung, die in der Forderung von Euthanasie gelegen ist, hingewiesen (*A. van Heijst*, „Euthanasie - Verschil tussen zorgen voor en zorgvuldig omgaan met..." (Vortrag Theologische Faculteit Tilburg, 29.1.2001, Internet-Publikation, online unter http://www.uvt.nl/faculteiten/tft/nieuws/nieuwsoverzicht/euthanasie/heijst.html). Vgl. auch ihren Beitrag jüngst zur Zumutung an die Ärzte, selbst über die Frage der Unerträglichkeit des Leidens, also einen subjektiven Zustand objektiv urteilen zu sollen: *A. van Heijst*, „Über die Verantwortung von Ärzten bei ‚unerträglichem Leiden':

Weder darf das ärztliche Berufsethos unterhöhlt werden, noch darf man die Ärzte sozusagen mit ihrem Berufsethos alleine lassen. Und wenn schon gewagte Entscheidungen zu treffen sind, dann soll sich die Gesellschaft als ganzes dessen bewusst sein. Womit wir wieder bei der Rechtsordnung wären.

Autonomie ist nicht nur schön und wertvoll, sie ist oft auch eine Last, so oder so. Autonomie auch als Fürsorge zu verstehen, lässt uns diese Last leichter tragen.

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eine moraltheologische Reflexion“, in: *J. Jans* (Hg.), Für die Freiheit verantwortlich, Festschrift für Karl-Wilhelm Merks zum 65. Geburtstag, Fribourg/Freiburg 2004, S. 251-264.

AUTONOMIE UND FÜRSORGE

Die Perspektive des Rechts

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1. EINLEITUNG

In der aktuellen Debatte um die so genannte „Sterbehilfe“ stellt Autonomie einen zentralen Begriff dar. Die Autonomie des Patienten wird vielfach als Schlüssel zur Lösung der schwierigen Rechtsprobleme angesehen, die aus der Forderung nach einem menschenwürdigen Sterben entstanden sind. Autonomie ist jedoch nicht einfach vorhanden, sondern beruht ihrerseits auf Voraussetzungen. Insbesondere die Ärzte und Pflegenden weisen auf die Notwendigkeit der Fürsorge für den Patienten hin. Im Folgenden soll daher zunächst der für das moderne Recht zentrale Begriff der Autonomie und sein Verhältnis zur Fürsorge aus Sicht vor allem des positiven deutschen Rechts behandelt werden (2.), bevor dann im Weiteren die Probleme der „Sterbehilfe“ erörtert werden (3.).

2. AUTONOMIE UND FÜRSORGE IM RECHT[1]

Rechtlich gesehen sind Autonomie und Selbstbestimmung eines Menschen keine tatsächlichen Eigenschaften, sondern ergeben sich aus der Anerkennung des Menschen als Rechtsperson durch die

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[1] Die dem 2. Abschnitt zugrunde liegenden Gedanken sind näher ausgeführt in *Lipp*, Freiheit und Fürsorge. Der Mensch als Rechtsperson, Tübingen 2000.

Rechtsordnung. Sie sind also Folge eines Rechtsaktes, der sich zwar einerseits auf die tatsächlichen Fähigkeiten eines Menschen bezieht, ihnen aber andererseits erst rechtliche Bedeutung vermittelt. Dieser Akt der Anerkennung ist durch die tatsächlichen Verhältnisse nicht determiniert, sondern erfordert eine Entscheidung des demokratisch legitimierten Gesetzgebers unter Abwägung verschiedener Gesichtspunkte.

2.1 Mündigkeit, Handlungsunfähigkeit und gesetzlicher Vertreter

In der rechtlich konstituierten Autonomie des Menschen liegt der gemeinsame Bezugspunkt der verschiedenen Rechtsinstitute der Mündigkeit, der unmittelbaren bzw. „natürlichen“ Handlungsunfähigkeit (Geschäftsunfähigkeit, Testierunfähigkeit, Einwilligungsunfähigkeit, Deliktsunfähigkeit usw.), der Betreuung und der elterlichen Sorge. Die *Mündigkeit* bedeutet die generelle Zulassung des einzelnen zum Rechtsverkehr durch die Festlegung einer Altersgrenze für Alleinentscheidungsbefugnis und Alleinverantwortung und damit seinen Status. Demgegenüber setzt die *unmittelbare Handlungsunfähigkeit* diese generelle Zulassung voraus und schließt die Anerkennung für eine konkrete einzelne Rechtshandlung aus, wenn die Eigenverantwortlichkeit tatsächlich fehlt. Sie betrifft allein die jeweilige Rechtshandlung. Die *Betreuung* hat die Funktion, die Selbstbestimmung des Betreuten herzustellen und zu verwirklichen und ihn einem Mündigen gleichzustellen, wenn und soweit seine tatsächliche Eigenverantwortlichkeit gemindert ist. Diese Aufgabe umfasst sowohl die Herstellung der Handlungsfähigkeit im Rechtsverkehr als auch den Schutz von Person und Vermögen des Betroffenen. Die *elterliche Sorge* für das Kind hat in erster Linie die Aufgabe, das Kind zu erziehen. Hinzu treten die Aufgaben, das noch minderjährige (unmündige) Kind zu vertreten und es zu schützen.

Verfassungsrechtlich gesehen verwirklichen die elterliche Sorge für Kinder und die Betreuung für Erwachsene deren Würde in Freiheit und Gleichheit. Sie sind damit durch Art. 1 I 2, 3 I GG bzw. die

Freiheitsrechte der EMRK zugleich legitimiert und gefordert. Auch die unmittelbare Handlungsunfähigkeit findet in diesen Vorschriften ihre verfassungsrechtliche Grundlage und ihre Rechtfertigung als Mindestschutz des Betroffenen im Rechtsverkehr. Der Gesetzgeber hat demgemäß die Aufgabe, die Eigenverantwortlichkeit des einzelnen als Grundrechtsvoraussetzung zu konkretisieren und auszugestalten, darf dabei aber die Grundrechtsausübung nicht inhaltlich determinieren. Der Primat der Fürsorge durch die Eltern für das Kind wird durch Art. 6 II GG, Art. 8 I EMRK, der Primat der Familienangehörigen bei der Betreuung für einen Erwachsenen durch Art. 6 I GG, Art. 8 I EMRK garantiert.

2.2 Voraussetzungen für die Handlungsunfähigkeit und die Betreuung

Wegen des gemeinsamen Bezugs auf die Selbstbestimmung des einzelnen markieren die vom Gesetzgeber festgesetzten Altersgrenzen für die Mündigkeit und ihre Abstufungen nicht nur den Grad der Eigenverantwortlichkeit, von dem ab ein Mensch zum Rechtsverkehr zugelassen wird (Mündigkeit), sondern zugleich umgekehrt, ab wann diese generelle Anerkennung wieder punktuell entzogen (unmittelbare Handlungsunfähigkeit, z.B. § 104 Nr. 2 BGB) oder beschränkt (Betreuung, § 1896 BGB) werden kann und muss. Sie legen damit die personalen Voraussetzungen für Entzug und Beschränkung der Selbstbestimmung fest.

Demnach verlangt die unmittelbare Handlungsunfähigkeit in personaler Hinsicht, dass die für den jeweiligen rechtlichen Handlungstyp rechtlich geforderten tatsächlichen Fähigkeiten hinter denen eines durchschnittlichen 7-jährigen Kindes zurückbleiben (vgl. § 104 Nr. 1 BGB). Die Betreuung setzt demgegenüber voraus, dass die Fähigkeiten des Betreuten im Aufgabenbereich des Betreuers hinter denjenigen eines typischen 14-Jährigen zurückbleiben, denn mit 14 Jahren erlangt ein Kind nach deutschem Recht zum ersten Mal die Mündigkeit für bestimmte Teilbereiche seiner Angelegenheiten.

Die mit der Mündigkeit verbundene Anerkennung der Autonomie des einzelnen schließt es in jedem Fall (auch verfassungsrechtlich) aus, dass das staatliche Gericht dabei auf einen außerrechtlichen Maßstab zurückgreift und die Handlungen des Betroffenen auf ihre „Vernünftigkeit“, „Vertretbarkeit“ o.ä. beurteilt.

Über die handlungsbezogenen Voraussetzungen der unmittelbaren Handlungsunfähigkeit entscheidet deshalb nicht der sachliche Inhalt oder die wirtschaftliche oder persönliche Bedeutung der konkreten einzelnen Handlung, sondern allein die Art der rechtlichen Zurechnung und die rechtliche Ausgestaltung des gewählten Handlungstyps. Die Deliktsfähigkeit betrifft die Fähigkeit, eine bestimmte, bereits bestehende Rechtspflicht einzuhalten. Jemand ist also unmittelbar deliktsunfähig, wenn seine tatsächliche Fähigkeit, die konkret verletzte Rechtspflicht einzuhalten, hinter der eines durchschnittlichen 7-jährigen Kindes zurückbleibt. Unmittelbar geschäfts-, prozess-, testier-, ehegeschäfts- oder einwilligungsunfähig ist dagegen jemand, dessen tatsächliche Fähigkeit, die rechtliche Bedeutung und Tragweite des jeweiligen Rechtsaktes zu verstehen und danach zu handeln, hinter der eines durchschnittlichen 7-Jährigen zurückbleibt. Geschäfts-, Prozess-, Ehegeschäfts-, Testier- und Einwilligungsunfähigkeit sind nur verschiedene Ausprägungen eines einheitlichen Grundsatzes. Ihre Verschiedenheit beruht allein auf den Unterschieden zwischen dem Typ des jeweiligen Rechtsaktes und seiner rechtlicher Ausgestaltung. Auch im Rahmen der unmittelbaren Geschäftsunfähigkeit ist daher nach der rechtlichen Ausgestaltung des jeweiligen Typs des konkreten Rechtsgeschäfts bzw. der rechtsgeschäftsähnlichen Handlung zu differenzieren. Eine wirtschaftliche Geschäftsunfähigkeit ist demgegenüber ebenso wenig anzuerkennen wie eine relative, d.h. an der Schwierigkeit des Geschäfts orientierte Geschäftsunfähigkeit.

2.3 Aufgabe der Betreuung

Die Betreuung hat die Autonomie des Betreuten in zweifacher Weise zu verwirklichen. Sie hat zum einen seine Handlungsfähigkeit herzustellen und ihn zum anderen davor zu schützen, sich aufgrund seines

Zustandes selbst an Person oder Vermögen zu schädigen. Dieser Schutz des Betreuten vor sich selbst ist betreuungs- wie verfassungsrechtlich nur zulässig, wenn und soweit er sich gerade aufgrund seiner beschränkten Eigenverantwortlichkeit selbst zu schädigen droht oder deswegen eine Gefahr für seine Person oder Vermögen nicht abwehren kann.

Dabei gewährleisten die privatrechtliche Organisation der Betreuung und das Zusammenspiel eines staatsfreien und selbständigen Betreuers mit dem kontrollierenden Vormundschaftsgericht die Autonomie des Betreuten auch gegenüber dem Staat. Das Vormundschaftsgericht stellt zwar die mangelnde Eigenverantwortlichkeit und den künftigen Fürsorgebedarf fest, die konkrete Entscheidung oder Handlung des Betreuten beurteilt jedoch allein der staatsfreie Betreuer. Die Anordnung der Betreuung durch das Vormundschaftsgericht schafft lediglich die generellen Voraussetzungen dafür, den Betreuten vor einer Selbstschädigung zu schützen. Erst der Betreuer verwirklicht diesen Schutz im konkreten Fall. Er (und nicht das Vormundschaftsgericht) hat daher zu prüfen, ob sich der Betreute durch seinen Wunsch selbst schädigen würde und dies auf dem vom Vormundschaftsgericht festgestellten Grund für die Anordnung der Betreuung beruht. Nur wenn und soweit dies zutrifft und demnach die materiellen Voraussetzungen dieses Schutzes im jeweiligen Einzelfall erfüllt sind, ist der Betreuer legitimiert, den Betreuten vor sich selbst zu schützen. Das Vormundschaftsgericht kontrolliert nur, ob er dabei seine Befugnisse missbraucht, d.h. gegen seine Pflichten als Betreuer verstößt.

Schutz und Hilfe hat die Betreuung zum einen hinsichtlich des Handelns im Rechtsverkehr zu gewährleisten, zum anderen bei der Wahrnehmung der tatsächlichen Handlungsmöglichkeiten. Schutz vor einer Selbstschädigung des Betreuten durch sein *Handeln im Rechtsverkehr* gewährleisten die gesetzliche Vertretung (§ 1902 BGB) und der Einwilligungsvorbehalt (§ 1903 BGB). Die Anordnung eines Einwilligungsvorbehaltes ist nur erforderlich, wenn die vorbeugende Kontrolle des Betreuers nicht schon auf freiwilliger Basis erfolgt, sondern rechtlich erzwungen werden muss. Der Betreuer darf seine Einwilligung im konkreten Fall nur versagen, wenn die materiellen Voraussetzungen für einen Schutz des Betreuten vor sich selbst erfüllt sind, d.h. sich der Betreute durch seinen Wunsch selbst schädigen würde und dies auf dem vom Vormundschaftsgericht festgestellten Grund für die Anordnung der Befugnis beruht.

Das Instrumentarium der gesetzlichen Vertretung und des Einwilligungsvorbehalts reicht jedoch nicht aus, um den Betreuten vor einer *Selbstschädigung durch faktische Einwirkungen* zu schützen. Hinzu tritt die Befugnis des Betreuers, seine Entscheidung ggf. auch gegenüber dem Betreuten durchzusetzen und dessen tatsächliches Handeln entgegen dessen Wunsch, d.h. dessen „natürlichen Willen“, zu bestimmen (*Bestimmungsbefugnis*). Ihre praktisch bedeutsamsten Anwendungsfälle sind die Befugnis zur Aufenthaltsbestimmung und Unterbringung, sowie zur Zwangsbehandlung; sie bildet aber z.B. auch die Grundlage für die „Unterbringung in der eigenen Wohnung“ des Betreuten. Als betreuungsrechtliches Instrument zum Schutz des Betreuten vor sich selbst ist sie sowohl privatrechtlich als auch verfassungsrechtlich gefordert und legitimiert.

Übt der Betreuer die Bestimmungsbefugnis nicht selbst aus, sondern *ermächtigt einen Dritten* zu ihrer Ausübung, bedarf diese Ermächtigung der Genehmigung des Vormundschaftsgerichts, um den Betreuten vor der faktisch unkontrollierten Gewalt eines privaten Dritten zu schützen. Dies bildet Grund und Grenze der Genehmigungspflicht für die Freiheitsentziehung des Betreuten (§ 1906 I und IV BGB). Jede Freiheitsentziehung durch einen anderen als den Betreuer ist deshalb genehmigungspflichtig.

2.4 Wunsch und Wohl des Betreuten

In der *Binnenstruktur* der Betreuung schlägt sich ihre doppelte Funktion nieder in der normativen Orientierung auf das subjektive Wohl des *äußerungsunfähigen* Betreuten (§1901 II BGB) und in Bindung des Betreuers an die Wünsche des *äußerungsfähigen* Betreuten, sofern dies dessen Wohl nicht widerspricht (§ 1901 III 1 BGB). Diese beiden Absätze des § 1901 BGB betreffen daher verschiedene Fälle.

Bei § 1901 III BGB geht es weder um das objektivierte Wohl bzw. die Interessen des Betreuten, denen der Betreuer entgegen dem Wunsch des *äußerungsfähigen* Betreuten Geltung zu verschaffen hätte, noch um eine willkürliche Abwägung von objektivem Interesse und subjektivem Wunsch, sondern um den Schutz des Betreuten vor sich selbst.

Ist der Betreute dagegen *äußerungsunfähig* und hat er auch früher keinen Wunsch geäußert, kommt es allein darauf an, wie der Betreute selbst entscheiden würde. Für diesen Fall enthält § 1901 II BGB eine normative Zielvorgabe für den Betreuer, die Entscheidung aus der subjektiven Sicht des Betreuten zu treffen.

Auf der Grundlage dieses Ansatzes lassen sich Antworten auf zahlreiche, in Praxis und Wissenschaft bislang sehr umstrittene Einzelfragen entwickeln: So erweist sich z.B. im Hinblick auf die *ärztliche Behandlung* ein Abbruch der vom Betreuten gewünschten Behandlung regelmäßig als unzulässig, weil die Weiterbehandlung meist nicht mit einer Selbstschädigung verbunden ist. Andererseits ist eine Zwangsbehandlung entgegen dem Wunsch des Betreuten nur dann zulässig, wenn dieser Wunsch gerade Ausdruck des eingeschränkten Eigenverantwortlichkeit ist, er sich gegen eine medizinisch notwendige und erfolgversprechende Behandlung richtet und der Betreute, ohne diese Behandlung zu sterben oder einen schweren und länger dauernden gesundheitlichen Schaden zu erleiden droht. In allen anderen Fällen ist eine weitere Behandlung gegen den Wunsch des Betreuten unzulässig. Insbesondere ist daher sein Veto gegen eine vom Betreuer befürwortete Behandlung beachtlich, die nicht mehr sein Grundleiden heilt sondern nur sein Leben und damit sein Leiden zu verlängern vermag.

Das *Außenverhältnis* ist durch die Abstraktion der Vertretungsmacht des Betreuers von der Pflichtbindung im Innenverhältnis gekennzeichnet. Sie gewährleistet die Selbständigkeit der um des Betreuten willen organisierten Rechtsperson gegenüber Dritten im Rechtsverkehr, weil sie deren unmittelbare Einmischung verhindert. Die Abstraktion findet ihre Grenze im evidenten Pflichtverstoß des Betreuers. Die damit verbundene Sicherheit für den *Rechtsverkehr mit dem Betreuer* ist nicht Grund, sondern Folge dieser Abstraktion.

Gleiches gilt für den *Rechtsverkehr mit dem Betreuten*. Die Mitwirkung des Betreuers erfolgt allein im Interesse des Betreuten. Gleichwohl gewährleistet sie Dritten Rechtssicherheit im Verkehr mit dem Betreuten. Da nämlich bereits der Betreuer den Betreuten davor schützt, sich aufgrund seiner eingeschränkten Eigenverantwortlichkeit selbst zu schädigen, ist ein zusätzlicher Schutz durch die §§ 104 Nr. 2, 105 II BGB (unmittelbare Geschäftsunfähigkeit, Einwilligungsunfähigkeit) nicht mehr gerechtfertigt. Denn sie führen nur zu einem Mindestschutz des Betroffenen, der in dem umfassenden Schutz durch die Betreuung bereits enthalten ist. Die Beteiligung des Betreuers schließt daher die Anwendung der §§ 104 Nr. 2, 105 II BGB aus. Die Frage der unmittelbaren Geschäfts- oder Einwilligungsunfähigkeit des Betreuten kann daher – wie vom Gesetzgeber beabsichtigt – offen bleiben. Das gilt unabhängig davon, ob die Beteiligung des Betreuers freiwillig oder infolge eines bestehenden Einwilligungsvorbehaltes rechtlich erzwungen ist. Entscheidend ist allein, dass er in vollem Umfang beteiligt wird, d.h. vom Arzt aufgeklärt wird, die verbraucherrechtlich vorgeschriebenen Informationen erhält usw.

3. AUTONOMIE UND FÜRSORGE AM LEBENSENDE: DIE PROBLEMATIK DER SO GENANNTEN „STERBEHILFE“

In der Debatte um die ärztliche Behandlung am Lebensende ist mittlerweile anerkannt, dass auch eine lebenserhaltende ärztliche Behandlung einerseits *ärztlich indiziert* sein muss und dass die grundrechtlich geschützte *Patientenautonomie* andererseits dem Patienten das Recht gibt, sich für oder gegen diese Behandlung zu entscheiden.[2] Bedeutung und Tragweite dieser Grundsätze sind jedoch heftig

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[2] Vgl. *Lipp*, Patientenautonomie und Lebensschutz. Zur Diskussion um eine gesetzliche Regelung der „Sterbehilfe“, 2005, 5, 11 ff.; *Taupitz*,

umstritten. Die rechtspolitische Debatte[3] hat bislang noch nicht zu einer gesetzlichen Regelung geführt. Will man sich in dieser unübersichtlichen Diskussion Klarheit verschaffen, muss man daher *das geltende Recht* analysieren (3.1-3.4), bevor man zur aktuellen *rechtspolitischen Debatte* Stellung nimmt (3.5).

3.1 Die Entwicklung der Rechtsprechung[4]

Zu Beginn der Rechtsprechung stehen strafgerichtliche Entscheidungen, die die Einstellung lebenserhaltender Maßnahmen auf Wunsch des Patienten („passive Sterbehilfe“)[5] für grundsätzlich zulässig erklärten, ebenso die ärztlich gebotene und mit Einwilligung des Patienten erfolgende Gabe von Medikamenten, die als Nebenwirkung das Leben des Patienten verkürzt („indirekte Sterbehilfe“).[6] Die Zivilgerichte bejahten dann die Frage, ob auch ein Vertreter die Einstellung lebenserhaltender Maßnahmen verlangen kann und forderten nur in Konfliktfällen eine vormundschaftsgerichtliche Genehmigung.[7] Diese Entscheidungen sind jedoch im Grundsatz wie in den Einzelheiten umstritten.[8]

Gutachten A zum 63. Deutschen Juristentag (DJT), 2000, A 12 ff.; *Verrel*, Gutachten C zum 66. DJT, 2006, C 70 ff.

[3] Die wichtigsten aktuellen Berichte und Stellungnahmen sind u. a. zusammengestellt auf http://www.aem-online.de/aemaktuell/patientenautonomie.htm (Stand: April 2007); vgl. i. Ü. die Nachweise in der vorigen Fn.

[4] Vgl. auch *Verrel* (Fn. 2), C 13 ff.

[5] *BGHSt* (Entscheidungen des Bundesgerichtshofs in Strafsachen) 37, 376 (379); 40, 257 (262).

[6] *BGHSt* 42, 301 (305); 46, 279 (284 f.).

[7] *BGHZ* (Entscheidungen des Bundesgerichtshofes in Zivilsachen) 154, 205 ff.; dazu *Lipp*, Zeitschrift für das gesamte Familienrecht (FamRZ) 2004, 317 ff.; *BGHZ* 163, 195 ff. m. Anm. *Lipp/Nagel*, Lindenmaier-Möring, kommentierte BGH-Rechtsprechung (LMK) 2006 (Beck-online Datenbank, 166262).

[8] Überblick bei *Lipp*, Patientenautonomie (Fn. 2), 5 ff.; *Verrel* (Fn. 2), C 15 ff., C 34 ff.

Wir werden uns deshalb zunächst mit den Grundfragen der ärztlichen Behandlung am Lebensende befassen (dazu 3.2), um dann die Rolle des Vertreters (dazu 3.3) und die Bedeutung der Patientenverfügung (dazu 3.4) nach geltendem Recht zu klären.

3.2 Ärztliche Behandlung am Lebensende

a. Rechtliche Struktur der ärztlichen Behandlung

Für die ärztliche Behandlung eines Menschen am Ende seines Lebens gilt dasselbe wie für jede andere Behandlung. Die dialogische Struktur des Behandlungsprozesses drückt sich in der Verpflichtung des Arztes aus, den Patienten kontinuierlich zu beteiligen und über die Bedeutung und Tragweite der vorgeschlagenen Schritte zu informieren. Dieser fachlichen Kompetenz folgt die rechtliche Verantwortung: Der Arzt verantwortet die fachgerechte Untersuchung, Diagnose sowie Indikation und hat den Patienten hierüber jeweils aufzuklären. Der Patient entscheidet, ob er in eine bestimmte ärztliche Maßnahme einwilligt.[9]

Der Arzt hat daher *kein* eigenständiges Behandlungsrecht. Recht und Pflicht zur Behandlung ergeben sich allein aus dem Auftrag des Patienten. Jede ärztliche Maßnahme bedarf einer zusätzlichen Einwilligung des Patienten, weil sie seine Patientenautonomie betrifft. Diese Einwilligung muss vor Beginn der Maßnahme eingeholt werden und setzt eine entsprechende Aufklärung durch den Arzt voraus.[10] Der Patient kann die Behandlung jederzeit ablehnen, also seine Einwilligung auch noch nach Beginn der Behandlung für die Zukunft widerrufen.

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[9] Zum Vorstehenden *Deutsch/Spickhoff*, Medizinrecht, 5. Aufl. 2003, Rn. 16, 187; *Uhlenbruck*, in: Laufs/Uhlenbruck, Handbuch des Arztrechts, 3. Aufl. 2002, § 52 Rn. 9.

[10] *BGHZ* 29, 46 (49 ff.); *BGH* Neue Juristische Wochenschrift (NJW) 1980, 1333; *BGH* NJW 1993, 2372 (2373 f.); vgl. *Laufs*, in: Laufs/Uhlenbruck (Fn. 9), § 61 Rn. 14 f., § 63.

Ein Verzicht auf den Widerruf (z.B. in einem Heimvertrag) ist wegen des Persönlichkeitsbezugs der Einwilligung ausgeschlossen.[11]

Diese rechtliche Grundstruktur der ärztlichen Behandlung missachtet, wer fragt, ob der Abbruch der Behandlung zulässig ist. Damit verkehrt man die Legitimationslast für eine ärztliche Behandlung in ihr Gegenteil. Denn nicht der Verzicht, sondern die *Aufnahme* der Behandlung, nicht ihr Abbruch, sondern ihre weitere *Durchführung* bedarf der Einwilligung des Patienten.[12] Auch eine lebensverlängernde Maßnahme ist nur zulässig, wenn und solange ihr der Patient zustimmt.[13] Behandelt der Arzt den Patienten gegen dessen Willen, begeht er eine Körperverletzung.

Die Patientenautonomie verleiht dem Patienten allerdings nur ein *Abwehrrecht* gegen eine vom Arzt vorgeschlagene Behandlung, verschafft ihm aber keinen Anspruch auf eine Behandlung. Es ist keine Frage der Patientenautonomie, ob z.B. eine bestimmte Behandlungsmethode von der Krankenkasse finanziert wird.[14] Vor allem kann der Arzt eine Behandlung verweigern, für die keine ärztliche Indikation besteht.[15] Ist eine Maßnahme gar kontraindiziert, darf er sie auch nicht auf ausdrücklichen Wunsch des Patienten durchführen.[16]

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[11] *BGHZ* 163, 195 (199); *Kohte*, Archiv für civilistische Praxis (AcP) 185 (1985), 105 (137 f.); *Deutsch/Spickhoff* (Fn. 9), Rn. 197.

[12] *BGHZ* 154, 205 (210 f., 212); 163, 195 (197); *BGHSt* 37, 376 (378); *Verrel* (Fn. 2), C 37 f.

[13] *BGHZ* 163, 195 (197 f.).

[14] Zur Verteilungsproblematik vgl. *Spickhoff*, NJW 2000, 2297 (2298); *Taupitz* (Fn. 2), A 25 ff.

[15] BGHZ 154, 205 (224); *Laufs*, NJW 1998, 3399 (3400); *Spickhoff*, NJW 2000, 2297 (2298); *Taupitz* (Fn. 2), A 23 f.

[16] *OLG Karlsruhe* Medizinrecht (MedR) 2003, 104 ff.; *OLG Düsseldorf* Zeitschrift für Versicherungsrecht (VersR) 2002, 611; *OLG Köln* VersR 2000, 492; *Deutsch/Spickhoff* (Fn. 9), Rn. 12, 198.

Hieran knüpft der BGH an, wenn er ausführt, dass für eine Einwilligung erst dann Raum sei, wenn der Arzt eine Behandlung „anbiete".[17] Damit wird deutlich, dass das Erarbeiten einer ärztlichen Indikation im konkreten Fall[18] zwar im Gespräch mit dem Patienten erfolgt,[19] aber letztlich allein in den Verantwortungsbereich des Arztes fällt.[20]

b. „Hilfe im Sterben" und „Hilfe zum Sterben"

Liegt ein Patient im Sterben, ist eine lebensverlängernde Behandlung nicht mehr indiziert.[21] Ihr Unterlassen bedeutet keine Tötung des Patienten. Geboten ist vielmehr ärztliche Hilfe und Begleitung im Sterbeprozess, die so genannte „Hilfe im Sterben".[22] Diese Änderung des Behandlungsziels muss zwar nach allgemeinen Grundsätzen zwischen Arzt und Patient besprochen werden. Die Entscheidung gegen lebenserhaltende Maßnahmen beruht jedoch auf der *fehlenden ärztlichen Indikation* und nicht auf einem Widerspruch des Patienten gegen diese Maßnahmen.[23]

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[17] *BGHZ* 154, 205 (225).

[18] *Spickhoff*, NJW 2003, 1701 (1709); *Taupitz* (Fn. 2), A 24.

[19] *Borasio/Putz/Eisenmenger*, Deutsches Ärzteblatt (DÄBl) 2003, A 2062 (2064).

[20] *Ankermann*, MedR 1999, 387 (389); *Dodegge/Fritsche*, Neue Justiz (NJ) 2001, 176.

[21] Vgl. die Grundsätze der Bundesärztekammer (BÄK) zur ärztlichen Sterbebegleitung vom 30.4.2004, Ziff. I., DÄBl 2004, A 1298; *Schreiber*, Festschrift Deutsch, 1999, 773 ff.; *Opderbecke/Weißauer*, MedR 1998, 395 (397); *Saliger*, Kritische Vierteljahresschrift für Gesetzgebung und Rechtswissenschaft (KritV) 2001, 382 (424ff.).

[22] *BGHSt* 40, 257 (260).

[23] *Ankermann*, MedR 1999, 387 (389); *Lipp*, in: May/Geißendörfer/Simon/Strätling, Passive Sterbehilfe: besteht gesetzlicher Regelungsbedarf?, 2002, 37 (52 f.); *Schwab*, in: Münchener Kommentar zum BGB (MünchKomm), 4. Aufl. 2002, § 1904 BGB Rn. 38.

Hält der Arzt dagegen eine Maßnahme für indiziert, obliegt es dem Patienten zu bestimmen, ob und wie er behandelt werden will. Lehnt er eine angebotene lebenserhaltende Maßnahme ab oder widerruft er seine Einwilligung, darf der Arzt diese Maßnahme nicht durchführen.[24] Stirbt der Patient deshalb, liegt darin keine Tötung, weil der Arzt gar nicht mehr behandeln darf. Es ist also kein Fall der „aktiven Sterbehilfe“, d.h. der Tötung auf Verlangen (§ 216 StGB). Vielmehr handelt es sich um die „Hilfe zum Sterben“ genannte Einstellung der Behandlung auf Wunsch des Patienten.[25]

Die Unterscheidung zwischen der „Hilfe beim Sterben“ in der Sterbephase und der „Hilfe zum Sterben“ in allen anderen Fällen verweist demnach auf die unterschiedlichen Gründe für die Einstellung der lebenserhaltenden Maßnahmen: Im Sterbeprozess ist sie zulässig, weil es an einer ärztlichen Indikation fehlt. Hat der Sterbevorgang noch nicht eingesetzt, muss eine ärztlich indizierte lebenserhaltende Maßnahme unterlassen oder abgebrochen werden, wenn es an der erforderlichen Einwilligung des Patienten fehlt.[26]

Der 1. Strafsenat des BGH umschrieb 1994 die Sterbephase dahingehend, dass das Grundleiden irreversibel ist, einen tödlichen Verlauf genommen hat und der Tod in kurzer Zeit eintreten wird.[27] Dieses *Abgrenzungskriterium* hat der 12. Zivilsenat in seinem Beschluss vom 17.3.2003 in einem die Gerichte nicht bindenden obiter dictum[28] als

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[24] *BGHZ* 163, 195 (197 f.); vgl. auch *Wagenitz*, FamRZ 2005, 669 (671).

[25] Zum Vorstehenden ausführlich *Lipp,* in: Passive Sterbehilfe (Fn. 23), 41 f.; *Hufen*, NJW 2001, 849 (851).

[26] Vgl. *BGHSt* 40, 257 (260); *Lipp*, Patientenautonomie (Fn. 2), 16 ff.; *Verrel* (Fn. 2), C 77 ff., C 99 ff.

[27] *BGHSt* 40, 257 (260), unter Hinweis auf die (damaligen) Richtlinien der BÄK, Ziff. II.d., MedR 1985, 38. Die heutigen Richtlinien (Fn. 21), Ziff. I, beschreiben sie als „irreversibles Versagen einer oder mehrerer vitaler Funktionen, bei denen der Eintritt des Todes in kurzer Zeit zu erwarten ist“.

[28] *Deutsch*, NJW 2003, 1567; *Lipp*, FamRZ 2003, 756.

strafrechtliche Grenze für die Zulässigkeit der „Sterbehilfe“ missverstanden: Er hielt einen Verzicht auf lebenserhaltende Maßnahmen nur in der Sterbephase für zulässig.[29] Eine solche Grenze existiert jedoch nicht und wurde vom 1. Strafsenat auch nicht aufgestellt.[30] Sie wäre im Übrigen ein verfassungswidriger Eingriff in das Selbstbestimmungsrecht des Patienten, weil er dann u. U. gegen seinen Willen zwangsweise behandelt werden würde.[31] Dieses unzutreffende obiter dictum hat der Senat inzwischen aufgegeben.[32] Allerdings bezeichnet er nun die strafrechtlichen Grenzen einer Sterbehilfe im weiteren Sinn („Hilfe zum Sterben“) als „nicht hinreichend geklärt“. Auch dies ist – wie gezeigt – unzutreffend. Eine gesetzliche Klarstellung würde hier allerdings zur dringend gebotenen Rechtssicherheit beitragen.[33]

3.3 Der entscheidungsunfähige Patient und sein Vertreter

a. Die Aufgabe des Vertreters

Ist der Patient einwilligungsunfähig, kann er weder mit dem Arzt die vorgeschlagenen Maßnahmen besprechen noch über ihre Durchführung entscheiden. Die fehlende tatsächliche Fähigkeit lässt allerdings das Recht des Patienten zur Selbstbestimmung nicht entfallen.[34]

Ist der Patient im Vorfeld der Behandlung (z.B. vor einer Narkose) von dem behandelnden Arzt informiert und aufgeklärt worden und hat er seine Einwilligung dazu erklärt, ist sein Selbstbestimmungsrecht

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[29] *BGHZ* 154, 205 (214 f.).

[30] Vgl. *BGHSt* 40, 257 (260 f.); *Kutzer*, Zeitschrift für Rechtspolitik (ZRP) 2003, 213 f.

[31] *Hufen*, ZRP 2003, 248 (252).

[32] *BGHZ* 163, 195 (200 f.).

[33] Vgl. zuletzt die Beschlüsse der strafrechtlichen Abteilung des 66. DJT 2006 zu II. Lebenserhaltende Maßnahmen und Behandlungsbegrenzung, abrufbar unter http://www.djt.de.

[34] *Lipp*, Deutsche Richterzeitung (DRiZ) 2000, 231 (233 f.); *Höfling*, Juristische Schulung (JuS) 2000, 111 (113 f.); *Hufen*, NJW 2001, 849 (850 ff.).

nach allgemeiner Ansicht gewahrt.[35] In allen anderen Fällen muss ein *Vertreter* an Stelle des Patienten dessen Rechte wahrnehmen und die nötigen Entscheidungen treffen. Hierzu ist zunächst die vom Patienten bevollmächtigte Vertrauensperson berufen,[36] andernfalls hat das Vormundschaftsgericht einen Betreuer als gesetzlichen Vertreter zu bestellen. In Eilfällen kann das Vormundschaftsgericht nach §§ 1908i Abs. 1, 1846 BGB unmittelbar selbst an Stelle eines Betreuers entscheiden. Nur falls auch das zu spät käme, darf und muss der *Arzt*[37] auf der Grundlage einer Geschäftsführung ohne Auftrag (§§ 677 ff. BGB) bzw., soweit es um den Eingriff in die körperliche Integrität geht, aufgrund einer mutmaßlichen Einwilligung des Patienten behandeln.[38]

Hat der Patient eine Vertrauensperson bevollmächtigt, umfasst die Vollmacht i. d. R. alle Behandlungsentscheidungen. Ebenso wird das Vormundschaftsgericht einem Betreuer regelmäßig die gesamte Gesundheitssorge zuweisen. Er ist dann auch zur Entscheidung befugt, ob lebensverlängernde Maßnahmen eingeleitet oder fortgesetzt werden sollen.[39] Ein Vertreter in Gesundheitsangelegenheiten hat jedoch nicht nur die Aufgabe, einer vom Arzt vorgeschlagenen Behandlung zuzustimmen oder sie abzulehnen. Er hat darüber hinaus die Rechte und Interessen des Patienten im *gesamten Behandlungsprozess* wahrzunehmen.

b. Handlungsmaßstab für den Vertreter

Der Vertreter des Patienten ist bei der Ausübung seiner Vertretungsmacht durch das jeweilige Innenverhältnis gebunden, der Bevollmächtigte durch den Auftrag, der Betreuer durch § 1901 Abs. 2 und 3 BGB. Auch

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[35] *Deutsch/Spickhoff* (Fn. 9), Rn. 199; *Wagenitz*, FamRZ 2005, 669 (671).

[36] § 1896 Abs. 2 S. 2 BGB.

[37] Zum Vorrang der Vertreterbestellung *BGHZ* 29, 46 (52); *BGH* NJW 1966, 1855 (1856); *Lipp*, Betreuungsrechtliche Praxis (BtPrax) 2002, 47 (51) m.w.N.

[38] *Deutsch/Spickhoff* (Fn. 9), Rn. 83.

[39] *BGHZ* 154, 205 (214); 163, 195 (198); MünchKomm/*Schwab* (Fn. 23), § 1904 BGB Rn. 38.

im Rahmen der Gesundheitssorge hat sich deshalb der Bevollmächtigte bzw. der Betreuer nach den Wünschen des Patienten zu richten. Davon dürfen sie nur abweichen, falls der Wunsch zu sterben ausnahmsweise krankheitsbedingt ist (§§ 665, 1901 Abs. 3 S. 1 BGB).[40]

Kennt der Vertreter die Wünsche des Patienten nicht, muss er die Angelegenheit mit dem Patienten besprechen.[41] Nur in Eilfällen darf der Vertreter sofort entscheiden. Der Bevollmächtigte hat dann dem *mutmaßlichen Willen* des Patienten zu folgen.[42] Der mutmaßliche Wille des Patienten ist jedoch nicht mit dessen tatsächlich geäußertem Willen gleichzusetzen.[43] Es handelt sich vielmehr um einen *Entscheidungsmaßstab* für den Vertreter.[44] Für den Betreuer ist nach § 1901 Abs. 2 BGB das vom Patienten her zu bestimmende *subjektive Wohl* maßgeblich. Danach hat der Vertreter neben den Wünschen auch die Vorstellungen des Patienten, d.h. seine Lebensentscheidungen, Wertvorstellungen und Überzeugungen zu berücksichtigen. Der Rückgriff auf die Interessen des Patienten ist ihm nur gestattet, wenn er die Wünsche und Vorstellungen des Patienten nicht feststellen kann.[45] Trotz der unterschiedlichen gesetzlichen Formulierungen für Beauftragte einerseits und Betreuer andererseits handelt es sich demnach beim mutmaßlichen Willen und beim subjektiven Wohl des Patienten in der Sache um denselben Maßstab:[46] Der Vertreter hat sich daran zu orientieren, wie der

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[40] *Baumann/Hartmann*, Deutsche Notar-Zeitschrift (DNotZ) 2000, 594 (608 ff.); *Lipp*, BtPrax 2002, 47 (49).

[41] § 665 BGB bzw. § 1901 Abs. 3 S. 3 BGB.

[42] *Palandt/Sprau*, BGB, 66. Aufl. 2007, § 665 BGB Rn. 6; *Czub*, in: Bamberger-Roth, Beck-Onlinekommentar BGB, Stand 1.7.2006, § 665 BGB Rn. 16.

[43] Insofern zutreffend *Höfling/Rixen*, Juristenzeitung (JZ) 2003, 884 (892 f.).

[44] *Lipp*, FamRZ 2004, 317 (322 f.).

[45] *Hahne*, FamRZ 2003, 1619 (1621); *Lipp*, BtPrax 2002, 47 (49 f.). Diese Frage ließ *BGHZ* 154, 205 (218 f.) ausdrücklich offen.

[46] *Baumann/Hartmann*, DNotZ 2000, 594 (609 f.).

Patient selbst entschieden hätte. Sind dessen individuelle Präferenzen nicht zu ermitteln, hat sich der Vertreter an den Interessen des Patienten zu orientieren. Auch hier ist allerdings kein Raum für die Regel „in dubio pro vita“, denn angesichts der Menschenwürdegarantie und ihres Primats kann eine solche Regel nur lauten: „in dubio pro dignitate“.[47]

c. Vormundschaftliche Genehmigung

Lange umstritten war, ob der Vertreter eine Genehmigung des Vormundschaftsgerichts benötigt, wenn er lebenserhaltende Maßnahmen ablehnt.[48] Der 12. Zivilsenat des BGH hat dies in seinem Beschluss vom 15.3.2003 im Grundsatz bejaht, jedoch nicht mit einer entsprechenden Anwendung des § 1904 BGB begründet, sondern aus einer Gesamtschau des Betreuungsrechts gewonnen.[49] Die danach bestehende Unsicherheit, wann eine Genehmigung des Vormundschaftsgericht eingeholt werden muss, hat der Senat in seinem Beschluss vom 8.6.2005 geklärt:[50] Eine Genehmigung ist erst erforderlich, wenn der Arzt eine lebenserhaltende Maßnahme anbietet, weil sie aus seiner Sicht ärztlich indiziert ist, der Vertreter sie jedoch unter Hinweis auf den Willen des Patienten ablehnen möchte und der Arzt hieran zweifelt. Eine vormundschaftsgerichtliche Genehmigung ist daher nur im Falle eines Konflikts zwischen Arzt und Betreuer einzuholen, d.h. wenn sie sich über den maßgeblichen Willen des Patienten nicht einig sind. Umgekehrt ist sie nicht erforderlich, wenn Betreuer und behandelnder Arzt sich gemeinsam gegen eine lebenserhaltende Maßnahme entscheiden.[51]

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[47] *Hufen*, NJW 2001, 849 ff.

[48] Zur Diskussion um vormundschaftsgerichtliche Genehmigung und Konsil *Lipp*, Patientenautonomie (Fn. 2), 41 ff.

[49] *BGHZ* 154, 205 (219 ff.).

[50] *BGHZ* 163, 195 ff. m. Anm. *Lipp/Nagel*, LMK 2006 (Becklink 166262, Fn. 7).

[51] So schon zuvor *Lipp*, FamRZ 2004, 322 ff.

Die Behandlung des Patienten während des Genehmigungsverfahrens ist verfassungsrechtlich unbedenklich, weil gerade der Wille des Patienten im Streit steht.[52] Das Genehmigungserfordernis dient der *präventiven Kontrolle* des Vertreters und damit dem Schutz des Selbstbestimmungsrechts des Patienten,[53] denn es gewährleistet, dass eine ärztlich indizierte lebenserhaltende Maßnahme nur mit dem Willen des Patienten eingestellt wird. Zugleich schafft die Genehmigung Rechtssicherheit für den Vertreter und andere Beteiligte.[54]

Der BGH hat die Genehmigung im Falle des Betreuers aus einer „Gesamtschau des Betreuungsrechts" abgeleitet. Daher ist unklar, ob dasselbe auch für den *Bevollmächtigten* gilt, der nur durch § 1904 Abs. 2 BGB einer Genehmigungspflicht unterworfen wird. Da die Lösung des BGH trotz ihrer anderen Begründung im Ergebnis einer analogen Anwendung des § 1904 BGB entspricht und die angeführten Gründe für eine Genehmigung auf alle Vertreter zutreffen, dürfte für den Bevollmächtigten letztlich nichts anderes gelten.

3.4 Die Patientenverfügung

a. Formen von Patientenverfügungen und ihre rechtliche Verbindlichkeit

Vorausverfügungen werden allgemein akzeptiert, wenn sie vom Patienten im Gespräch mit dem behandelnden Arzt erklärt werden, z.B. im Vorfeld einer unter Narkose erfolgenden Behandlung.[55] Als „Patientenverfügung" bezeichnet man eine Vorausverfügung, wenn sie unabhängig von einer konkreten Behandlungssituation erfolgt.

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[52] *Hufen*, ZRP 2003, 248 (251 f.).

[53] *BGHZ* 154, 205 (216 f., 223, 227).

[54] *BGHZ* 154, 205 (218 f., 227); ebenso z.B. *OLG Karlsruhe* FamRZ 2002, 488 (490); *Bauer*, BtPrax 2002, 60 (62).

[55] *Deutsch/Spickhoff* (Fn. 9), Rn. 199; *Wagenitz*, FamRZ 2005, 669 (671).

Häufig enthält sie die Erklärung des Patienten gegenüber dem unbekannten künftigen Arzt, er stimme bestimmten Maßnahmen zu bzw. lehne sie ab. Der Patient übt damit sein Selbstbestimmungsrecht im Hinblick auf eine künftige Behandlung aus.[56] Dieser Ansicht hat sich nun auch der 12. Zivilsenat angeschlossen.[57] Für eine derartige *antizipierte Einwilligung* bzw. Ablehnung des Patienten gelten dieselben Grundsätze wie für jede Einwilligung.[58] Sie entfaltet ihre Wirkung, wenn sie die konkrete Behandlungssituation erfasst und frei von Willensmängeln ist. Dafür bedarf sie keiner bestimmten Form und ist auch ohne Aufklärung durch den Arzt wirksam, weil der Patient auf diese verzichten kann. Sie bindet zwar den Arzt, nicht aber den Patienten, da sie nur solange gilt, bis er seine Erklärung ändert oder konkrete Anhaltspunkte für eine Willensänderung vorliegen.[59]

Neben derartigen antizipierten Erklärungen kann eine Patientenverfügung auch *Wünsche, Einstellungen und Werthaltungen* des Patienten mitteilen.[60] Diese Mitteilung erzeugt keine unmittelbare Rechtswirkung, sondern muss erst von einem Vertreter oder dem Arzt konkretisiert werden. Eine solche narrative Patientenverfügung enthält

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[56] So z.B. die Richtlinien der BÄK (Fn. 21), Ziff. IV. und V.; vgl. schon die Handreichungen der BÄK für Ärzte zum Umgang mit Patientenverfügungen, DÄBl. 1999, A 2720, Ziff. 1.1.; *Taupitz* (Fn. 2), A 105 ff.; *Lipp*, DRiZ 2000, 231 (234).

[57] *BGHZ* 154, 205 (210 f.).

[58] Zum Folgenden *Taupitz* (Fn. 2), A 28 ff.; *Wagenitz*, FamRZ 2005, 669 (671); *Lipp*, in: Passive Sterbehilfe (Fn. 23), 43 f.; Handreichungen der BÄK für Ärzte zum Umgang mit Patientenverfügungen, DÄBl. 1999, A 2720, Ziff. 6.

[59] Ebenso die Richtlinien der Bundesärztekammer (Fn. 21), Ziff. IV.; *Eisenbart*, Patienten-Testament und Stellvertretung in Gesundheitsangelegenheiten, 2. Aufl. 2000, 67; *Baumann/Hartmann*, DNotZ 2000, 594 (608 ff.); gegen eine mutmaßliche Änderung z.B. *Taupitz* (Fn. 2), A 115f.

[60] Vgl. z.B. *Sass/Kielstein*, Patientenverfügung und Betreuungsvollmacht, 2. Aufl. 2003, 50 ff., 58; *Wagenitz*, FamRZ 2005, 669 (671).

Anhaltspunkte, wie der Patient in der aktuellen Situation entschieden hätte.[61] Sie dient zur Konkretisierung des mutmaßlichen Willens bzw. subjektiven Wohls des Patienten und bindet daher den Bevollmächtigen bzw. Betreuer nach den oben dargelegten Grundsätzen.[62]

Eine Patientenverfügung ist daher stets verbindlich. Den *Grad ihrer Verbindlichkeit* bestimmt der verfügende Patient selbst, indem er entweder eine Entscheidung bereits vorwegnimmt oder Vertreter und Arzt einen Spielraum belässt.

b. Notwendigkeit der Auslegung einer Patientenverfügung

Jede Patientenverfügung bedarf daher der Auslegung.[63] Sie ist Aufgabe derjenigen, an die sich eine Patientenverfügung richtet, d.h. des Arztes, des Vertreters oder der Angehörigen.[64] Sie dürfen dabei den Text des Dokuments oder die mündliche Äußerung nicht einfach wörtlich nehmen, sondern müssen vielmehr fragen, was der Patient damit erklären wollte (vgl. § 133 BGB). Bei dieser Feststellung des Patientenwillens müssen sie alle Informationen über den Patienten berücksichtigen, die ihnen bekannt geworden sind, und sich darüber hinaus, soweit möglich, weitere Informationen verschaffen. Vor diesem Hintergrund haben sie dann die Patientenverfügung auszulegen.[65]

c. Patientenverfügung und Vertreter

Der Vertreter ist an den in der Patientenverfügung geäußerten Willen des Patienten nach den oben dargelegten Grundsätzen[66]

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[61] Viele verstehen „die“ Patientenverfügung *generell* als ein solches Indiz, vgl. z.B. *Laufs*, NJW 1998, 3399 (3400); *Deutsch/Spickhoff* (Fn. 9), Rn. 513 ff.

[62] Oben 3.3.b.

[63] *Palandt/Diederichsen* (Fn. 42), vor § 1896 BGB Rn. 9 a.E.; *Roth*, JZ 2004, 494 (498 ff.).

[64] *Roth*, JZ 2004, 494 (500 ff.).

[65] Zu den Auslegungsgrundsätzen *Roth*, JZ 2004, 494 (499 ff.).

[66] Oben 3.3.b.

gebunden. Dieser Wille des Patienten muss allerdings erst noch verwirklicht werden, indem z.B. Arzt und Pflegepersonal über die Patientenverfügung informiert oder zu ihrer Beachtung aufgefordert werden. Der BGH beschreibt deshalb die Aufgabe des Betreuers zutreffend damit, dass er „dem Willen des Betroffenen gegenüber Arzt und Pflegepersonal in eigener rechtlicher Verantwortung (…) Ausdruck und Geltung zu verschaffen“ hat.[67] Betreuer wie Bevollmächtigter müssen mit haftungs- und strafrechtlichen Folgen rechnen, falls sie gegen diese Verpflichtung verstoßen. Darüber hinaus kann das Vormundschaftsgericht gegenüber dem Betreuer Aufsichtsmaßnahmen ergreifen (§§ 1908i, 1837, 1908b BGB) bzw. einen Kontrollbetreuer zur Überwachung des Bevollmächtigten bestellen (§ 1896 Abs. 3 BGB) oder in Eilfällen selbst tätig werden (§§ 1908i Abs. 1 S. 1, 1846 BGB).

Im *Außenverhältnis* gegenüber dem Arzt ist dagegen die Entscheidung des Vertreters maßgeblich.[68] Ein „Durchgriff“ auf die Patientenverfügung ist dem Arzt verwehrt. Diese Bindung entfällt nach allgemeinen Grundsätzen bei einem Missbrauch der Vertretungsmacht, d.h. wenn der Vertreter sich nicht an den Willen des Patienten hält und dies für den Arzt evident ist.[69] Im Übrigen kann der Arzt stets das Vormundschaftsgericht anrufen.

d. Bestellung eines Betreuers trotz Patientenverfügung?

Eine Patientenverfügung macht demnach die Bestellung eines Betreuers in aller Regel *nicht entbehrlich*. Er bleibt zum einen für alle weiteren, nicht in der Patientenverfügung vorweggenommenen Entscheidungen erforderlich, und muss zum anderen die Patientenverfügung durchsetzen.[70]

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[67] *BGHZ* 154, 205 (211); 163, 195 (198).

[68] *BGHZ* 163, 195 (198 f.); vgl. auch *Wagenitz*, FamRZ 2005, 669 (672).

[69] *Lipp*, Patientenautonomie (Fn. 2), 35 f.

[70] *Lipp,* BtPrax 2002, 47 (51 f.); das übersieht z.B. *Vosseler*, BtPrax 2002, 240 (241).

Eine „isolierte“ Patientenverfügung ist daher die schwächste Form der privaten Vorsorge. Sie sollte stets mit der Benennung einer Vertrauensperson verbunden werden, entweder in Form einer Betreuungsverfügung oder einer Vorsorgevollmacht. Welche Form vorzugswürdig ist, lässt sich dagegen nicht generell sagen. Das hängt vom Ausmaß des persönlichen Vertrauens in die ausgewählte Person ab und von dem Grad an Freiheit, den der Betroffene seinem Vertreter einräumen möchte, bzw. dem Maß an Kontrolle, das er über den Vertreter wünscht.

3.5 Zur aktuellen rechtspolitischen Debatte in Deutschland[71]

Seit dem Beschluss des BGH vom 8.6.2005[72] dürfen viele Fragen als geklärt betrachtet werden. Die hiernach noch bestehende Unsicherheit über die so genannten „strafrechtlichen Grenzen der Sterbehilfe“ lässt sich zwar durch eine Lektüre der einschlägigen Entscheidung des 1. Strafsenats des BGH[73] beseitigen. Angesichts der in der Praxis allenthalben konstatierten Rechtsunsicherheit besteht jedoch erheblicher gesetzgeberischer Handlungsbedarf. Er betrifft jedoch allein das *Strafrecht*, nicht das Zivilrecht und die dort geregelten Möglichkeiten privater Vorsorge. Klarzustellen ist dort vor allem, dass eine lebenserhaltende Maßnahme stets der Zustimmung des Patienten bedarf und daher insbesondere auch ein Veto des Patienten gegen eine bestimmte Behandlung immer beachtlich ist, ohne dass dies auf eine bestimmte Phase der Erkrankung beschränkt ist.[74]

Im Bereich der *Vorsorgemöglichkeiten* existieren gesetzliche Regelungen für die Betreuungsverfügung und die Vorsorgevollmacht, die auch die Bindung dieser Vertreter an eine Patientenverfügung sicher stellen.[75]

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[71] Vgl. dazu auch *Lipp*, Patientenautonomie (Fn. 2), passim; *Lipp/Nagel*, Forum Familienrecht (FF) 2005, 83 ff.

[72] *BGHZ* 163, 195 ff.

[73] Zu BGHSt 40, 257 ff. siehe oben bei Fn. 27.

[74] Dazu *Verrel* (Fn. 2), C 78 ff.

[75] Oben 3.3.b.

Keine Regelung hat die Patientenverfügung lediglich im Verhältnis zum Arzt gefunden, da das Behandlungsverhältnis von Arzt und Patient insgesamt nicht gesetzlich geregelt ist, sondern von den Grundsätzen beherrscht wird, die Rechtsprechung und Rechtswissenschaft entwickelt haben. Auch hier besteht nach der inzwischen erfolgten Klärung dieser Grundsätze durch die Rechtsprechung[76] *kein Handlungsbedarf für den Gesetzgeber*, sondern ein – allerdings erheblicher – Bedarf nach Aufklärung und Information über das geltende Recht.

Insgesamt erscheint daher eine gesetzliche Regelung der Patientenverfügung entbehrlich. Falls sie gleichwohl in Angriff genommen werden sollte, sind dabei die nachfolgenden Punkte von zentraler Bedeutung.

a. „Reichweite" der Patientenverfügung

Ein wesentlicher Streitpunkt in der gegenwärtigen Debatte betrifft die sogenannte „Reichweite der Patientenverfügung". Insbesondere die Enquete-Kommission „Ethik und Recht der modernen Medizin" hatte vorgeschlagen, sie für alle Formen der Patientenverfügung auf die Fälle zu beschränken, in denen das Grundleiden irreversibel ist und trotz medizinischer Behandlung nach ärztlicher Erkenntnis zum Tode führen wird.[77] Zum Teil wird dies auch nur für bestimmte Krankheitsbilder gefordert. Demgegenüber lehnen der Deutsche Juristentag und der Referentenentwurf des Bundesjustizministeriums eine solche Einschränkung ausdrücklich ab.[78] Der Sache nach geht es hier jedoch nicht um die Reichweite der Patientenverfügung, sondern um die allgemeine Frage, ob der Patient auch außerhalb der Sterbephase

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[76] Oben 3.4.a.

[77] Zwischenbericht „Patientenverfügungen" vom 13.9.2004, BT-Drucks. 15/3700 (künftig: Enquete-Kommission, EK), S. 38.

[78] Beschlüsse des 66. DJT 2006 (Fn. 2); Referentenentwurf eines 3. Betreuungsrechtsänderungsgesetzes vom 1.11.2004 (künftig: Referentenentwurf, RefE), S. 13, 18 f., abgedruckt u.a. bei *Lipp*, Patientenautonomie (Fn. 2), 65 ff.

auf lebenserhaltende Maßnahmen verzichten kann, also um die strafrechtliche Problematik.[79]

b. Wirksamkeitsvoraussetzungen für eine Patientenverfügung?

In der Praxis werden die meisten Patientenverfügungen schon deshalb schriftlich niedergelegt, um damit ihre spätere Beachtung zu sichern. Zwingend vorgeschrieben ist dies freilich nicht. Insbesondere hängt die rechtliche Wirksamkeit des Patientenwillens nicht davon ab, in welcher Form er erklärt oder nachgewiesen ist.[80]

In der rechtspolitischen Diskussion wird von manchen gefordert, nur *schriftliche* Patientenverfügungen als bindend anzuerkennen. Zum Teil verlangt man zusätzlich eine vorherige *Beratung*.[81] Mit der Schriftform sollen der Nachweis der Ernstlichkeit und des Inhalts der Erklärung erleichtert werden.[82] Die Aufklärung soll sicherstellen, dass sich der Patient der Bedeutung und Tragweite seiner Erklärung bewusst ist.[83] Andere Erklärungen sollen als Indiz für den mutmaßlichen Willen dienen.[84]

aa. Schriftform?

Problematisch ist ein Formzwang vor allem deshalb, weil die antizipierte Einwilligung bzw. Ablehnung des Patienten nur deshalb einen geringeren Grad von Verbindlichkeit haben soll, weil sie nicht formgerecht erklärt worden ist. Ist sie auf andere Weise nachgewiesen, besteht jedoch kein Grund, ihr nicht die gleiche Verbindlichkeit zuzubilligen wie einer schriftlich niedergelegten Erklärung. Gerade wenn man dem

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[79] Vgl. dazu den Beitrag von *Verrel* (Fn. 2), C 85 ff.

[80] Siehe oben 3.4.a.

[81] Z.B. die Bioethik-Kommission des Landes Rheinland-Pfalz in ihrem Bericht „Sterbehilfe und Sterbebegleitung“ vom 23.4.2004, abrufbar unter www.justiz.rlp.de (künftig: Bioethik-Kommission Rheinland-Pfalz (RPf), S. 42 f.

[82] *EK* (Fn. 77), 40 f.; vgl. auch *RPf* (Fn. 81), 42 f.

[83] *RPf* (Fn. 81), 42 f.

[84] EK (Fn. 77), 41; *RPf* (Fn. 81), 43.

Selbstbestimmungsrecht des Patienten Geltung verschaffen will, dürfen keine Hürden aufgebaut werden, die nicht schon in der Sache selbst begründet sind, wie z.B. das Erfordernis der Einwilligungsfähigkeit.[85] Auch nach Ansicht der Enquete-Kommission soll deshalb z.B. der Widerruf formlos möglich sein.[86] Das Ziel der Beweissicherheit rechtfertigt also die Schriftform nicht.

Im Übrigen wären mit der Einführung einer Formvorschrift weitere Probleme verbunden: Es genügt für eine im Vorfeld einer Behandlung gegenüber dem Arzt erklärte Einwilligung oder Ablehnung weiterhin, dass sie mündlich erklärt wird. Auch für den Betreuer und für den Bevollmächtigten bleiben Anweisungen des Patienten unabhängig von ihrer Form verbindlich. Die mit der Schriftform für Patientenverfügungen notwendig verbundene eingeschränkte Verbindlichkeit für nicht formgerechte Erklärungen führt deshalb zu Abgrenzungsproblemen und Wertungswidersprüchen. Die angeführten Beweisschwierigkeiten treten nämlich bei vielen in die Zukunft gerichteten Anweisungen an den künftigen Betreuer (Betreuungsverfügung, § 1901a BGB) oder Bevollmächtigten (§ 665 BGB) auf, ohne dass hierfür die Einhaltung der Schriftform erforderlich ist. Letztlich spricht daher alles dagegen, für die Patientenverfügung die Schriftform durch Gesetz vorzuschreiben.

bb. Beratungspflicht?

Hinsichtlich der Aufklärung stellt sich die Frage, ob eine ärztliche bzw. rechtliche Beratung bei der Errichtung einer Patientenverfügung lediglich empfohlen sein sollte, oder aber ob sie zur Voraussetzung für deren rechtliche Verbindlichkeit erhoben werden sollte. Eine vorherige Aufklärung kann zum einen den Patienten über seine Krankheit und die möglichen Behandlungsalternativen informieren und ihn so in die Lage versetzen, sich zu entscheiden. Zum anderen kann sie dem

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[85] So zutreffend in anderem Zusammenhang *Roth*, JZ 2004, 494 (497).

[86] *EK* (Fn. 77), 42 f.

später behandelnden Arzt das Verständnis einer Patientenverfügung erleichtern.[87]

Unter dem erstgenannten Gesichtspunkt dient die Aufklärung der *Wahrnehmung des Selbstbestimmungsrechts* des Patienten; auf sie kann der Patient deshalb auch verzichten.[88] Die Aufklärung als Wirksamkeitsvoraussetzung macht die Beratung zur Pflicht und bedarf daher als Beschränkung des Selbstbestimmungsrechts des Patienten der Rechtfertigung. Eine Beratungspflicht erscheint dann sachlich sinnvoll und deshalb gerechtfertigt, wenn die Beratung durch einen Arzt erfolgt und der Bezug zu einer bestimmten Krankheit bereits vorhanden oder absehbar ist. Die Beratungspflicht würde aber auch für diejenigen gelten, die in gesunden Tagen für Unfall oder plötzlich auftretende Krankheiten vorsorgen wollen. Hier ist eine ärztliche Information über die gesundheitliche Situation und mögliche Behandlungsalternativen nur in sehr allgemeiner Form möglich, so dass eine mit der Pflicht zur Beratung verbundene generelle Beschränkung des Selbstbestimmungsrechts des Patienten unter diesem Gesichtspunkt nicht als gerechtfertigt erscheint. Die Beratungspflicht könnte somit allenfalls mit dem *Interesse des Arztes* an einer verständlichen Patientenverfügung, also dem zweiten Aspekt, gerechtfertigt werden. Auf die Interessen bzw. den Schutz des Arztes kommt es aber bei der Einwilligung generell nicht an;[89] entscheidend ist hier allein der Wille des Patienten.

Eine ärztliche bzw. rechtliche Beratung bei der Errichtung einer Patientenverfügung sollte zwar empfohlen und gefördert, aber nicht zur Voraussetzung ihrer rechtlichen Verbindlichkeit erhoben werden.

c. Patientenverfügung und Vertreter

Teilweise wird vorgeschlagen, die Bindungswirkung einer Patientenverfügung gegenüber einem Vertreter zu beschränken. So soll z.B. nach

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[87] *RPf* (Fn. 81), 42 f., nennt zwar beide Aspekte, unterscheidet sie aber nicht deutlich.

[88] Vgl. nur *Taupitz* (Fn. 2), A 28 ff.

[89] *Deutsch/Spickhoff*, (Fn. 9) Rn. 197.

dem Vorschlag der Enquete-Kommission eine nicht formgültig errichtete Patientenverfügung nur ein Indiz für die Ermittlung des mutmaßlichen Willens darstellen und darüber hinaus ein allgemeiner Vorbehalt zugunsten des Wohls und des Lebensschutzes des Betreuten eingeführt werden.[90]

Beides würde zu Wertungswidersprüchen im Betreuungsrecht führen: *Erstens* ist der Wille des Patienten für den Betreuer oder Bevollmächtigten nach §§ 1901 Abs. 3 S. 1, 1901a BGB bzw. § 665 BGB auch dann verbindlich, wenn er nicht formgerecht erklärt wird.[91] Er ist also bereits de lege lata mehr als das Indiz, zu dem ihn die *Enquete-Kommission* machen will und es besteht kein Grund, hier hinter das geltende Betreuungsrecht zurückzugehen. *Zweitens* findet die Wohlschranke des § 1901 Abs. 3 S. 1 BGB bei einer antizipierten Einwilligung oder Ablehnung keine Anwendung;[92] der Vorschlag würde sie erst einführen. *Drittens* ist verfassungs- wie betreuungsrechtlich eine Behandlung gegen den Willen des Patienten allenfalls dann erlaubt, wenn die Ablehnung krankheitsbedingt ist.[93] Der Vorrang des Wohls und vor allem des Lebensschutzes ist daher insgesamt abzulehnen.

d. Verfahrensregelungen: Konsil und Vormundschaftsgericht

Nach geltendem Recht, wie es insbesondere die jüngste Rechtsprechung ausgeformt hat, ist eine vormundschaftsgerichtliche Genehmigung (nur) dann erforderlich, wenn der Arzt eine (weitere) lebenserhaltende Maßnahme für indiziert hält und sie vorschlägt, der Vertreter des Patienten sie jedoch ablehnt.[94] Während von den einen eine regelmäßige Einschaltung des Vormundschaftsgerichts und eines Konsils verlangt wird, schlagen andere die Abschaffung der Genehmigungspflicht für Bevollmächtigte vor.

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[90] EK (Fn. 77), 41, vgl. auch *RefE* (Fn. 78), 23.

[91] Siehe oben 3.3.b.

[92] *BGHZ* 154, 205 (216 ff.).

[93] Vgl. nur *BVerfGE* (Entscheidungen des Bundesverfassungsgerichts) 58, 208 (225); *BVerfG* BtPrax 1998, 144 (145).

[94] Dazu oben 3.3.c.

aa. Konsil?

Zum Teil wird verlangt, zunächst ein *Konsil* aus Arzt, Betreuer, Pflegedienst und Angehörigen einzuschalten, und erst danach und zusätzlich die *Genehmigung des Vormundschaftsgerichts* einzuholen. Gleiches soll für den Bevollmächtigten gelten.[95] Die Beratung im Konsil soll die Berücksichtigung aller verfügbaren Informationen und vorhandenen Ansichten sicherstellen,[96] die zwingende Einschaltung des Vormundschaftsgerichts soll die Missbrauchsgefahr bannen.[97]

Diese umfassende Absicherung bewirkt, dass der Patient für die Dauer des Verfahrens auch dann behandelt wird, wenn dies seinem Willen widerspricht. Ein solcher Eingriff in die Patientenautonomie bedarf der Rechtfertigung und muss dem Verhältnismäßigkeitsgrundsatz entsprechen: Die Einbeziehung weiterer Personen in den Behandlungs- bzw. Entscheidungsprozess ist vielfach sinnvoll, um die Wünsche und Vorstellungen des Patienten zu ermitteln. Allerdings kann die Notwendigkeit, weitere Personen zu beteiligen, nur im Einzelfall beurteilt werden.[98] Ein *obligatorisches Konsil* würde jedoch die Verwirklichung des Willens des Patienten auch dann verzögern, wenn seine Einschaltung weder erforderlich noch sinnvoll ist, um diesen Willen zu ermitteln und umzusetzen. Die zwingende Einschaltung eines Konsils ist daher weder praktikabel[99] noch verfassungsrechtlich zu rechtfertigen.

bb. Regelmäßige Einschaltung des Vormundschaftsgerichts?

Die Genehmigung durch das Vormundschaftsgericht dient der präventiven Kontrolle des Betreuers. Sie soll verhindern, dass der Betreuer seine Rechtsmacht missbraucht und damit dem Patienten irreparablen Schaden zufügt. Nach der Vorstellung insbesondere der

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[95] *EK* (Fn. 77), 44.

[96] *EK* (Fn. 77), 43 f.

[97] *EK* (Fn. 77), 44 f.

[98] Die *EK* (Fn. 77), 43 stellt dies selbst ausdrücklich fest; ebenso *RefE* (Fn. 78), 21.

[99] *RefE* (Fn. 78), 21.

Enquete-Kommission ist dieser Schutz nur mit einer umfassenden Genehmigungspflicht gewährleistet.[100]

Normalerweise ist eine präventive Kontrolle im Vorfeld der Behandlungsentscheidung bereits dadurch gewährleistet, dass ein Konsens zwischen Arzt und Betreuer über die Notwendigkeit der Behandlung und den maßgeblichen Willen des Patienten erforderlich ist.[101] Wenn allerdings der Betreuer eine Maßnahme *ablehnt*, die nach Ansicht des Arztes sowohl indiziert ist als auch dem Willen des Patienten entspricht, versagt diese Form der präventiven Kontrolle. Denn gegen das Veto des Betreuers darf der Arzt grundsätzlich nicht behandeln. In einem solchen Fall ist daher die Erzwingung einer präventiven Kontrolle durch die Genehmigungspflicht erforderlich. Aus Sicht des Patienten und seines Selbstbestimmungsrechts ist die damit verbundene Verzögerung in der Verwirklichung seines Willens unvermeidbar, denn es ist gerade umstritten, was der Patient will. Insofern ist die Behandlung des Patienten während des Verfahrens verfassungsrechtlich unbedenklich. Stimmen Betreuer und Arzt jedoch überein, hat die präventive wechselseitige Kontrolle keine Beanstandungen ergeben. Für das verbleibende Risiko des Missbrauchs genügen die auch hier eingreifenden allgemeinen Sicherungen: Jedermann kann sich bei Verdacht des Missbrauchs an das Vormundschaftsgericht wenden; darüber hinaus sichern zivil- und strafrechtliche Sanktionen, dass Arzt und Betreuer ihre rechtlichen Pflichten einhalten.[102] Eine nochmalige präventive Kontrolle durch das Vormundschaftsgericht ist daher nicht erforderlich. Eine Genehmigungspflicht führt hier zu einer nicht zu rechtfertigenden Zwangsbehandlung des Patienten; sie ist deshalb verfassungswidrig.[103]

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[100] *EK* (Fn. 77), 44 f.

[101] So auch *RefE* (Fn. 78), 23.

[102] Zum Vorstehenden nur *RefE* (Fn. 78), 23.

[103] Eine Zwangsbehandlung ist nur zulässig, wenn die Ablehnung der Behandlung krankheitsbedingt ist, vgl. nur *BVerfGE* 58, 208 (225f); *BVerfG* BtPrax 1998, 144 (145).

Demnach ist eine *umfassende Genehmigungspflicht abzulehnen*. Vorzugswürdig ist hier das geltende Recht, d.h. die Genehmigungspflicht in Konfliktfällen, in denen Arzt und Betreuer kein Einvernehmen über den Willen des Patienten herstellen können.[104]

cc. Keine Genehmigungspflicht für Bevollmächtigte?

Zum Teil wird vorgeschlagen, die Genehmigungspflicht für den Bevollmächtigten ganz abzuschaffen und auf die allgemeinen Kontrollmechanismen zu vertrauen. Die Formvorschrift des § 1904 Abs. 2 S.2 BGB für die Vollmacht steht dabei jedoch nicht in Frage.[105]

Der Verzicht auf eine präventive Kontrolle des Bevollmächtigten, der eine lebenserhaltende Maßnahme ablehnt, die der Arzt für indiziert hält und die aus dessen Sicht dem Willen des Patienten entspricht, ist nur gerechtfertigt, wenn der Patient selbst auf diese Form der Kontrolle verzichtet hat.[106] Insofern kommt dem Erfordernis, dass der Vollmachtgeber die Befugnis zum Verzicht auf eine lebenserhaltende Behandlung *ausdrücklich* und *schriftlich* erteilen muss (§ 1904 Abs. 2 BGB), besondere Bedeutung zu. Bestehen bleibt darüber hinaus die unverzichtbare *allgemeine Missbrauchskontrolle* durch das Vormundschaftsgericht, das von jedermann angerufen werden und entweder einen Vollmachts- bzw. Kontrollbetreuer einsetzen (§ 1896 Abs. 3 BGB) oder in Eilfällen selbst tätig werden kann (§§ 1908i Abs. 1 S. 1, 1846 BGB).[107]

Letztlich bestehen gegen die Abschaffung der Genehmigungspflicht für Bevollmächtigte daher keine durchschlagenden Bedenken. Es bleibt allein die praktische Frage, ob man das Vertrauen in die Vorsorgevollmacht

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[104] Siehe oben 3.3.c.

[105] RefE (Fn. 78), 13, 24.

[106] *RefE* (Fn. 78), 24; Arbeitsgruppe (*AG*) „Patientenautonomie am Lebensende“ des Bundesjustizministeriums („Kutzer-Kommission“), Bericht vom 10.6.2004, 49 f., abrufbar unter http://www.bmj.bund.de/files/-/695/Bericht_AG_Patientenautonomie.pdf .

[107] *RefE* (Fn. 78), 24; *AG* (Fn. 106), 49 f.

nicht besser dadurch fördert, dass man auch dem Bevollmächtigten im Konfliktfall den Weg zum Vormundschaftsgericht eröffnet, wie dies die Bioethik-Kommission Rheinland-Pfalz vorschlägt.[108]

3.6 Zur Notwendigkeit einer gesetzlichen Regelung

Seit dem Beschluss des BGH vom 8.6.2005[109] dürfen die *zivilrechtlichen Fragen* als geklärt betrachtet werden. Die Unsicherheit über die so genannten „*strafrechtlichen Grenzen* der Sterbehilfe" lässt sich zwar durch eine Lektüre der einschlägigen Entscheidung des 1. Strafsenats des BGH[110] beseitigen. Eine höchstrichterliche Entscheidung, die die hier dringend gebotene Rechtssicherheit herstellen könnte, ist jedoch zurzeit nicht in Sicht. Der Gesetzgeber ist daher aufgefordert, die strafrechtliche Rechtslage klarzustellen. Eine zivilrechtliche Regelung der Patientenverfügung ist dagegen nicht erforderlich. Der Gesetzgeber muss in diesem Bereich allenfalls dann tätig werden, wenn man die vormundschaftsgerichtliche Kontrolle bei Bevollmächtigen lockern möchte.

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[108] *RPf* (Fn. 81), 60.

[109] *BGHZ* 163, 195 ff.

[110] Zu BGHSt 40, 257 ff. siehe oben bei Fn. 27.

3

PECULIAR FORMS OF RESPONSIBILITY?

THE LIMITS OF DISCOURSE ETHICS CONCERNING THE RESPONSIBILITY TOWARD NATURE, NONHUMAN ANIMALS, AND FUTURE GENERATIONS[1]

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1. INTRODUCTION

In a talk given to a group of students at Munich University during the winter of 1918-19, Max Weber distinguishes between two kinds of ethics: the *ethics of ultimate ends* and the *ethics of responsibility*. In his opinion, the main difference among them is that for the former, "the Christian does rightly and leaves the results with the Lord" and for the latter, "one has to give an account of the foreseeable results of one's action."[2] Otherwise said, if for someone who follows the maxim of an ethics of ultimate ends an action fails to achieve a good intention, "in the actor's eyes, not he but the world, or the stupidity of the other men, or God's will that made them thus, is responsible for the evil."[3] On the contrary, someone who is committed to an ethics of responsibility does not presuppose *the goodness or perfection of the people* but takes into consideration "the conclusions that must be drawn according to the *objective* interests that came into

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[1] This essay is an extended version of a previous paper published in the *Romanian Journal of Bioethics* entitled "From Consensus to Responsibility as Solidarity or How does Discursive Ethics Overcome its Critiques?" 5(2007):3.

[2] Max Weber, *Politics as a Vocation*, trans. H. Gerth and C. Wright Mills (Philadelphia: Fortress Press, 1965), p. 47.

[3] Idem.

play and what is the main thing in view of responsibility toward the future which above all burdens the victor."[4]

One could reply to Weber that his ethics of responsibility does not abandon a traditional ethical framework because he still thinks that the existence of a future world is obvious. Hans Jonas, among other ethicists, thinks that an ethics of responsibility should be concerned with the fact that the *conditions for the persistence of life in the future* can no longer be merely assumed. A simple awakening with respect to the dangerous situation in which the world is might be insufficient. Thus, our *praxis* should imply an obligation to preserve nature, as environment and as nonhuman animals surrounding us, and an obligation toward future generations. Everyone can notice that the number of species in danger of extinction has increased extremely fast.[5] Along these lines, a question needs to be raised: how can one be responsible for something that neither belongs to our sphere of language nor exists yet but must exist tomorrow?

Jonas claims that Kant's error concerning his categorical imperative lies in the fact that it entails the existence of a human community. While this fact was obvious for Kant, it is not an evidence anymore for Jonas. Kant's maxim, which calls for an accord between our reason and the way we act, must be reviewed because it does not take into consideration the emergency of the situation. Jonas gives an argument for a new form of ethical obligation which entails the idea that human actions have to be in agreement with the future survival of humanity. How does discourse ethics, sometimes called an updated version of Kant's ethics, answer to the challenge raised by Jonas? Is there a possibility for a model based on a symmetrical relationship among existing and

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[4] Ibid., p. 45.

[5] Norman Myers, Russell A. Mittermeier, Cristina G. Mittermeier, Gustavo A. B. da Fonseca & Jennifer Kent, "Biodiversity hotspots for conservation priorities," *Nature*, 403 (24 Feb. 2000), p. 853-8, and Norman Myers, "Trees by the billions," *International Wildlife*, 12 (Sept./Oct. 1991), p. 5.

communicative subjects to integrate a responsibility which implies an asymmetrical relation (linguistically non-reciprocal) or a non-existing subject? In other words, what can discourse ethics tell us about our responsibility with respect to nature, nonhuman animals, and future generations?

In the following pages, I will evaluate the way in which these questions have been answered by Jürgen Habermas and K.O. Apel. My paper will have a twofold structure. First, I will attempt to bring out Habermas' definition of communicative normativity through speech-act theory. My purpose is to state clearly the governing conception of discourse ethics. In other words, I will point out the construction of the normative output of Habermas' ethical model. Second, I will raise some critiques regarding the limits of this normativity. In doing so, I will test this normative framework to see if it is compatible or not with a real responsibility for nature, for nonhuman animals, and for future generations. These critiques point out, on the one hand, an inconsistent criterion that determines which attitudes are *rationalizable* and, on the other hand, an insufficiency of the communicative ethical model in non-reciprocal relations.

2. COMMUNICATIVE ACTION AS SOURCE FOR NORMATIVITY

Unlike his predecessors Horkheimer and Adorno, Habermas realizes a 'paradigmatic shift' from a theory of consciousness to a communicative framework. This change entails that subjects are linguistically mediated before being instrumentally mediated. In his critique of instrumental reason, Habermas criticizes Horkheimer and Adorno on two main things. First, they have wrongly generalized the category of reification.[6] Second, they failed to explain how

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[6] Jürgen Habermas, *Theory of Communicative Action* (Mass: Beacon Press, 1984), vol. 1, p. 378. (Hereafter as *TCA*.)

a subject-object relation could be constitutive for any "interpersonal relations subject to subject."[7] For Habermas, what is paradigmatic "is not the relation of a solitary subject to something objective in the world that can be represented and manipulated, but the intersubjective relation that subjects take up when they come to an understanding with one another about something."[8] Does he propose an alternative to this instrumental rationality understood as total reification and as "mastery of nature?"[9] While he criticizes Lukacs for reducing the question of rationality only to its purposive aspect, Habermas asks himself if "the critique of the incomplete character of the rationalization that appears as reification does not suggest taking a complementary relation between cognitive instrumental rationality, on the one hand, and moral-practical and aesthetic-practical rationality, on the other, as a standard that is inherent in the unabridged concept of practice, that is to say, in communicative action itself."[10] Therefore, he shows here the limit of any theory which has a goal-directed form of rationality as a unique referent. He proposes a communicative rationality "based on the central experience of the unconstrained, unifying, consensus-bringing force of argumentative speech, in which different participants overcome their merely subjective views and, owing to the mutuality of rationally motivated conviction, assure themselves of both the unity of the objective world and the intersubjectivity of the lifeworld."[11]

The actor of a communicative action is not anymore a solitary subject related to something which can be manipulated in the world. Participants in a communicative action are in an intersubjective relation that "takes up when they come to an understanding with one

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[7] *TCA,* p. 379.

[8] *TCA,* p. 392.

[9] *TCA,* p. 379.

[10] *TCA,* p. 363.

[11] *TCA,* p. 10.

another about something."[12] Rationality is therefore defined in terms of validity claim and consensus. Habermas' communicative shift interests us not only for having removed obstacles to understand the difference between a goal-directed action and communication but also for having found a solution regarding the question of the normative grounding. In this sense, one of his significant contributions is doubtlessly *the theory of communicative ethics* or as Habermas calls it, "a cognitivist ethics of language."[13] In the section 2 of my paper, I will lay out a brief outline of the theory of speech act upon which Habermas builds the communicative ethics as it is presented in the volume one, chapter three of *Theory of Communicative Action*. In the third section, I will focus on the question of norm-conformative attitude toward nature presented in *TCA* and in *Reply to my Critics*. I will also develop Habermas' ethics of compassion and the question of the status of animals out of his book *Justification and Application*.

2.1 From speech act theory in *Theory of Communicative Action* to discourse ethics

Habermas wants to ground discourse ethics on a linguistic structure where moral claims are made and justified in a discursive argumentation. At the beginning of chapter III of volume I of *TCA*, he proposes a new schema regarding the different types of actions. There are two action situations: nonsocial and social; and two action orientations: one oriented to success and one oriented to reaching understanding. Using these criteria Habermas distinguishes three kinds of actions: instrumental action (nonsocial/oriented to success), strategic action (social/oriented to success), and communicative action (social/oriented to reach understanding). In Habermas' opinion, it is impossible to have a

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[12] *TCA,* p. 392.

[13] Seyla Benhabib, "The utopian dimension in communicative ethics," *New German Critique*, 35 (Spring-Summer, 1985), p. 86, makes reference to Habermas, *Theorie und Praxis* (Frankfurt / M.: Suhrkamp, 1978), p. 25.

nonsocial action oriented to reaching understanding because there is no understanding outside of a language experience. While the two actions oriented to success follows technical rules of action or rational choice and assess the efficiency of the intervention in complex circumstances or in the decisions of a rational opponent, the communicative action implies "agents involved […and] coordinated not through egocentric calculations of success but to acts of reaching understanding."[14] He continues: "reaching understanding is considered to be a process of reaching agreement among speaking and acting subjects."[15]

What does exactly Habermas mean by reaching an agreement or a consensus? For him, an agreement must be mutual and valid for the participants in a communicative action. Even more, an agreement "cannot be imposed by either party"[16] because it is by definition a nonviolent communicative act. A consensus among two participants in a communicative action supposes a speech act which has passed from a 'yes' or 'no' position on a validity claim to a recognized, accepted position based on reasons given in an argument. Therefore, "reaching understanding is the inherent *telos* of human speech."[17] Certainly, Habermas does not say that all actions mediated linguistically are communicative action. In order for a speech act to be oriented to a communicative action, it has to support more than a validity claim. It needs that "the speaker claims that what she says is *true*, what her speech act is supposed to bring about is *right*, and that the expression she is giving of her own intentions and emotions is *truthful* or sincere."[18]

Even though some speech acts might be used strategically, Habermas points out that their *constitutive meaning* appears only in a

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[14] *TCA,* p. 286.

[15] *TCA,* p. 287.

[16] Idem.

[17] Idem.

[18] Steve Vogel, *Against Nature: The Concept of Nature in Critical Theory* (NY: State University of NY Press, 1996), p. 147.

communicative action. This kind of action is purposely oriented toward an agreement that "will provide the basis for a consensual coordination of individually pursued plans of action."[19] The moment when an agreement is constituted is followed by certain obligations. Only a fully understood speech act can be accepted, and only something accepted rationally can raise a moral obligation for the other participants in the communicative action.

Without being able here to develop the entire Austinian and Searlian aspects of Habermas' theory of speech acts we should take into consideration how the question of normativity appears. It is certainly related to the question of *rightness* in regulative speech acts. As Habermas will mention in a latter essay, "the central semantic component in a normative sentence is the fact that the speaker recommends or prescribes to the hearer a certain option from among alternative courses of action."[20] In other words, saying that an option or a validity claim is right means that its rightness can be defended discursively by supporting it with arguments. Between two different utterances which both support a moral claim, one can choose precisely the one which gives sufficiently good reasons in order to be accepted not only by me but by all interlocutors. Thus, "the validity of normative claims can only be established via practical argumentations in which they are shown to be defensible with good grounds."[21] Discursive and practical arguments beyond any controversial validity claim are rationally motivated toward consensus. However, for Habermas, a consensus is far from being a compromise or a mere convenience.

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[19] *TCA,* p. 296.

[20] Jürgen Habermas, *Moral Consciousness and Communicative Action* (Mass: MIT Press, 1990), p. 57.

[21] Seyla Benhabib, "The utopian dimension in communicative ethics," p. 86.

In order for an argument to be a moral argument it has to presuppose a principle of universalization.[22] Otherwise said, the structure of communication is supposed to allow one to formulate a principle which goes further than a cultural or a timely situated validity claim. This is the Habermesian *principle D* which asserts that "only those norms can claim to be valid that meet (or could meet) the approval of all affected in their capacity as participants in a practical discourse."[23]

It is not difficult to identify this principle of universalization as a reinterpretation of a Kantian universalism. A moral argumentation committed to universalism has already assumed that validity exists in so far as all participants involved in that communicative action give their approval. Critics have seen in this principle of universalization a new form of Kantian transcendentalism. "Personal autonomy is determined by reasons which worth for all members of a moral community. This interpretation of the free will and practical reason transforms the moral community in an inclusive and auto-legislative community made by free and equal individuals that have reciprocally to understand each other as ends in themselves."[24] The principle of universalization appeals to an ideal moral community. It is the equivalent of an ideal speech situation which defines the formal properties of any discursive argumentation.

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[22] "The principle D presupposes the principle U since D already *presupposes that we can justify our choice of a norm.*" Cf. Thomas Murphy, "Discourse ethics: Moral theory or political ethic?" *New German Critique*, 62(Spring-Summer, 1994), p. 117. Murphy quotes Habermas (in italic), "Discourse ethics: Notes on a program of philosophical justification," in: *The Communicative Ethics Controversy*, eds. Seyla Benhabib and Fred Dallymar (Cambridge: MIT, 1990), p. 71.

[23] Jürgen Habermas, *Moral Consciousness and Communicative Action*, p. 93.

[24] Jürgen Habermas, *L'éthique de la discussion et la question de la vérité*, trans. Patrick Savidan (Paris: Grasset, 2003), p. 21 (the author's translation).

Like in the latter situation, the moral argumentative discourse supposes symmetrical and reciprocal conditions. The former refers to speech acts alone and how to employ them. The second set of conditions refers to social conditions and requires a shift from an established egological center to a position of equality of the subjects involved in moral communicative action. Even if Habermas follows Kant, it is certainly in a weaker and fallibilist way. The transcendentalism of the former can hardly be separated from a rational argumentative reconstruction. He does not accept any form of substantive ethical theses but only "an ideal procedure for the justification of rightness claims: subjecting them to the scrutiny of a public discourse in which all affected are equally able to speak."[25]

One could summarize the main elements of the discourse ethics by articulating its four principal aspects. First, for Habermas, discourse ethics is a *universalistic moral theory*. The main function of the *principle D* is to go further than a cultural or historical consensus. Second, the discourse ethics is *formal or procedural* because it gives a principle of justification of moral norms. Third, this principle of justification plays as a "transcendental-pragmatic justification of a rule of argumentation with normative content."[26] Fourth, there is no *a priori moral claim* before any intersubjective discussion. Otherwise said, the question becomes: which are the conditions for a norm to be valid?

Habermas makes a double shift: first, from the question regarding when an act is good from an ethical perspective to the one of rightness or justice of a communicative action; second, from the question of happiness to the one concerned with the prescriptiveness of valid norms. Thus, the moral question about the rightness of a particular action has to be set apart from ethical questions which are concerned with our own preferential choices. The discourse ethics is a *deontological theory*.

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[25] Steve Vogel, *Against Nature: The Concept of Nature in Critical Theory*, p. 148.

[26] Habermas, *Moral Consciousness and Communicative Action*, p. 94.

It makes a sharp distinction between moral questions about norms and ethical questions about values. The everyday communication has to be divided in two parts: norms and values. "The first part of the domain of the practical [norms] is susceptible of requirement of moral justification in terms of its deontological validity; the second part, which consists of particular value configuration belonging to collective and individual modes of life, is not."[27]

After we have seen the way that normativity is the consequence of moral validity claim which successfully passed the test of universalization, we should ask ourselves what does Habermas mean when he talks about norm-conformative attitude toward nature? This aspect leads us to our next point regarding the relation between discourse ethics and nature.

2.2 The impossibility for a norm-conformative attitude toward external nature

In his examination of the formal-pragmatic relations, Habermas distinguishes between three *basic attitudes* (objectivating, norm-conformative, and expressive) and three *worlds* (objective, social, and subjective). Habermas includes the expressive and norm-conformative relation with nature in a large category called *moral-aesthetic relation to a nonobjectivated environment*. If the former is "provided by works of art, phenomena of style in general, but also theories in which a morphological way of looking at nature finds expression," the latter seems to be exemplified by a "fraternal relationship with nature" not far from "anthropomorphizing treatment of animals."[28]

However, not all relations "permit […] a development of cultural value spheres with their own inner logic," [29] and therefore they are not valid systems of claim. In order to be a system of claim they have to be

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[27] Ibid., p. 177.

[28] *TCA,* p. 236.

[29] *TCA,* p. 237.

"sufficiently productive from the standpoint of acquiring knowledge."[30] Thus, the norm-conformative attitude toward nature cannot be *rationalized and consciously sublimated*. Values spheres are distinguished by their production of knowledge which is not efficient outside of a learning process. Out of this analysis, Habermas thinks possible the rationalization of society as an arrangement of different levels of cultural values spheres.

This process occurs by a systematic institutionalization of each one of these spheres of value: instrumental rationality in scientific enterprise, aesthetic-practical rationality in artistic enterprise, and moral-practical rationality of the ethics of brotherliness in salvations religions. Hence, for Habermas, the norm-conformative attitude toward the objective world is not a value sphere and even less a part of the process of rationalization of society. Should we conclude that a communicative actor has only a cognitive instrumental relation with the external nature? It seems that Habermas' position on this question supports this claim. "While we can indeed adopt a perfomative attitude to external nature, enter in a communicative relation with it, have aesthetic experiences and feelings analogous to morality with respect to it, there is for this domain of reality only one theoretically *fruitful attitude*, namely the objectivating attitude of the natural-scientific, experimenting observer."[31]

Why does Habermas think that any attempt to reconsider the unity of nature and morality is not a fruitful attitude? It is probably because Habermas fears a return to a metaphysical standpoint, and thus moving "behind the levels of learning reached in the modern age into a re-enchanted world."[32] Thereby Habermas precludes any possibility for a moral attitude with respect to external nature as long as "an ethical

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[30] Idem.

[31] Jürgen Habermas, "A reply to my critics," in: *Habermas*: *Critical Debates*, ed. by J. Thompson and D. Held (Cambridge: MIT Press, 1982), p. 243-244.

[32] Jürgen Habermas, "A reply to my critics," p. 245.

universalism supposes that a norm-conformative attitude of morally acting subjects *restricts* their view to interpersonal relations—here, too, nature-in-itself cannot become a theme."[33] In Habermas opinion, the absence of a consensual normativity among a communicative actor and nature is mainly due to non-symmetrical and non-reciprocal aspects of their relationship. If we don't have a moral normativity to regulate our relation with nature, how do *analogous feelings to morality* help us to integrate a certain form of non-instrumental behavior toward nature? As long as normativity is connected to language, can we deduce a form of responsibility toward nature? Otherwise said, what is it the answers of a communicative ethics to the question of responsibility for the environment?

2.3 Toward a theory of compassion

Habermas claims that we, as actors of a communicative action, cannot have a norm-conforming attitude toward nature as long as normativity is based on a consensus among participants. Nature does not have a 'participant' status in its relation with us. Therefore, Habermas speaks in terms of compassion and solidarity. "The impulse to provide assistance to wounded and debased creatures, to have solidarity with them, the compassion for their torments, abhorrence of the naked instrumentalisation of nature for purposes that are ours but not its, in short the intuitions which ethics of compassion place with undeniable right in the foreground, cannot be anthropocentrically blended out."[34] Habermas mentions however a few difficulties regarding this project.

First, an ethics of compassion will always run the risk of being grounded in naturalism, which, following Habermas, often entails a metaphysical point of view. Habermas raises this difficulty as a post-metaphysical thinker for whom there is no *a priori* worldview which can prevail on other worldviews.

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[33] Idem.

[34] Idem.

Second, an ethics of compassion risks erasing the significant differences among moral concepts like equality or reciprocity. These key notions of the discourse ethics are also the central concepts of the theory of communicative action. There is no communication without symmetry understood as equal possibility for each participant to have the chance to start and to continue a communicative process, or assert, explain, or challenge justifications. At the same time, each actor of a communicative action must have the chance to express feelings, wishes, and intentions as well as to resists orders, to refuse them, or to ask for account from others. These conditions of symmetry and reciprocity are not available in the case of animals (or in an environmental case) because of their difference from humans, namely a linguistic difference. Thus, an ethics of compassion "would become accessible to moral consideration only if this ethics were extended beyond the domain of interpersonal relations to our relationship with creatures that cannot fulfill the conditions of responsible actions."[35] Due to their lack of participation in a communicative action and consequently to their lack of responsibility, living creatures involved in this form of ethics "would inevitably depend upon a form of paternalism inconsistent with modern conception of the moral point of view."[36]

Third, Habermas brings out that in the case on an ethics of compassion it is hard to define a clear criterion to designate for which living creatures we have to feel compassion. How do we have to deal when a moral principle might be in conflict with our own needs? In this case, if "the norm-conformative attitude toward external nature does not yield any problems susceptible of being worked up cognitively,"[37] the last standpoint which will prevail is the normative validity. Therefore, one is not obligated, unless this person is committed to some religious

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[35] Jürgen Habermas, "A reply to my critics," p. 247.

[36] Steve Vogel, *Against Nature: The Concept of Nature in Critical Theory*, p. 154.

[37] Jürgen Habermas, "A reply to my critics," p. 248.

maxim, to be a vegetarian by compassion for animals.[38] The limit of our morality is reached when our vital interests conflict with those of animals. There is no similar moral duty for animals as for humans without a direct interaction, or without a communicative action.[39] Moreover, for Habermas there is no moral duty without intersubjectivity.

Even though, in *Justification and Application,* it seems that Habermas moves further from an ethical theory of compassion to a quasi-moral form of responsibility regarding animals and nature in general, there will always be an impassable limit. "Human beings always find themselves already within this horizon [of intersubjectivity] and as persons can never leave it, whereas animals belong to another species and other forms of life and are integrated into our forms of life only through participation in our interactions."[40] Habermas concedes an *analogous moral duty* with respect to animals as long as we admit that "asymmetries in the interaction admit comparison with relation of recognition between persons."[41] In other words, animals do not have an intrinsic value which would be the source of our moral duties but only to the extent "that we encounter them in the role of an alter ego as an other in need of protection."[42]

In short, the answer to the question concerning how Habermas integrates nature in his discourse ethics will help us to summarize the upshot of this first part. First, normativity in discourse ethics arises out

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[38] Jürgen Habermas, "Remarks on discourse ethics," in: *Justification and Application*, trans. C. Cronin (Cambridge: MIT Press, 1994), p. 111.

[39] "By interaction, I understand *communicative action*, symbolic interaction. It is governed by binding *consensual norms*, which define reciprocal expectations about behavior and which must be understood and recognized by at least two acting subjects." Jürgen Habermas, *Towards a Rational Society,* trans. Jeremy Saphiro (London: Heinemann, 1971), p. 92.

[40] Jürgen Habermas, "Remarks on discourse ethics," p. 110-111.

[41] Ibid., p. 110.

[42] Ibid., p. 109.

of situations in which validity claims have been the object of a consensus among participants in a communicative action. This ethical theory has four main features. 1) It is a deontological moral theory because it focuses on the question of the validity of prescriptive norms of actions. 2) It has a cognitive aspect because moral questions for Habermas raise validity claims to truth. 3) Discourse ethics is also procedural because it embraces a principle of justification of moral norms. 4) Through its *principle D*, discourse ethics reaches a universal standpoint which overtakes cultural and historical worldviews.[43] Thus, Habermas does not concede a norm-conformative attitude regarding nature. The only moral attitude toward nature that communicative actors are able to perform is through a stance of compassion or, at most, an *analogous feeling to morality* with respect to animals.

3. THE LIMITS OF NORMATIVITY CONCEPT BASED ON DISCOURSE ETHICS

A number of authors have tried to answer the question of what discourse ethics can tell us about our responsibility with respect to nature, nonhuman animals, and future generations. Intuitively, one might think that these questions are left out of our set of moral duties. As long as normativity is a consensual consequence of a communicative action, it is explicitly reserved to relations among existing humans. Thus, one could reasonably doubt about the ability of this ethical model to account for a norm-conformative attitude outside of a communicative framework.

The purpose of this second part is to present some of the limits of this ethical model. We will test Habermas' ethics of discourse by showing how his theoretical apparatus functions in applied situations. The

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[43] A really helpful account of the characteristics of discourse ethics is given by Mark Hunyadi in: "Liminaire du traducteur," Jürgen Habermas, *L'Ethique de la discussion* (Paris: Cerf, 1992), p. 8-9.

three critiques which are presented here are meant to reveal the limits of this ethical model. These critiques are related to the anthropocentrism of discourse ethics, to the 'quasi' status of moral duties toward nonhuman animals, and to the question of future generations.

3.1 Anthropocentrism and nature

In his article "The problem of nature in Habermas," Joel Whitebook points out the impossibility for discourse ethics to understand nature other than instrumentally. He thinks that the major reason for Habermas' point of view is his dualistic framework. "While the logic of instrumental rationality governs the domination of eternal nature, the logic of communicative rationality governs that of internal nature."[44] Habermas tries to overcome the question of domination raised by his predecessors by dividing the realm of nature on three major levels: objective nature, subjective nature, and nature-in-itself.[45] If the external nature or objective nature is the object of scientific observation, reification, or instrumetalisation, the subjective nature is the possibility for *the internalization of intersubjective norms*. Subjective nature aims to increase the autonomy of an individual by differentiating him from other communicative actors. As we have already seen in his *Reply to my Critics*, for Habermas nature-in-itself cannot be thematized as long as it is prehuman (prelinguistic) or nonhuman (nonlinguistic). Therefore, by losing the "connection between the domination of internal and external nature, and by granting a degree of relative autonomy to the communicative level, Habermas can conceptualize moral progress."[46]

How does Habermas conceptualize this moral aspect of the subjective nature? The *pragmatic universal* functions as a "quasi-

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[44] Joel Whitebook, "The problem of nature in Habermas," *Telos,* 40(1979), p. 43.

[45] Jürgen Habermas, *Knowledge and Human Interests*, trans. J. Shapiro (Boston: Beacon Press, 1972), p. 27.

[46] Joel Whitebook, "The problem of nature in Habermas," p. 44.

transcendentalism."[47] This universal is constructed from the perspective of any communicative actor as long as he supports his validity claims toward a rational consensus. "Our first sentence expresses unequivocally the intention of universal and unconstrained consensus."[48] Along with Habermas, Whitebook raises the question: "Is it not plausible that the laws which were introduced into the course of evolution with the emergence of man as *zoon logikon*, and which constitutes conditions of possibility for human association, also constitutes the fundamental norm of this association?"[49] Habermas agrees on the emergence of a linguistic being as a constitutive element of any human association since he holds for true the premise that "what raises us out of the nature is the only thing whose nature we can know: *language*."[50] Therefore, we define the limits of our autonomy as well as the limits of our responsibility through the use of the language.

Whitebook maintains that Habermas' doctrine of nature proceeds from "his transcendental investigation [which] reveals not only conditions of possibility of the evolution of species, but also the norm that Habermas employs as the basis of his communicational ethics."[51] However, can the model of discourse ethics be pertinent in the context of the planetary ecological crisis as long as it presupposes a communicative competence? For Whitebook, the model of discourse ethics fails to perform an adequate answer. "This is due to the fact that, to use the terminology of traditional ethical theory, communicative ethics is *thoroughly anthropocentric*."[52] If there is no possibility for normativity regarding external nature because we are unable to engage in a communicative situation based on language, "communicative ethics represents

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[47] Ibid., p. 45.

[48] Jürgen Habermas, *Knowledge and Human Interests*, p. 314.

[49] Joel Whitebook, ibid., p. 46.

[50] Jürgen Habermas, ibid., p. 314.

[51] Joel Whitebook, ibid., p. 46.

[52] Ibid., p. 52.

[only] a variation on the anthropocentric theme in that it maintains that man, by virtue of his communicative capacity, is the only value-bearing being that can be identified."[53] One could deduce that if our norm-conformative relation with nature cannot be the consequence of rationalization and does not offer us access to nature-in-itself, external nature cannot be conceived as an end-in-itself. Human beings as competent speakers and hearers are qualitatively different from the rest of natural world. This is certainly why for Habermas they have to be treated as ends-in-themselves.

At this point, Habermas attempts to open his discourse ethics to external nature by integrating the ideas of compassion and solidarity toward "wounded and debased creatures."[54] However, Whitebook says, insofar as nature remains merely an object of knowledge "our relation to nature can only be an *instrumental control.*"[55] Habermas' transcendental linguistic schema does not allow any living thing to be granted the intersubjective status of moral subject. Therefore, with respect to an increasing instrumentalisation of nature, one question persists: "Can we continue to deny all worth to nature and treat it as mere means without destroying the natural preconditions for the existence of subjects?"[56] For this question seems to be no answer from a Habermesian perspective.

Furthermore, the restriction made by this ethical model of our moral duties toward nature could be equally attacked on an epistemological level. As we have already seen in 1.2, Habermas' "conjecture is that only a few of these formal pragmatic relations are suitable for accumulation of knowledge."[57] His conclusion in *Reply to my Critics* follows the same steps of the *TCA*. "We cannot expect to be able to

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[53] Idem.

[54] Jürgen Habermas, "A reply to my critics," p. 245.

[55] Joel Whitebook, "The problem of nature in Habermas," p. 55.

[56] Ibid., p. 53.

[57] Jürgen Habermas, "A Reply to my Critics," p. 245.

use the experiential potential gathered in non-objectivating dealings with external nature for purposes of knowledge and to make them theoretically fruitful."[58]

The main critique of Habermas' view on the question of the possibility of the rationalization of norm-conformative attitude toward nature has been raised by Thomas McCarthy in *Reflections on Rationalization.* As we have seen, for Habermas, the "*only one theoretically fruitful* attitude*, is* the objectivating attitude of the natural-scientific, experimenting observer."[59] In Habermas' opinion, a non-restrictive objective attitude toward external nature creates a double risk. First, it destabilizes science in its effort *to reestablish the unity of reason in the theoretical dimension*. Second, it represents a step back to a metaphysical standpoint where external nature is an object of ethics since it possesses value. McCarthy lays out the two assumptions of this argument. First, "any attempt to rethink the unity of nature and morality would inevitably lead back to metaphysics."[60] Second, "any philosophy of nature that re-established this unity would have to compete with the modern sciences of nature."[61] Do we have models to rationalize nature in such a way to avoid Habermas' fears?

It seems that Kant should be recalled in the first place. Both, Whitebook and McCarthy, point out the solution that Kant states in his *Critique of Judgment* to resolve the nature dilemma. Nature is a possible object for experience and in the mean time it has a teleological aspect. The Kantian question could be summarized as it follows: if nature, as a possible object of experience, can be reduced to a causal nexus, there is no place for purposefulness. Kant solves this difficulty by introducing

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[58] Idem.

[59] Ibid., p. 243.

[60] Thomas McCarthy, "Reflections on rationalization," in: *Habermas and Modernity*, ed. by Richard Bernstein (Cambridge: MIT Press, 1985), p. 189.

[61] Idem.

a difference among judgments: on the one hand, the "determinant judgments"[62] are those through which a singular subject "determines the conditions of possibility of objects and knowledge of experience through an investigation act of transcendental consciousness"[63]; on the other hand, the "reflective judgments," founded on transcendental principles, lead to the idea that nature is systematically organized. McCarthy says that the latter form of judgments does not "compete with the causal explanation but is complementary to it."[64] Even more, the reflective judgment is not a metaphysical judgment. In other words, Kant offers us a possibility to reconsider the question of the unity between theoretical and practical reason. Therefore, one should not fear a turn back to metaphysics as long as "there is no *conceptual necessity* for the philosophy of nature to take on the form of the metaphysics of the nature claiming a validity independent of and prior to science."[65]

The criterion for rationalization as possibility for accumulation of knowledge seems fruitful for McCarthy in social actions systems. Though, at this point, it is still problematic why aesthetic relations are considered to produce more knowledge than a norm-conformative attitude toward the world. McCarthy notes that "the view of the human species as in-and-of-nature that we would get from a non-objectivating perspective would be quite different from the view of human species as set-over-against nature that lies behind the objectivating sciences which are structured by a cognitive interest in prediction and control."[66] In McCarthy's view, this change in our attitude toward external nature should have consequences for our sense of obligation with respect to speechless living things. He does not pretend that there is a real

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[62] Immanuel Kant, *Critique of Judgment*, trans. J. Meredith (Oxford: OUP, 1973), p. 18.

[63] Joel Whitebook, "The problem of nature in Habermas," p. 45.

[64] Thomas McCarthy, "Reflections on Rationalization," p. 190.

[65] Idem.

[66] Idem.

interaction between nature and communicative actors. What he might pretend to make available is the formulation of the continuities between human history and natural history. At least, Habermas grants his theory this.[67] The question regarding the continuity among humans and nature cannot explain, in Habermas' opinion, the transition from prehuman to human nature.[68] Moreover, "the analyses of the *worlds* specific to species, serve as an example of the idea of a privative access to *natura naturans* that is guided by a pre-understanding of the lifeworld specific to humans."[69] Habermas fears a turn back to a metaphysical standpoint. Thus, even if he makes some concessions to Whitebook and McCarthy, he does not think that there is continuity between humans and nature. In these terms, how should one understand the *analogous feelings to morality* with respect to animals?

3.2 Avoiding pain as source of moral obligation for animals

In order for normativity to exist between at least two communicative subjects, there should be a consensual outcome of a linguistic interaction. Thus, if we find a common place on which there might be an 'agreement' among humans and nonhuman animals, this commonness will obligate humans to stand in a moral relationship to animals. Following this assumption, one could say with Günther Patzig and Mark Bernstein that humans are "under an obligation to prevent and mitigate animal pain and suffering."[70] Why are they? The argument claims that as long as all human beings avoid pain and suffering and they struggle to alleviate them, it *would be rational* that humans do not cause the same painful experience to others. "If I expect you not to

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[67] Jürgen Habermas, "Questions and counterquestions," in: *Habermas and Modernity*, p. 211.

[68] Jürgen Habermas, *Knowledge and Human Interests*, p. 41.

[69] Jürgen Habermas, "A reply to my critics," p. 242-3.

[70] Steve Vogel, *Against Nature: The Concept of Nature in Critical Theory*, p. 157 and Mark Bernstein, *Without a Tear—Our Tragic Relationship with Animals* (Urbana: University of Illinois Press, 2004), p. 23.

cause pain to me, then on universalistic grounds I must acknowledge that I may not cause pain to you; and a general duty to refrain from hurting others is derived."[71]

Moreover, Bernstein emphasizes that in our relationship with nonhuman animals, we act in the presence of innocents. Thus, our moral behavior should be even more adjusted with respect to the welfare of those blameless beings. This assertion is based upon a philosophical distinction between moral agents and moral patients.[72] Roughly, a moral patient is anything who could be 'better off' or 'worse off'; in sum, anything whose welfare[73] we have to consider when we act. A moral agent is someone able of moral thinking, or along with Habermas, someone who is able to participate in a communicative framework and internalize a rational consensus as norm of his moral actions. It seems obvious that all moral agents are moral patients. However, it is equally clear that not all moral patients are inherently moral agents as well. Children, severely brain damaged people, chronically senile or insane people, nonhuman animals, each one of these moral patients have welfare since they all feel pain and suffering. In the course of his actions, one ought to consider the welfare of moral patients anytime his conduct might affect it. In other words, moral patients have the right to enjoy their welfare and have no responsibility since they are not capable of moral reasoning.

Does this argument succeed in ascribing moral obligations in the case of nonhuman animals? If we consider that animals experience pain

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[71] Steve Vogel, ibid., p. 157.

[72] See also, Mark Rowlands, *Animals Like Us* (NY: Verso, 2002), p. 63-66.

[73] There is a large debate whether or not the notion of welfare should be extended to non-linguistic and non-conscious beings. For the brevity of the argument, we consider that anyone who feels pain and pleasure has a well-being. A counter position is held by Peter Carruthers, *The Animals Issue* (Cambridge: CUP, 1992), p. 56-62.

as well as humans do, one should performs actions in accord with this obligation of avoiding pain. By talking about duties toward animals, Patzig and Bernstein yearn for a principle of universalization of moral duties for humans and to the same extent for innocent and speechless living creatures. Habermas concedes that the force of this type of argument lies precisely in the fact that the latter does not "overstep the limits of an ethics without metaphysics."[74]

How far does this argument go? Patzig asks: "is it possible to extend the sphere of validity of moral obligation beyond the human realm to encompass all living creatures who are capable of experiencing pain and suffering but also pleasure?"[75] He continues, "we run up against a clear barrier […] for animals cannot enter into relation of principled reciprocity with us of the kind that govern our conduct toward other human beings."[76]

Against this type of argument, Habermas argues that we can have duties only to creatures which stand in a symmetrical and reciprocal moral relation with us. This is the limit of responsibility for a competent user of language. Patzig's and Bernstein's arguments cannot be deontological because they do not succeed the test of the reciprocal universality. The only moral duty that humans could have for animals, Habermas thinks, is a quasi-duty similar to what humans have for "vulnerable creatures whose physical integrity we must protect *for its own sake*."[77]

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[74] Jürgen Habermas, "Remarks on discourse ethics," in: *Justification and Application*, p. 106.

[75] Günther Patzig, "Okologische Ethik, innerhalb der Grenzen bloßer Vernunft," in: H.J. Elster (ed.), *Umweltschutz: Herausforderung unserer Generation* (Studienzentrum Weikersheim, 1984), p. 67. See also Habermas, "Remarks on Discourse Ethics," p. 106.

[76] Günther Patzig, ibid., p. 67; Habermas, ibid., p. 106.

[77] Habermas, "Remarks on discourse ethics," in: *Justification and Application*, p. 106.

Two questions needs to be raised: What is the status of a moral obligation *for* and *in respect of* animals? What kind of responsibility toward animals does this quasi-duty determine? Habermas talks about a *sense of being under categorical obligations* with respect to animals. "The horror inspired by the torment of animals is, at any rate, more closely related to outrage at the violation of moral demands than to the pitying or condescending attitude toward people who, as we are wont to say, have made nothing of their lives or are failures by their own standards of authenticity."[78] Habermas moves here toward the defenders of animals and preservation of species by conceptualizing the possibility of an analogous moral obligation for living creatures. He does not speak about a similar moral obligation as for humans but about a *quasi-moral* responsibility toward animals. He concedes some forms of interaction which reveals a kind of continuity in our relation with domestic animals. However, they do not have an intrinsic value but a value "grounded in the potential for harm inherent in all social interaction."[79]

Humans should adopt a performative attitude toward animals because our forms of interaction are *of the same kind as intersubjective relations*. Therefore, one can speak about analogous moral duties based on *the presupposition of a communicative action*. However, these analogous moral duties do not define a responsibility toward animals and nature identical to the responsibility we have toward communicative actors. There are at least two examples when one is not under a moral obligation with respect to animals but one is under moral obligation with respect to communicative actors. In the case of animal experiments, it is permissible and not seen as a murder if there are fatal results but it would be morally abhorrent to experiment on communicative agents without their consent regardless any possible outcome. A similar permissibility appears in the case of nonvegetarians who are not under

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[78] Ibid., p. 107.

[79] Ibid., p. 109.

the obligation of changing their nutrition. Thus, these cases point out limits of our empathy with respect to nonhuman animals.

3.3 Does a moral communicative agent have a responsibility for future generations?

It seems difficult for discourse ethics to take into consideration the future generations because their non-existence renders them incapable to participate in a communicative action. One might be tempted in this case, as K.O. Apel thinks, to turn back to a metaphysical standpoint. Moreover, in the case of the ecological crisis, it is unclear how the question of responsibility could be raised as long as human activities "whose effects and side effects are most far-reaching and risky are usually not caused by individual actors."[80] Therefore, one may ask: "Must an ethics meant to *found* our solidary responsibility for the collective actions of humanity in the midst of the present critical situation step behind Kant and revert to a religio-metaphysical belief that is incapable of a rational foundation?"[81] Deeply aware of the veracity of Jonas' challenges, Apel and Habermas have reflected upon the possibility for a discourse ethics to integrate a responsibility for the future generations[82] without stepping back to a metaphysical standpoint. They think that the ethics of responsibility has to confront itself with "the specifically novel and

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[80] K.O. Apel, "Discourse ethics as a response to the novel challenges of today's reality to coresponsibility," *The Journal of Religion*, 73(Oct., 1993):4, p. 500.

[81] K.O. Apel, "Macroethics, responsibility for the future, and the crisis of the technological society: Reflections on Hans Jonas," in: Eduardo Mendieta (ed.), *Ethics and the Theory of Rationality: Selected Essays of Karl-Otto Apel*, vol. 2 (Atlantic Highlands, New Jersey: Humanities Press, 1996), p. 219.

[82] A similar moral argument could be applied also to the case of 'the third world.' Both examples, future generations and third world, represent two hypothetical situations of communicative actions.

simultaneously important aspects of today's reality."[83] Does solidarity as a genuine source of motivation for my moral behavior require, like the founders of discourse ethics think, that the moral agent places himself in communicative situation? If the answer is positive, how could be realized a communicative framework since future generations do not exist, and thereby cannot participate in a communicative action?

Sharing Jonas' analyses,[84] Apel discerns three novel problems for moral responsibility that have emerged as a consequence of our sociocultural evolution. First, *science-based technology* has completely changed our way of referring to ourselves and to nature in general.[85] Often, we are not able to detect possible damage done by our technological intervention into the world until the harm is done like in the case of asbestos.

Second, a "scientific knowledge concerning the complex structure of the relevant facts and the possible effects and side-effects of our actions and sustainable activities"[86] is needed today for a *morally relevant decision making.* In Apel's opinion, this new challenge raised by our evolutionary situation shows that *the common man* can no longer *listen to his inner sense* to know what *he ought to do.*[87]

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[83] K.O. Apel, "Discourse ethics as a response to the novel challenges of today's reality to coresponsibility," p. 496. See also, Jürgen Habermas, *The Future of the Human Nature* (Cambridge: Polity, 2003).

[84] Hans Jonas, *The Imperative of Responsibility: In Search of an Ethics for the Technological Age*, trans. H. Jonas and D. Herr (Chicago: UCP, 1984), p. 6-8.

[85] "Since their effects and side-effects transcend every face-to-face encounter with the affected human persons, it becomes very difficult to compensate for this loss of proximity to one's fellow human beings, say, through imagining what they might have to suffer from our actions or activities." Ibid, p. 498.

[86] Ibid., p. 499.

[87] Reference to Kant, *Groundwork of the Metaphysics of Morals*, trans. Allen Wood (NY: Yale UP, 2002), p. 43.

Third, as we have previously seen, "individual actors in a sense cannot be held accountable for these [technological] actions and activities in the way that individuals have been held responsible for their actions according to traditional morals."[88] If one seriously considers these new problems regarding the concept of responsibility, a question naturally arises: whether or not we actually need a novel ethics of responsibility.[89] This question discloses Apel's intention. He suggests a possible solution to our problem from a *transcendental pragmatics of human communication*. Apel thinks that "discourse ethics as […] a postmetaphysical transformation of Kantian ethics"[90] may fulfill our task. This argument, "as it is proposed by Jürgen Habermas and my self [Apel]"[91] is based on three constitutive elements: the Kantian fact of practical reason, the regulative ideal, and the foundation for an ethics of responsibility conceived as an ethics commanding us to preserve the being of the real community of communication.[92] Moreover, Apel thinks that the ideal community of communication needs progressively to be realized.[93]

The fact of practical reason makes us, as real members of a communicational community, open our responsibility to all possible communicative actors. We are not responsible only for our real communication community but also for the progression toward the future

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[88] K.O. Apel, "Discourse ethics as a response to the novel challenges of today's reality to coresponsibility," p. 500.

[89] Ibid., see also p. 501.

[90] Ibid., p. 506.

[91] K.O. Apel, "A planetary macroethics for humankind: The need, the apparent difficulty, and the eventual possibility," in: Eduardo Mendieta (ed.), *Ethics and The Theory of Rationality: Selected Essays of Karl-Otto Apel*, vol. 2 (Atlantic Highlands, New Jersey: Humanities Press, 1996), p. 284.

[92] For a full account of this argument, see Nicolae Morar, "Consensus and responsibility as solidarity," in *Romanian Journal of Bioethics*, 5(2007):3, p. 29-32.

[93] K.O. Apel, "Macroethics, responsibility for the future, and the crisis of the technological society: Reflections on Hans Jonas," p. 233.

communication community. In that sense, we represent the interest for perpetuation for every non-linguistic realm. We have coresponsibility or a collective responsibility that the ideal communicational community *must always remain to be realized—progressively*. For Apel and Habermas, a promising answer to the ecological crisis, to the settlement of international conflicts, or to the question of future generations has to take the form of *a discursive organization of solidary responsibility*. Otherwise said, we express solidary responsibility for non-linguistic situation or living creatures by deliberating on their behalf and thereby engaging them in a representational way in an interaction with the real communicational community.

The concept of solidarity, as foundation for a new ethics of responsibility for the future, does not change the fact that our personal responsibility is morally accountable but introduces a primordial coresponsibility with respect to the global and indirect effects of our actions. It is a postconventional ethics based on a pragmatic-transcendental principle regulating our communicative actions. We share not only equal rights with all real and possible (future) communicative actors but also a collective responsibility for finding solutions to all problems which can be debated in an argumentative manner. Is this form of responsibility as solidarity a sufficient condition to motivate my own moral behavior?

As many critiques have pointed out, it is hardly conceivable that in virtue of some self-awareness of my language ability and of my membership to a communicative community, I will act in such a way that the hypothetical welfare of non-existing communicative actors will always be considered. Even if this philosophical model seems attractive, it is nonetheless implausible that putting myself in a hypothetical communicative situation will be a sufficient condition to act in a normative way with respect to the interests of the possible communicative actors. Thus, the notion of an ideal communication community that must always remain to be realized seems somehow being more a highly philosophical device than an adequate source of motivation for a moral behavior toward future generations.

4. CONCLUSIONS

Overall, the critiques raised in the second part of our paper have shown the limits of discourse ethics concerning our responsibility toward external nature, nonhuman animals, and future generations.

First, normativity is internally connected to language. If communicative actors raise and discursively debate their validity claims, they will probably reach a consensus for the best interest of each participant. In that sense, speechless beings will never be considered as participants in a discursive action. Thus, our linguistic ability is morally relevant in allowing us to treat nonhuman animals differently than humans. Therefore, even if Habermas concedes on some points that the discourse ethics can be the source of some performative attitudes toward living creatures, they will always be a *natura naturans* and not an end in itself. Our moral responsibility is both undermined by an instrumental treatment of speechless beings and by the idea that they have only a *quasi-moral status*. This enforces the special moral value of communicative actors.

Second, this linguistic disparity is certainly one of the reasons for the impossibility of rationalization of a norm-conformative attitude with respect to nonhuman living creatures. Habermas worries that if we agree to rationalize this formal-pragmatic relation, we have on one side to accept a metaphysical standpoint, and on the other side to lose the unity between the practical and theoretical discourses. Thus, without a process of rationalization of our relation with nature, the accumulated knowledge cannot be differentiated as a value sphere.

Third, even if Patzig and Bernstein suggest an ethics model without metaphysics, Habermas thinks that their argument fails the test of reciprocal universality. Once again, he grants our relation with nonhuman animals only with a moral similitude. Speechless beings “remain an object of morality which is to say that it may indeed have value but it does not *determine* value through its contributions to a normative discourse."[94] As we pointed out, this quasi-form of normativity seems to fail whenever we bring into question our nutrition, experiments on animals, and probably also hunting and zoo.

In short, we can conclude that discourse ethics, as a postconventional ethics, fails to give a positive answer to the question of responsibility for nature, for nonhuman animals, and for future generations. Discourse ethics is certainly grounded on a pragmatic-transcendental principle. Normativity is a consequence of a consensual argumentative situation. Habermas and Apel attempt to integrate non-linguistic realms in a normative situation by appealing to highly sophisticated philosophical devices such as quasi-moral duties or solidary responsibility. However, as long as the linguistic ability confers to communicative actors a special moral status, it is unlikely that nature, nonhuman animals, and future generations will be considered differently than a second class of moral objects.[95]

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[94] Steve Vogel, *Against Nature: The Concept of Nature in Critical Theory*, p. 161.

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TOWARD AN ETHICS OF SPECIES
Is there a Responsibility to Preserve the Integrity of (Human) Species?

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> ‘I had a friend, once, that if you burnt him with a red-hot poker, it would take years and years before he felt it!’ ‘And if you only *pinched* him?’ queried Sylvie. ‘Then it would take ever so much longer, of course. In fact, I doubt if the man *himself* would ever feel it, at all. His grandchildren might.’ ‘I wouldn’t like to be the grandchild of o pinched grandfather, would *you*, Mister Sir?’ Bruno whispered. ‘It might come just when you wanted to be happy!’
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> Lewis Carroll, *Sylvie and Bruno*

1. DEFENDING THE INTEGRITY OF THE SPECIES: IS THERE ANYTHING TO PROTECT?

There is something childish in Bruno’s anxiety about him having to feel on his own skin the effect of some action, which his ancestors had not considered carefully because, at the time, they deemed they were not forced to experience it themselves. But the fact that the outcome of our present actions can show itself only after several generations and even in the most unexpected forms is no longer a childish fantasy in the age of genetic technologies. What looks like a little nonsense in Lewis Carroll’s imagination is at the same time a vivid illustration of the idea that all generations are linked with a special ‘chain of being’. This unity over the time is supposed to prove the existence of a common good at the species level, something that we all share and to which we all make our little contribution. Pointing to the consequences for everyone's well-being, the argument tells us that this 'common heritage' might be subject to harm, therefore we should protect it, maintain it untouched, keep it away from interventions whose consequences one cannot fully foresee. In other words, we should respect the integrity of the species. We call this the moral imperative about species integrity.

The imperative about integrity can be expressed like this: biological species in general and human species in particular have an intrinsic value, which is recognizable beyond the value of each individual. The respect of this intrinsic value requires protection of the species as they are, in their wholeness and intactness or, in other words, in their integrity.[1] Technological manipulations that lead to modifications at the genome level or cross the species boundaries violate this intrinsic value and, as a consequence, violate the integrity of the living species. If this integrity is threatened by some biotechologies, we have a duty to ban them. There is a duty to protect species (human species above all) on this dimension of integrity. We can eventually infer other particular duties from this general duty.

Although this imperative builds up on many more or less plausible assumptions, it doesn't mean it could only be justified through some kind of religious intuitions. This moral imperative can function as well in secularized ethics, which is based only on agreement achieved through rational argumentation. One could probably find it easier to build arguments for the imperative about integrity if one takes for granted one or two moral intuitions emerging from a particular religious tradition. For instance, the claim made on the background of Christian tradition that God has created man and animal species, therefore anyone who violate

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[1] When Jan Vorstenbosch defines integrity, he has in mind a state of " 'wholeness', 'intactness', an 'unharmed or undamaged' state of something, presumably a living being." Cf. J. Vorstenbosch, "The Concept of Integrity. Its Significance for the Ethical Discussion on Biotechnology and Animals," *Livestock Production Science*, 36(1993), p. 110.

their integrity run the risk of offending God's Creation and its author. It's obvious that we must evaluate the content of this statement, and bring arguments acceptable only on rational grounds, that is, regardless of particular religious views on the world. Let us suppose that the concept of integrity makes a very important contribution to our self-understanding as humans. Let us suppose that some religions have a point in making it our duty to preserve Creation, meaning all species and human integrity. Even so, we cannot take the arguments we found inside those religious traditions and integrate them in a secularized ethics. The duty to preserve species *as they are*—supposing that there are sound arguments for such a duty—could be reinterpreted as duty for individuals, as long as they represent their species and contribute to the intrinsic value that inherently belongs to their species. The moral imperative about species integrity could then be essential in making us sensitive to the obligations we have to individuals.

In the following sections I will discuss some arguments for and against the moral imperative about species integrity. Basically, the former arguments say that the moral imperative about integrity has a normative substance, from which we can infer other particular obligations. The latter arguments deny the existence of an intrinsic value of the species although they can recognize some obligations we have to protect living species. These obligations do not require assuming that species are intrinsically valuable. I am not interested here in the question whether species membership has a moral significance *per se*. Some may argue that from the mere fact of belonging to a species one could infer special obligations that justify us in making distinctions about how we should treat individuals belonging to different species. Since I will not give special attention here to the species membership, it will not be essential to ask the question whether we should recognize the intrinsic value of some species, but not of others. This approach needs neither to put this question nor to grant humans a special position, at least not for the moment. A proper defense of species integrity must take place irrespective of the preferences for some stages of the evolutionary process or for the way we evaluate these stages. I am interested only in how we use the appeal to species as a whole—a current tendency in many bioethics arguments—further, whether species integrity is valuable *per se*, and whether from the general obligation to protect the integrity of species must follow some special moral obligations, as for instance the obligation not to cross the species boundaries and to protect species as such. The result is expected to be negative, that is, such obligations will be always questionable. But the problem of integrity is quite relevant for ethics, because it points to real issues of moral concern about the well-being of individuals and to the responsibilities humans have to other beings.

There are mainly two possible positions about species integrity:

1) Some biotechnologies like genetic engineering or hybridization are *intrinsically wrong*, because they neglect the intrinsic value and moral consideration that all species deserve. Technological manipulations have consequences not only for individuals but for the species as a whole. Such manipulations could affect species in their integrity.

2) Biotechnologies cannot be intrinsically wrong because species have no intrinsic value. Biotechnologies could be wrong only as long as they lead to *bad or unacceptable consequences*. There is no special intrinsic value that functions as a source for the obligation to preserve the integrity of species. If there are obligations to protect species and individuals, these can only result from the obligation to avoid inflicting harm on a living being.

The next section deals with some arguments from both sides, whereas the third part of this study extends the debate to the ethics of human species.

2. ARGUMENTS FOR AND AGAINST PROTECTING SPECIES INTEGRITY

These are some arguments from the first position:

1.a) The moral imperative of integrity is based on the idea that species have an intrinsic value. The first step will then be to show what this value consists of. If some technologies offend this intrinsic value, then they are intrinsically wrong. This position says precisely that they are wrong not only because they could lead to undesirable consequences, but that they are *fundamentally or intrinsically wrong*, i.e. they are wrong even if they harm nobody and whatever benefits they may result in. That such intrinsic wrongdoing really exists, the supporters of this position are saying, is shown by destructive research approaches like creating human embryos in order to derive embryonic cell lines. This approach is considered in our present society *intrinsically wrong* (although not in some Asian societies), and no possible positive outcome could outweigh this wrong, not even the prospect of new therapeutic methods that could cure severe or untreatable diseases. The same applies to species issues. The extinction of species and genome manipulations using biotechnical means are intrinsically wrong whatever the consequences of those actions may be. There are things we can consider *per se* morally wrong, things one should not do. This 'do not'-thing builds, of course, its legitimacy mostly upon the moral intuitions available in a particular society.

1.b) Another account for this intrinsic value is to argue that it is important for man to keep the order of the nature untouched. One can trace the problem of integrity by making a simple review of well-known common arguments against biotechnologies, whose main ideas are such metaphors like 'the nature as gift', 'playing God', 'violating the sanctity of life', etc. These arguments are alternative expressions for the same intuition that some applications of biotechnology, e.g. genetic engineering, are just morally wrong because they violate the intrinsic value of the biologic entities that make the subject of the intended modifications. We can think about this intuition as a theological residuum, which is also present in contexts where religious positions are no so important. A wide debate is taking place today about what biotechnologies are acceptable (vaccination is a form of enhancement that is usually accepted) and what are not acceptable (positive eugenics is highly controversial). However, it is common sense that there must be a limit for technological intrusions in human and animal life. This idea that there are boundaries no one should cross brings in foreground the integrity question and the idea of an intrinsic value. And the simplest way to defend this intrinsic value is to say that such value gets its significance from beyond this world, for instance that the natural order of Creation has something sacred in it, and that the intrinsic value is transcendent to this world or at least measurable from a perspective beyond this world. If some entities in our world (individuals, species, ecosystems, life in all its dimensions) possess a sacred value, nothing could be said against the fundamental character of this value and against the obligations that follow from it.

1.c) A weaker alternative to the argument of the sanctity of nature, life or Creation is to only say that living things are simply good and that the mere fact that things exist the way we found them around us requires us to respect them, to protect them as they are, to preserve this givenness of nature and of all the living things. Man is only a small part of life on earth. Species are intrinsically good, they are good the way they are, and therefore we must protect them all. The natural order *per se* is good no matter where it comes from and no matter what results it brings about in subsequent stages of evolution. We could of course argue that one should not infer an ‘ought’ from an ‘is’, that is we must not be tempted to lapse into the naturalistic fallacy. But the argument could be saved in two ways. *Firstly*, we can say that the intended modifications that man operates in the natural order, like genetic engineering of plant and animal species or producing new species through hybridization, are an expression of human arrogance, a lack of respect for nature and for its creatures. The natural order features so complex connections within and between the life-supporting systems that man’s interventions do not come close to even a rough approximation of the fine process of evolution, the only force able to create new species and push others to extinction. That *these* species exist is a state of things that is intrinsically good, because species coexist in a state of equilibrium, the result of millions of years of evolution. Even if this equilibrium seems to be relative, even if new species emerge through some inevitable evolutionary movement and others disappear, this phenomenon is the result of a lot of complex fine-tuning processes. Compared to that, man's technological possibilities are rough, inexact, and blind to the real object of the intended modifications. *Secondly*, to change the order of the nature is not only a proof of man's arrogance, given the limited human knowledge, but also an expression of man's 'temptation to tyranny', a well-known accusation in the ethical debate about enhancement, as for instance referring to the parents' desire to design their children.[2]

Let us focus now on some arguments of the second position. Afterwards, it will be necessary to reconsider the arguments above.

2.a) The second position challenges the intuition that some living entities have an intrinsic value, and that some biotechnologies are intrinsically wrong if they disregard this value. Take for instance the case of embryonic stem cell research. It seems plausible to think that making embryos for research purposes is *intrinsically wrong*. We know that some cultural traditions (the Jewish one for instance) take birth and not conception as the critical point from which human life begins. We expect a wider acceptance for embryonic cell research within those cultures, as for instance in some European countries. However, in some of these countries the interdiction to create embryos only for research purpose coexists with the permission to do research on the spare embryos from the IVF clinics. Some clinics conserve the spare embryos to satisfy future requests for in vitro fertilization, even if these requests come from clients other than the biological parents of the frozen embryos. Other clinics destroy the spare embryos or sell them to research institutions that derive from them embryonic cell lines. If creating embryos for research is intrinsically wrong and research on spare embryos or cloned human embryos is not, then the only thing that makes the moral difference must be the way these embryos are obtained. To put it another way, neither the research itself nor the intentions linked up with this research, but the mere origin of these

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[2] Thomas H. Murray, "Enhancement," in: Bonnie Steinbock (ed.), *The Oxford Handbook of Bioethics* (Oxford: Oxford University Press, 2007), p. 491-515, here p. 507.

entities would decide exclusively when research on embryos is morally wrong. If there is something that we can qualify as 'intrinsically wrong' in the creation of embryos for research purpose, then this something should make research on spare embryos or cloned human embryos just as unacceptable. But, strictly speaking, there is no such thing that we could call 'intrinsically wrong', or at least it seems to be so only for people who take a religious stance and plead for the idea that embryos are from the very beginning human persons and therefore subject to absolute protection. But, for the time being, we don't want to justify this intrinsic value by referring to religious intuitions about the sanctity of life or something similar, because in this way we will not obtain the assent of people who don't share these intuitions. For these people, there is no such intrinsic value and they would not reject embryo research because it is intrinsically wrong. Neither can they argue that research on embryos is wrong because it has bad consequences for embryos, as long as these entities are not yet sentient beings. They can however argue that making embryos for research purposes is morally wrong because of the intention behind this activity, and this is the treatment of embryos as mere means, i.e. their total instrumentalization.

2.b) The second position rejects therefore the arguments that some entities have intrinsic value. In the case of species, it is even easier to show that they don't represent something valuable *per se*, irrespective for human intentionality. An argument that came often in the discussions about species integrity emphasizes the conceptual difficulties that occur in defining the idea of species and in setting adequate criteria to trace the difference between similar species. Not a single definition built upon biological criteria rules out all possible exceptions. The debate about species integrity seems to lead rather to an agreement about how inappropriate the concept of species is for it to describe living things accurately.[3] Some critics have stressed the misinterpretations that this concept may lead to and shown that many arguments

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[3] Donald Graft, "Against Strong Speciesism," *Journal of Applied Philosophy*, 14(1997):2, p. 107-118.

against 'crossing species borders' are based on "a mistaken, biblical or Aristotelian view of species as fixed and immutable rather than being slices of a dynamic, ever-changing process."[4] We can of course avoid these difficulties if we agree that we use the species concept mostly as representing a fixed given entity, and that this entity is for us as much as a moral construct.[5] If the entity that we want to describe through the concept of species is 'a dynamic, ever-changing process', then the 'wholeness and intactness' that we try to work out of the idea of species integrity is just a normative projection of our minds over the natural reality. We cannot really *mean* something by speaking about the identity of a species and about the obligation to respect its integrity, if we don't embrace some normative view that fills up the concept of species. The moral imperative about species integrity can then be understood as an appeal for the respect of a particular view about the concept of species. But in this case, the object of the protection is, at most, our moral concept of species, an image that we want to keep untouched, and not the living entities as such.

2.c) There is another argument in this line. If we understand integrity as 'wholeness and intactness', the debate about integrity makes sense for individuals but seems to become confusing at the level of the species. One can generally speak of the integrity of an individual animal, a species, an eco-system, or a human being. At the individual level one can talk about its corporal, psychological, genetic integrity, and, if we address humans, we can speak about their moral, cultural, linguistic integrity and so on. The list of the dimensions that could be relevant for the integrity of an individual living entity is no doubt longer. In each case we have a relatively clear representation about the subject whose integrity is at stake. It is reasonable to put the integrity

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[4] Bernard E. Rollin, "Ethics and Species Integrity," *The American Journal of Bioethics*, 3(2003):3, p. 15.

[5] Jason Scott Robert & Françoise Baylis, "Crossing Species Boundaries," *The American Journal of Bioethics*, 3(2003):3, p. 6.

question in those cases where the boundaries of an entity are obvious or at least possible to identify, for instance in cases where these boundaries are clearly determinable through the fundamental fact of the bodily or physical existence. Technological manipulations that endanger the bodily existence of an individual are infringements of his integrity. Integrity requires first of all protecting the body of the individuals. This requirement is difficult to maintain at the level of such complicate entities like species, which are the sum of a theoretically infinite number of individuals and which undergo natural mutations at the same time. Even though we use a moral concept of species,[6] the difficulty of identifying the referential for this concept remains. We can identify duties only relating to entities that are clearly determinable spatially and temporally. This applies for individuals, not for species. The latter are not fixed entities, they change steadily. Their evolution depends on the environmental conditions. A particular phenotype is passed on to the next generations through the selection of particular genetic patterns. At a specific moment in time, the phenotypic differences could become large enough to generate a new taxonomic cluster and to justify the distinction between two species, but no one can say when this step to a new species occurred.

2.d) Let us give up the question of a referent for species. The biological concept of species does not contribute much to justify an obligation for protecting living species. Man alone attaches value to some particular aspects of the world, living species inclusively. Because species have no intrinsic value, regardless of man's evaluative perspective, biotechnologies cannot be intrinsically wrong when we use them to create new species or when they work for some economic interests like for instance the selection of some particular, especially profitable animal individuals. Biotechnologies can be wrong only in as much as they lead to bad or unacceptable consequences. This is the position behind the

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[6] Robert & Baylis, 2003.

second set of arguments.[7] The systematic animal breed selection based on economic criteria, e.g. how productive animal individuals are, is wrong, because it reduces the biological diversity within a species and its capacity to answer with a robust reaction to new pathogenic agents. From the perspective of the species, biotechnologies are wrong if they lead to consequences that endanger the survival of that species. There is no integrity imperative, from which one can infer the special moral obligation to protect species as they are because of their special or intrinsic value. There are of course sound reasons for protecting species, but they could be justified only if we consider the possible consequences of our actions carefully. There are (at least) two kinds of consequences about breading animal species that we must consider. At the individual level we must consider the risk for the health and the well-being of the individual animals. At the species level, a consequence we want to avoid would be for instance to expose species to risk factors that jeopardize the survival of the entire population. If a fatal disease kills all individuals of a species, we cannot be moral responsible for the individual harm done as long as we haven't caused the apparition and the spreading of the disease. But one can say that we have produced harm at the species level if we have preferred some special individuals over others and if these manipulations of individuals have lead to a worse outcome for the species as a whole. But the reverse could be also true. Successful technological interventions at individual level, like genetic engineering, are not morally wrong, supposing that we can guarantee that no harm would occur on the species level.

2.e) A more radical version of the second position says that the harm produced by the current technologies can eventually affect the individuals. Our responsibilities concern the health and welfare

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[7] Bernard E. Rollin argues for instance in this way: destroying species is not intrinsically wrong, however, it is wrong from an instrumental point of view. Cf. Bernard E. Rollin, *Science and Ethics* (Cambridge: Cambridge University Press, 2006), p.151 ff.

of individual animals, not the health and welfare of the entire species. Only living bodies can be harmed. A species cannot be harmed.[8] Therefore, one cannot speak about duties to species, although there are duties to individuals. But even these duties are sometimes questioned. The ethics based on the social contract concept understand rights and obligations as something that people recognize and accept reciprocally. Only rational agents can negotiate their rights and obligations. Only these beings can then become the object of protection and might claim protection from other people. Since no other living creature besides humans can enter the reciprocal social process of recognizing obligations and claiming rights, it's at least misleading to speak about duties that humans have to beings belonging to other species. Other positions criticize this conclusion and highlight the difficulties the contractualist model has to deal with in animal ethics.[9]

Reflections about the harm and suffering that human interventions can bring about are of course important. Nevertheless, it's quite possible for this kind of ethical perspective not to shed enough light on the species integrity problem. Here are some points in which the first position brings the last arguments into question:

1.d) Germline gene modifications in humans or animals are changes of the genetic code that are passed on to the next generations. These alterations can have direct effects on the phenotype of the individuals and they propagate automatically at the species level. To calculate the consequences of these actions and to evaluate the amount of harm they bring about is not enough. As we know, many of the humans' interventions have resulted in the creation of new races and could probably easy made possible the apparition of entirely new species. This can take

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[8] Rollin, 2006, p. 147.

[9] Cf. Martha C Nussbaum, "Beyond 'Compassion and Humanity': Justice for Nonhuman Animals," in: Cass R. Sunstein & Martha C. Nussbaum (eds.), *Animal Rights. Current Debates and New Directions* (Oxford: Oxford University Press, 2004), p. 299-320.

place theoretically without causing bad or unacceptable consequences. But the question if this activity is morally right remains. In fact, this question is quite controversial and this is so not only because we cannot anticipate all consequences and weight all the impact the new species could have once they are released in the environment. There is another aspect we must take into account. Jan Vorstenbosch shows that there are at least three dimensions relevant for the ethical debate about the use of biotechnology on animals:[10] 1) the health of individual animals, measured by physiological and pathological parameters; 2) the welfare of individual animals, meaning the success of the interaction between animals and environment, and 3) an intrinsic value associated with individual animals. The last dimension points out that a number of ethical concerns related to the autonomy, the integrity or the naturality of the animal individual are also important in how we treat nonhuman animals. Do we really have to move to considerations about integrity? Vorstenbosch answers affirmatively and argues that precisely the case of transgenic animals shows how important it is to consider biotechnologies from the third perspective. Invasive technical interventions can affect something fundamental about individuals without putting in danger their health or welfare. Humans can manipulate genetic material and make individuals look different from the individuals that provided the genetic material. It's quite possible to create a new species that is completely adapted to the environment and whose individuals reach excellent values for the first two dimensions, health and welfare. Is this action morally permissible? The third dimension allows us to restate the question of the limits of biotechnology without direct connection with the question about their good or bad consequences. This is the question about their integrity and it has nothing to do with how much harm humans cause to animals. In fact, the concept of integrity

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[10] Jan Vorstenbosch, "The Concept of Integrity. Its Significance for the Ethical Discussion on Biotechnology and Animals," *Livestock Production Science*, 36 (1993), p. 109-112.

enables us to question the moral value of some actions, which cannot be properly evaluated strictly from their consequences.

1.e) The integrity question is important also from another perspective. We can think of integrity not as a label for an intrinsic value, but as an index for some moral standards and requirements that we must respect when we consider the state of individual animals. Concerns about integrity must enable us to take seriously into account a wider range of moral values that we should consider when we speak about animals and biotechnologies. Jan Vorstenbosch argues as follows: While welfare is a gradual value that allows different treatments in order to reach different states of welfare, integrity is a dichotomic value. It can be either fulfilled or not. Therefore, integrity requests to treat all individuals of a species equally. There is another relevant difference. While health and welfare of individuals can be affected by external environmental factors, integrity depends exclusively on the moral value that humans grant to nonhuman animals and to the living world generally. This close connection between human action and the existential dimension of each individual and of species as a whole shares a moral weigh to the question of integrity and underlines the genuine responsibility that humans have to all living creatures: “Actually this strong connection between integrity and action may have important implications for the discussion. It directly refers us back to the moral responsibility of human beings for the state of animals. … But integrity seems to have other implications for research and assessment. It points us back to our moral position, purposes and perspectives with regard to animals.”[11] The integrity question is therefore a real one, pointing directly to the responsibility to animal individuals. How to articulate this responsibility may be still controversial, but the fact that this responsibility exists cannot be questioned anymore.

2.f) But if we understand integrity this way—the supporters of the second position will reply—one can reduce the responsibility to protect

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[11] Jan Vorstenbosch, 1993, p. 110-111.

species to its component parts, and this means to work out the responsibility for individuals belonging to that species. To protect a species in its 'wholeness and intactness' depends on our ability to recognize and protect the interests and needs of individuals. One of these interests common to all beings is for instance to grow and flourish in the proper conditions of the ecosystem that meets their needs. If humans respect these interests, if they manage to protect each individual of a particular species, there is no need to expand our responsibility to make it cover the species as a whole. If we protect the parts, we manage to save the whole, and we need neither to go back to cultural representations about species nor to refer to moral concepts about species. Bernard E. Rollin pointed out that "one's ultimate moral responsibility is to individuals, not to species."[12] Although this position sounds reasonable, it overlooks some situations, when humans can equalize the advantages or the disadvantages for individuals, and therefore treat them equally, while the outcome of their action can shift on the species level in one direction or another. Take for instance the negative selection in respect to the predisposition for some genetic diseases or the mass administration of growth hormones.[13] These interventions may perhaps look fair for all individuals and could even respect their needs and interests. However, even if these actions have no significant effect on the individual level, they lead to changes that are obvious only at a global level. One should consider their moral value as well.

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[12] Bernard E. Rollin, "Telos, Value, and Genetic Engineering," in: Harold W. Baillie & Timothy K. Casey (eds.), *Is Human Nature Obsolete?* (Cambridge, MA: MIT Press, 2005), p. 326.

[13] Cf. Dan W. Brock, "Enhancements of Human Functions: Some Distinctions for Policymakers," in: Erik Parens (ed.), *Enhancing Human Traits: Ethical and Social Implications* (Washington: Georgetown Univ. Press, 1998), p. 48-69; and Thomas H. Murray, "Enhancement," in: Bonnie Steinbock (ed.), *The Oxford Handbook of Bioethics* (Oxford: Oxford University Press, 2007), p. 509 ff.

The argument in 2.b) has brought a serious objection against the imperative about species integrity: the concept of species gives no proper account on the realities we relate to it. Let us see how the first position defends the integrity question over this objection.

1.f) It's misleading to say that the moral imperative about species integrity is at best an expression of the desire to keep our special moral concept about species unchanged. Even if species are not fixed, immutable entities, but ever-changing phenomena, it doesn't mean that our concepts don't relate in some important ways to these entities. It is possible that our description is not fully accurate, but it helps us to understand forms of life, which are different from us. Not only is a particular species an abstract concept, but it also expresses a form of life that propagates itself through the individuals that belong to that species, and prevails over entire generations. Holmes Rolston holds that we should protect the various forms of life rather than species *per se*: "What humans ought to respect are dynamic life forms preserved in historical lines, vital informational processes that persist genetically over millions of years, overleaping short-lived individuals. It is not *form* (species) as mere morphology, but the *formative* (speciating) process that humans ought to preserve, although the process cannot be preserved without its products. Neither should humans want to protect the labels they use, but the living process in the environment."[14] This argument does not demand a final account about the referential of the species concept; it also does not need to answer the question on how to differentiate between closely related species. Each form of life has a genuine value, and this value is not inherent to the existence of individuals or species, but to the phenomenological fact of their manifestation. The dynamic manifestation of the living creatures, their particular way of coming into the world is what counts. Protecting the integrity of species means protecting the specific forms of life that

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[14] Holmes Rolston, "Duties to Endangered Species," *BioScience*, 35(1985):11, p. 722.

become manifest at different levels of evolution. This argument highlights another critical point for the integrity question. It points to the strong connection between each form of life and the environment where this form manifests and evolves. The argument makes it easy to integrate obligations directed toward species in a more complex ethical approach, in which one can reasonably ask for a more sensitive view over questions like climatic changes or questions about altering the environment where we and other species are living. "The full integrity of the species must be integrated into the ecosystem. Ex situ preservation, while it may save resources and souvenirs, does not preserve the generative process intact. Again, the appropriate survival unit is the appropriate level of moral concern."[15] The view that emphasizes the formative process of living species is closely related to Aristotle's concept of biology. Many critics of the modern biology have argued in favor of the teleological understanding of life. Surviving and flourishing means for living creatures satisfying a number of specific interests, rather than pursuing a pre-established plan that one could grasp if one were to fully scan the whole gene pool of a given species. Animals do not 'embody' a set of prescriptions encoded in some genetic programs. We cannot understand the behavior of nonhuman animals if we are entirely committed to the deterministic view, a view that is quite typical to modern biology. We cannot fully explain organisms by revealing their chemical structure and the mechanisms behind their functions. Like humans, animals have also interests, which they seek to fulfill. The idea of *telos* is meant to concentrate all the interests a being has. The critics of the deterministic view in biology have often brought up the idea that animals' behavior 'shows directedness', that is to say that nonhuman animals also manifest interests and want to satisfy them.[16] The moral imperative about species integrity tells us about the

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[15] Ibid., p. 724.

[16] Rollin, 2005, p. 318; Leon R. Kass, *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002),

obligation to respect the *telos*, i.e. the tendency of beings to fulfill their interests in a specific form of life.

2.g) It sounds quite plausible to apply this concept of integrity when we deal with changing species through genetic engineering. However, there are even now other difficulties with the moral imperative about integrity. Bernard E. Rollin holds that the moral imperative about *telos* commits us to a 'logical error'.[17] This imperative says that, if a *telos* is given, we must respect the interests that follow from it. Or, to put it another way, given a species, we must respect its unique and typical form of life. From this request one can derive other particular obligations, like for instance the obligation to preserve the environment, in which a species emerges and evolves. The imperative about *telos* expresses in another way the same concern about protecting specific forms of life that we have articulated through the imperative about species integrity. However, Rollin argues that we would commit a logical error if we derive from this the obligation to maintain the *telos* unchanged. The imperative to protect the *telos* and its related interests does not imply the interdiction to modify it in order to generate new or alternative interests. The only possible way to justify an obligation to preserve the *telos* of a living species is to show that a given *telos* guarantees a maximum of well-being and flourishing in respect to a particular species. This cannot be proved to be true, neither a priori, nor empirically. So, no one could claim that we shouldn't create a new *telos*, a new form of life, and thus generate new interests that arise from it. The only obligation that actually results from the imperative about *telos* is that, before initiating any change at the *telos* level, through genetic engineering for instance, we must make sure that the new individuals will not live worse than if we had left the situation unchanged. Ideally, we should endorse changes that will result in an increase of well-being. Therefore, *telos* and forms of life are not sacred. They are neverthe-

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p. 277 ff.

[17] Rollin, 2005, p. 322.

less open to modifications that naturally occur and they can as well undergo modifications that humans manage to carry out. Thus, if we follow this argument, the normative idea of maximizing the well-being is the only thing that counts. Actually, Rollin transforms the imperative about *telos* in the *Principle of Conservation of Well-Being*.[18]

1.g) This reading of the integrity imperative brings a new light over the ethics of genetic engineering. Each organism that evolves and flourishes has its own teleology, and this teleological development seems to be a process directed toward a generic goal: increasing the well-being, realizing one's full potential, irrespective of what this potential involves for each individual and species apart. Respect for species integrity means at least letting things take their course when it comes about the tendency of 'realizing one's full potential' or 'maximizing one's well-being'. This is what one should do even if, or primarily when this entails well-directed modifications of the *telos* itself. Genetic modifications are morally acceptable, say the supporters of the second position, when these modifications increase the capacity to fulfill one's *telos* and the related interests. This idea reminds us of a difficult topic in the ethics of enhancement. It is a well-know dilemma for both the advocates and the critics of human enhancements to correctly identify the *telos* of the human species. The latter plead for the genuine value of humanity, a value we must preserve as it is and as we know it, whereas the former want to see the tendency to shape oneself as 'natural' and enhancements as belonging *per se* to the human *telos*. In fact, the real difficulty consists in drawing the line from where the tendency to maximize one's well-being begins to become self-destructive or can be only realized by limiting the same tendency in others. There is no doubt that the flourishing of many species has negative effects on the same potential of flourishing for others. The real difficulty is thus to find out the coordinates for *that* level of well-being, which fits the individuals in their relations with one another. To specify the *telos* with such precision is an infinite, unreasonable task. But this is

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[18] Ibid., p. 325.

what is happening on the other hand through natural feed-back regulation. So, it is this natural order that we want to preserve rather than some abstract 'conservation of well-being'. But this means that there is something intrinsically good about this order, an end result that brings us back to the first position about integrity.

3. TOWARD AN ETHICS OF THE HUMAN SPECIES

We are far from having made a complete inventory of all arguments of the two positions discussed above. However, this is the moment when we want to move on to similar considerations about integrity of human species, a topic that might very well be a part of the ethics of species. The current debates over the various biotechnologies applied on humans move back and forth between moral considerations related to individuals and moral considerations related to humanity as a whole, that is to humans as species. Both normative perspectives relate to specific values. The step to an ethics of species is meant to underline a set of values that must be protected beyond the individual values. Some values play a normative role in both ethics, as for instance safety, protection, and flourishing, which make sense both for individuals and for human species. Some other values can function only in a narrow zone and are designed to be parochial. Autonomy is a central value for individual ethics, while it makes no sense when it comes about the ethics of species. Quite the opposite may be the case for something like the conservation and the protection of the genetic identity of the human species. This prospect could contribute some normative insights at the level of the ethics of species, but has no meaningful counterpart at the level of individuals as long as the perfect conservation and perpetuation of one's genetic inheritance is not possible in any other way but by cloning. The previous arguments for or against the imperative about integrity could bring some light about the ethics of human species, but the question may be a little more complex, because integrity could mean for humans more than just protecting a form of life. I will consider three contributions to the ethics of human species. Each of them gives a special interpretation to the imperative about protection of the species as a whole.

3.a) Many arguments about human integrity and biotechnology are similar to those we found in the ethical debate about altering nonhuman species. The request not to challenge the natural order by using genetic engineering is the same. These arguments drop some sort of 'normative anchors', which should fix the moral discourse on the solid ground of the natural state of things. They point to a special 'naturality' of the human nature and reiterate therefore the significance of the 'given', of the fact that we find things out there and that we should keep them untouched, i.e. protect their integrity. Depending on how much this 'given' should weigh in the debate about the acceptance of biotechnological interventions, there are various 'normative anchors': sometimes the norm refers to the human body from the biological point of view, sometimes the species identity is meant or humanity itself, understood in the context of a particular philosophical conception of human nature. These 'given facts' should set normative limits to human interventions and ban those technologies that weaken the 'solidity' of the given. The integrity of the human species begins and ends with this special, providential naturality. Here are some examples from this direction (our highlight): "To guide the proper use of biotechnical power, we need something in addition to a generalized appreciation for nature's gifts. We would need also a particular regard and respect for the special gift that is our own given nature. For only if there is a *human 'givenness'*, or a *given humanness*, that is also good and worth respecting, either as we find it or as it could be perfected without ceasing to be itself, will the 'given' serve as a positive guide for choosing what to alter and what to leave alone."[19]—"*The idea of an*

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[19] President's Council on Bioethics, *Beyond Therapy: Biotechnology and the Pursuit of Happiness* (Washington, DC: President's Council on Bioethics, 2003), p. 187.

independent moral status of human nature is therefore linked as much to a philosophical tradition as it is to widespread and in part legally institutionalized moral intuitions. *Nature is thereby seen as a given fact* and in this way it is hoped to achieve an objective point of reference for normative restrictions as regards the admissibility of biotechnological interventions on human beings."[20]—"… *we should regard the 'traditional shape' of the human body as a common heritage*, not simply as property and a tool of its owner who can do with it whatever she or he want." and: "I think we have good reasons to regard *the traditional genetic equipment of the human body* and its contingent evolution as an important part of our natural heritage."[21]

All these 'normative anchors' are supposed to relate to given, final and fundamental facts, which should function as points of reference in setting normative boundaries to biotechnologies. To cross these limits means to bring man in a state of *hybris*, to alienate him, to separate him from his proper essence. Yet, however intuitive all these references to man's naturality might be, few things seem to be harder than giving a serious account about what this 'naturality' means.[22] One of the puzzling questions about naturality is this: Do we find in man's very naturality the tendency to take in his hands the destiny of his own evolution and to shape his own naturality deliberately? Should we give course to this tendency or should we dismiss it as being outside man's 'naturality'? The case for enhancement makes this dilemma even more sensitive.

3.b) Modifying nonhuman species at the level of their *telos* is in many aspects similar to the attempts to enhance human traits through negative or positive selection. It seems to be quite easy to put into practice eugenic temptations when these are connected with reproductive

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[20] Kurt Bayertz, "Human Nature: How Normative Might it Be?," *Journal of Medicine and Philosophy*, 28(2003):2, p. 131-150, here p. 133.

[21] Ludwig Siep, "Normative Aspects of the Human Body," *Journal of Medicine and Philosophy*, 28(2003):2, p. 171-185, here p. 174 and 180.

[22] For this difficulty see for instance Dieter Birnbacher, *Natürlichkeit* (Berlin/New York: de Gruyter, 2006).

techniques. Through positive selection of specific traits and abilities we are on the way to controlling how our children relate to their life prospects, how they set up their goals and how they manage to achieve them. We shape not only the range of possible and desirable objectives one can pursue, but also the way we generally set up our goals and try to fulfill them, and this has consequences over the way we define ourselves. Enhancements challenge therefore our very self-understanding. If some preferences and abilities become innate, and if they cannot be shaped anymore by human desire and effort, they cease in fact to relate with human intentionality. It might be quite similar to the condition of a spoilt child that gets all by command and feels no need to struggle for something. Theoretically, we face the possibility of modifying the *telos* of human species at this subtle and elusive level. Can we work out some reasonable normative restrictions relating to this prospect without banning biotechnological interventions altogether?

Boundaries must be set, of course, to the alterations we make to the *telos*. Let us see some illustrative recommendations. A very common position says that no modification of human nature through genetic engineering should challenge the normative concept of a human being, that is, what humans should be like. There has always been a dominant conception about what humans are, which encapsulated the normative image of humankind. Alterations by genetic engineering should not jeopardize this normative image. Bernard E. Rollin points out to those modifications that challenge the normative content of the current conception about humankind, and classify them as modifications at the 'ought' level: "… we would not accept as moral any genetic engineering of humans that conflicts directly with our long-standing and currently strongly held moral traditions regarding what a human ought to be."[23]

Another common approach tries to isolate something like a minimal core of essential traits that must be subject to absolute protection. It is not the occurrence of a specific genetic structure that guarantees

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[23] Rollin, 2005, p. 331.

our integrity, but some few fundamental features, which make humans what they are. These features should be protected, and if we do so, we manage to save human species as well, in its 'wholeness and intactness'. Even the most convinced advocates, who endorse the idea of engineering human nature,[24] support the thesis about some final boundaries that no one should cross. From their perspective, protecting the integrity at the level of human species means protecting fundamental goods, like the capacity to act autonomously, as free agents, or "the capacity to act on the basis of normative reasons," which is the same as "the capacity to display practical rationality."[25] Enhancements should be "consistent with developement of autonomy in the child and a reasonable range of future plans."[26] It is obvious that this position is compatible not only with germline genetic enhancements, but also with the prospect of human-animal hybrids, as long as it maintains these prospects in harmony with the normative image about a being able to act on the basis of normative reasons, a being able to display

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[24] John Harris, *Enhancing Evolution. The Ethical Case for Making Better People* (Princeton: Princeton University Press, 2007); John Harris, "Enhancements are moral obligation," Wellcome Trust, November 14, 2005, http://www.wellcome.ac.uk/doc_WTD023464.html [accessed at Feb. 11th, 2008]. Julian Savulescu, "Genetic Interventions and the Ethics of Enhancement of Human Beings," in: Bonnie Steinbock (ed.), *The Oxford Handbook of Bioethics* (Oxford: Oxford University Press, 2007), p. 516-535. Julian Savulescu, "Justice, Fairness, and Enhancement," Ann. N.Y. Acad. Sci. 1093, 2006, p. 321–338; Julian Savulescu, "Why I believe parents are morally obliged to genetically modify their children," *Times Higher Education Suplement*, November 5, 2004, p. 16; Julian Savulescu, "Human-Animal Tansgenesis and Chimeras Might Be an Expression of Our Humanity," *The American Journal of Bioethics*, 3(2003):3, p. 22-25; Julian Savulescu, "Procreative beneficence: Why we should select the best children," *Bioethics*, 15(2001):5/6, p. 413-426.

[25] Savulescu, 2003, p. 23.

[26] Savulescu, 2007, p. 528.

'practical rationality': "Actions that express or promote rationality are expressions of our humanity. Insofar as transgenesis and the creation of human-animal chimeras both promote and express our rationality, it is the essential expression of our humanity."[27] For this position, as well as for the former one, it seems enough to preserve the integrity of the human species at the 'ought' level of the *telos*, whereas alterations of the *telos* at the 'is' level through alterations by genetic engineering are morally acceptable.[28] Human individuals are different from one another from the biological point of view and they might become even more different. The point is that they must keep their identity in their normative self-understanding.This reading of the imperative about integrity supports the idea that we can generate alternative conceptions about mankind, all of them compatible with the concept of moral agency.

There is always a big problem with arguments that point to some essential property or fundamental core of human nature. They only function if they split this nature. Inevitably, these arguments embrace a reductionist view. They emphasize the capacity of displaying practical rationality at the cost of the mind-body separation, which takes increasingly radical forms, and this is happening at the same time with the devaluation of the corporal dimension of the human existence, as for instance in such statements like: "Genes, cells, organs, or bodies are not what matters intrinsically" and "What matters are mental states, qualities of our mental lives. I believe what matters and what defines our humanity is, at least in part, our rationality."[29] It is reasonable to argue that the other component, the disregarded dimension, that is, the connection to the self through one's own body, plays an important role as well in the selection of goals, in planning and carrying out actions, in finding reasons and defining normative standards compatible with the actually given interests and capabilities. If we understand the widely

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[27] Savulescu, 2003, p. 24.

[28] Rollin, 2005, p. 331.

[29] Savulescu, 2003, p. 23-24.

established tendency to deepen the separation between mind and body, to divide the whole and to build a ranking of the parts, no wonder that the integrity question is very close to vanish.

3.c) Jürgen Habermas[30] and Ernst Tugendhat[31] have shown another possibility to work out the question of integrity from the perspective of the ethics of species. Habermas agrees that there may be many conceptions about our self-understanding and about humankind. But not all these conceptions are compatible with our self-understanding as moral subjects, as moral responsible persons. The main concern in evaluating the various applications of biotechnologies is to maintain intact this particular image about self as moral subject. The self-understanding in the sense of moral agency depends on the possibility to choose between many life-projects. If this open space for personal choices narrows up, if we don't manage to leave some room for the unpredictable, the very essence of morality is endangered. For Habermas, it is clear that parents set up more or less deliberately many fundamental aspects about the future of their children, but the thing we must not compromise is the very possibility for the child to confront himself with this setting, to revise his parents' intensions at a later stage, through critical examination. To put it another way, Habermas points to the necessity to give the child the opportunity to define himself as moral subject by approving or disapproving the prospects that others have linked up with his or her existence, and to change these prospects if he or she sees it fit.

Ernst Tugendhat has expressed this condition in a similar way. Man's actions are always possible within the frame of a more or less wide range of options. These options are qualified as 'better' or 'worse' in relation with other options and evaluative criteria that make sense in a given moral community. The basic precondition for this evaluation is the

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[30] Jürgen Habermas, *Die Zukunft der menschlichen Natur. Auf dem Weg zu einer liberalen Eugenik?* (Frankfurt / M.: Suhrkamp, 2001).

[31] Ernst Tugendhat, *Vorlesungen über Ethik* (Frankfurt / M.: Suhrkamp, 1993).

implicit option of belonging to a moral community, or, in Tugendhat's words, the implicit option, through which individuals choose to think of themselves as "members of a moral universe."[32] Even a criminal or an immoral person can only qualify his behavior as criminal or immoral by judging his actions in the light of the norms of a moral community. If the option of belonging to a moral universe is an implicit one, there is no doubt that few of us feel the need to question this option. There are, of course, people who have no such feeling of belonging to a moral community (the amoralists) and there are no doubt ways to raise a child so that it doesn't get to be aware of this feeling. Both Habermas' critical comment on liberal eugenics and Tugendhat's account about the prerequisites of morality stress upon this idea: Biotechnology might confront us with new subtle forms of manipulating human life that can fundamentally challenge our self-understanding as moral subjects and our feeling of belonging to a moral community.

It can reasonably be argued that genetic technologies, especially germline genetic enhancements, are, at least for now, far from being so powerful that they can seriously alter our self-understanding and make us lose this image of ourselves as moral agents or the feeling of

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[32] Tugendhat argues that moral consciousness begins with an act of will, through which individuals manifest their intention to belong to a moral world: "Mit diesem Willensakt ist nicht gemeint, dass es schon geradezu gut sein will, wohl aber, dass es sich als zugehörig zu dieser moralischen Welt ansehen will ... Ohne dieses Dazugehörenwollen kann es, wenn es die entsprechenden Normen verletzt, keine Scham empfinden und keine Empörung, wenn andere sie verletzen. ... jetzt bedeutet das So-sein-Wollen, dass man Mitglied eines moralischen Kosmos sein will, der durch wechselseitige Forderungen, bezogen auf ein Konzept des Gutseins, definiert ist, und erst auf dem Umweg über diesen Kosmos kann man (muss aber nicht) in dieser Hinsicht faktisch gut sein wollen. Auch wer im Sinn seiner Moral schlecht handelt, gehört, wenn er sich als zugehörig versteht, zu diesem Kosmos. Ob er sich so versteht, zeigt sich daran, ob er sich dann schämt." (Tugendhat, 1993, p. 60-61.)

belonging to a moral community. But if this does become possible, the point made by Habermas against liberal eugenics could be a reason to ban some genetic technologies. It is important to point out the difference between this argument and the previous one, brought by the supporters of the liberalization of the enhancement technologies. They say that it is enough to secure the ability to act autonomously, and the "capacity to act from normative reasons, including moral reasons."[33] Habermas and Tugendhat have stressed another requirement, beyond this condition. It is not only the personal autonomy that counts when we want to define the normative dimension of human actions, but also the way we interact with others, and this is what matters when a moral community comes into being, functions and manages to preserve itself. It is also the basic need to belong to a moral world that defines our integrity. If we don't preserve the possibility for all human intentions to undergo that critical, revising examination from the children's perspective, especially for the cases where parents determine children's characteristics at the very moment of conception, the symmetry and the equilibrium of our 'moral universe' are bound to disappear.

Another difference between Habermas' argument and the argument presented in 3.b) is that Habermas and Tugendhat operate with only one conception of man as a moral being. This, in their view, is the only possible one because it is the only one compatible with the idea of morality. (The latter must be understood in a wider sense, as structured by norms and interests, sanctions and rewards, normative reasons etc.) From the many possible ways of conceiving us as members of the species *homo sapiens*, not all of them are compatible with the image about man as a moral subject. With Habermas, the possibility of moral argumentation depends on this particular self-understanding.[34] With Savulescu, as

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[33] Savulescu, 2003, p. 23.

[34] Habermas assumes that we have historically developed a unified conception of ourselves, belonging to species called 'humans', and that there are no available alternatives to this conception: "Die wahrgenommenen und

we have seen, more alternative views about humanity are conceivable; many of them could be compatible with the idea of moral subject. It is difficult to say which of these two positions is more plausible. If the wish to belong to a 'moral world', a world of norms and values, is the pre-condition for the capacity to act morally, that is to 'display practical rationality', we must see how this 'moral world' actually comes into being. Tugendhat assumes that this world depends on some substantial understanding of the concept of good. There are many possible substantial conceptions of good, and we should therefore accept a plurality of 'moral worlds', each of which defined in relation to a particular conception of good. If this is true, a plurality of alternative and conflicting conceptions of humans as moral beings might become commonplace. Genetic technologies would only diversify this landscape.

4. SUMMARY

The ethics of species deals with the moral value of biotechnological interventions on living creatures from a supraindividual perspective, that is, at the level of species. A common assumption is that species are valuable *per se*. Furthermore, that we, humans have a responsibility to protect the value all species represent, beyond the special obligations one has related to particular individuals of various species. Protecting integrity of living species means maintaining and protecting the diversity of nature. It is a warning signal about the fact that human interference with natural mechanisms of evolution may lead to damaging effects for whole ecosystems and species as well. One can think about species integrity by analogy with situations in which the whole is more than the sum of the parts. There are many ways to draw

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befürchteten Entwicklungen der Gentechnologie greifen das Bild an, das wir uns von uns als dem kulturellen Gattungswesen 'Mensch' gemacht hatten—und zu dem es keine Alternative zu geben schien." (Jürgen Habermas, *Die Zukunft der menschlichen Natur*, p. 73).

attention to this global value, for instance by pointing to the quantity of well-being at the level of the entire population. Another approach is to say that the basic interests of individuals (i.e. staying alive and flourishing) can only be fulfilled if we refrain from interfering with the particular form of life of those individuals. Others claim that the form of life as such, i.e. the speciation process, is valuable in itself. Some point to the genetic identity as a constant term in the equation of life, whereas others underline the genetic diversity in species as a fundamental condition for their survival.[35]

For humankind it is not simple to specify what it means to endanger its integrity (apart from the special case of its complete extinction). To speak about a special 'human form of life' and understand it as a result of the speciation process we meet in nature will surely not clarify what shall be so specific about this 'form of life'. It is rather plausible that mankind displays not only *one* form of life, in the sense we use this expression relating to the kingdom of nature, but more (cultural) 'forms of life'. In addition to that, it seems that no account about 'human naturality' can go beyond the cultural frame that makes it generally possible to understand human nature. Neither could the search for some fundamental properties of humankind, the essence of humanity, bring us a step further because we run the risk of splitting the whole and just missing its integrity. It might be that the only reasonable way to see the integrity of mankind is to trace the fundamental features that guarantee the preservation of our identity at the 'ought' level of the *telos*. In most cases, this means to delineate and justify a normative, coherent image about our humanity, about what we want to be, from an ethical point of view. It might be that this task will remain an unfinished one (and perhaps it is even better to keep it open for revising projects), but the thing we certainly don't want to lose about our self-understanding is the idea that we are bound to provide

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[35] Genetic diversity is also important for the speciation process; cf. for instance Bernard E. Rollin, *Science and Ethics*, 2006, p. 140, 192.

reasons for our actions and to claim responsibility for the consequences. I assume that it is plausible to think that most of us feel it better to live in a world where people see themselves as moral beings, as ‘members of a moral community’. We talk here about the prerequisites of morality, about the obligation to preserve the very possibility for moral interactions. We can make this more intuitively by analogy with the debate about the integrity of animal species. We cannot think of the integrity of endangered species without pleading for the integrity of their habitat. Similarly, we cannot explore and protect human integrity without thinking of what makes and secures that ideal ‘moral universe’. One can call this the argument of preserving the special language-game of moral discourse. Biotechnological interventions that compromise the image about man as a being able to enter the discursive space of moral argumentation and to see himself as a member of a moral community are unacceptable. Integrity is a matter of self-definition; it points to the way we understand ourselves from the point of view of our community, and, in the end, from the point of view of the hypothetical community of all human beings.

THE PRINCIPLE OF RESPONSIBILITY FOR ILLNESS AND ITS APPLICATION IN THE ALLOCATION OF HEALTH CARE

A Critical Analysis[1]

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1. PRELIMINARY CONSIDERATIONS

In this paper I will analyze a view that is increasingly spreading among philosophers and even physicians these days. Many of them believe that it is right to apply the principle of responsibility for illness in the allocation of health care. I will attempt to show, in as pertinent a manner as possible, that this idea is unacceptable.

The principle of responsibility for illness upholds two main claims. Firstly, the individuals responsible for causing their own diseases, whether totally or in part (that is, those who became ill due to their own deliberate lifestyle), should cover the treatment costs from their own resources, totally or partially.[2] For instance, John Roemer has recently

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[1] To read the Romanian version of this paper see: Bogdan Olaru (ed.), *Current Ethical Controversies in Biotechnology: Individual Autonomy and Social Responsibility / Controverse etice în epoca biotehnologiilor. Autonomie individuală şi responsabilitate socială* (Jassy: Alexandru Ioan Cuza University Press, 2008), p. 205-244.

[2] See for e.g. Tristram H. Engelhardt, "Human well-being and medicine," in: Tristram H. Engelhardt & Daniel Callahan (eds.), *Science, Ethics and Medicine* (Hastings-on-Hudson: Institute of Society, Ethics and the Life Sciences, 1976), p. 120-139; John H. Knowles, "The responsibility of the individual," *Daedalus*, 106(1977), p. 57-80; John E. Roemer, "A pragmatic theory of responsibility for egalitarian planner," *Philosophy and Public*

stated that society could or even should participate financially in covering treatment costs for the individuals suffering from a disease caused by their lifestyle (only) function of the proportion of their responsibility for that particular lifestyle. Thus, the costs of the medical care needed by a patient who was not entirely responsible for the behavior that resulted in a disease, should be compensated for the proportion of the responsibility that was all but his own (if, for instance, the individual was 80% responsible, he should cover 80% of the treatment costs, while society should cover the remaining 20%). If the individual was not at all responsible, it follows that society ought to pay for the medical services entirely. However, if "an individual were entirely responsible ... then ... he should pay the costs of the consequent diseases."[3] In view of applying this claim in practice, Roemer even proposes a 'pragmatic' formula of establishing the profile of the individuals responsible for their unhealthy lifestyle and the ensuing proportion of their responsibility.[4]

Affairs, 22(1993):2, p. 146-166, published also in: John E. Romer, *Egalitarian Perspectives: Essays in Philosophical Economics* (Cambridge University Press, 1994), pp 179-198; John E. Roemer, "Equality and responsibility," *Boston Review*, 20(1995):2, p. 3-7. This claim must not be mistaken for a more frequent one, which is not the object of this study: the claim according to which the persons who deliberately expose themselves to a high risk of illness should contribute more to the financing of the medical services (either by paying higher insurance premiums or by 'sin taxes'). For a more recent defense of this idea, see, for instance, Alexander W. Cappelen & Ole Frithjof Nordheim, "Responsibility in health care: a liberal egalitarian approach," *Journal of Medical Ethics*, 31(2005):8, p. 476-480 and Cappelen & Nordheim, "Responsibility, fairness and rationing in health care," *Health Policy*, 76(2006):3, p. 312-319.

[3] John E. Roemer, "Equality and responsibility," *Boston Review*, 20(1995):2, p. 3-7 [http://bostonreview.net/ BR20.2/roemer.html].

[4] According to this formula, doctors and/or other specialists must decide first what are the relevant circumstances in determining the various unhealthy lifestyles like smoking, alcohol abuse, inadequate eating habits, leading a sedentary life, etc. These circumstances will represent the factors beyond the individual control, for which, consequently, they cannot be

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legitimately held accountable. For instance, in the case of smoking, these factors might be age, occupation, sex, family environment (if the parents smoke or not), income, addiction, etc. In the second stage, the persons with unhealthy lifestyles (here, smokers) will be divided into types, each of them including persons who share the same values for all the characteristics previously described in the first stage (same age, occupation, and so on). One of these types could be, for instance, 60 year-old male steelworkers, and another type could be 60 year-old female college professors. Finally, a third stage consists of the calculation of the average number of years that the members of each type are likely to smoke. Let us assume, referring to the two examples after Roemer's model, that this number is 30 and 10, respectively. Now, both the identification of the smokers responsible for their lifestyle and the calculation of the ensuing proportion of their responsibility is made function of the position the patients have and the average number of years calculated in stage three for each type separately. To be more precise, the guilty smokers will be those who smoked for more years than the average number specific to their type. The persons who smoked for an equal number of years or smaller than the average specific to their type, on the other hand, must be considered exonerated from responsibility for the lifestyle that caused the disease since the average specific to each type is determined by circumstantial factors beyond the individual's control. Such smokers who are considered responsible are bound to be, for example, 60 year-old male steelworkers who smoked for 35, 40, or 45 years, or 60 year-old female college professors who smoked for 15, 20, or 25 years. The proportion of responsibility in the case of these smokers is a function of the additional number of years they smoked over their type average. In other words, a 60 year-old male steelworker who smoked for 35 years will have to be considered more responsible than one who smoked for 25 years, in the same way that a 60 year-old female college professor who only smoked for 15 years will be considered less responsible than one who smoked for 25 years. For a few very penetrating objections to this formula, see: Richard Epstein et al., "Social equality and personal responsibility," *Boston Review*, 20(1995):2 [http://bostonreview.net/dreader/series/equality.html]; Andrew Mason, "Equality, personal responsibility, and gender socialization," *Proceedings of the Aristotelian Society*, 100(2000), p. 235-239; Norman Daniels, "Democratic equality. Rawls's complex egalitarianism," in: Samuel

The second claim of the principle of responsibility for illness in the allocation of health care is that the individuals found responsible for causing their own disease should have low priority in the distribution of scarce medical resources when the former compete for them against patients who are 'innocent victims' of a disease.[5] For instance, Julian Le Grand invites us to imagine a situation in a hospital where there is only one emergency room. Here are brought two patients who need emergency care as a result of a serious car crash. The doctors are unable to take care of both casualties at the same time. Also, they know that one of them is the innocent victim in that crash (he was walking his

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Freeman (ed.), *The Cambridge Companion to Rawls* (Cambridge: Cambridge University Press, 2002), p. 254-255; Susan Hurley, "Roemer on responsibility and equality," *Law and Philosophy*, 21(2002):1, p. 39-64, published also in: Susan Hurley, *Justice, Luck and Knowledge* (Harvard University Press, 2003) p. 183-207; Mathias Risse, "What equality of opportunity could not be," *Ethics*, 112(2002):44, p. 720-747.

[5] Julian Le Grand, "Equity, health, and health care," *Social Justice Research*, 1(1987):3, p. 257-274; Julian Le Grand, *Equity and Choice. An Essay in Economics and Applied Philosophy* (London: Harper Collins, 1991), p. 103-126; Alvin H. Moss & Mark Siegler (1991), "Should alcoholics compete equally for liver transplantation?" in: Helga Kuhse & Peter Singer (eds.), *Bioethics: An Anthology*, 2nd ed. (Oxford: Blackwell, 2006), p. 421-427; Eike-Henner Kluge, "Drawing the ethical line between organ transplantation and lifestyle abuse," *Canadian Medical Association Journal*, 150(1994):5, p. 745-746; B. Smart, "Fault and the allocation of spare organs," *Journal of Medical Ethics*, 20(1994):1, p. 26-30; Walter Glannon, "Responsibility, alcoholism and liver transplantation," *Journal of Philosophy and Medicine*, 23(1998):1, p. 31-49; Robert Veatch, *Transplantation Ethics* (Washington: Georgetown University Press, 2000), p. 311-324; Erik Rakowski, *Equal Justice* (Oxford: Clarendon Press, 1991), p. 313-332; Frank Dietrich, "Causal responsibility and rationing in medicine," *Ethical Theory and Moral Practice*, 5(2002), p. 113-131; Re'em Segev, "Well-being and fairness in the distribution of scarce health resources," *Journal of Medicine and Philosophy*, 30(2005):3, p. 231-260; David Brudney, "Are alcoholics less deserving of liver transplants?" *Hastings Center Report*, 37(2007):1, p. 41-47.

dog on the sidewalk when he was hit by the car) while the other is responsible for the crash (he lost control of the vehicle due to alcohol intoxication). Which of the injured should have priority in getting emergency medical care? According to Le Grand, the one who was the innocent victim in the crash. Things should be the same, Le Grand thinks, even when the hospital in question is a private one and when the person who caused the accident has a medical insurance whereas the victim has none.[6] In the same way, most of those who support this claim of the principle of responsibility for illness in the allocation of health care sustain that the patients who can be legitimately blamed for suffering from end stage liver disease should—since they are responsible for causing their own disease—be at the bottom of the waiting list for a liver transplant. Moreover, as the former are inclined to think, so should things go even when other rationing criteria for medical services (such as urgency) lead to the opposite verdict.[7]

The principle in question states, therefore, that both inequality of access to medical care and inequality in the treatment for their medical needs are justified in the case of the individuals accountable for causing their own illnesses. In other words: the limitation of the right to health care for these patients is legitimate.

Although I will not rule out the first claim of the principle of responsibility for illness in the allocation of health care, I will focus mostly on the second claim thereof. The main reason is that, unlike

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[6] Le Grand, 1991, p. 103.

[7] However, we must make it clear that not all defenders of this claim of the principle of responsibility for illness favor this idea. Some of these authors (such as, Robert Veatch) uphold much more 'moderate' ideas (Veatch, 2000, p. 311-324; cf. also Robert Veatch, "Just Deserts?," *Hastings Center Report*, 37(2007):3, p. 4.). That is because, although they think that the principle of responsibility can be legitimately considered by doctors in the allocation of scarce medical services, they do not favor the idea that this principle should take precedence, too, as the decisive criterion in the process, as Frank Dietrich says (Dietrich 2002, p. 117).

in the case of the first claim, which aroused vehement criticism and was subsequently abandoned even by the supporters of the principle in question, the legitimacy of the second seems plausible at least at first sight. As a matter of fact, it even looks plausible to some of the authors who criticized other ideas usually promoted in the name of the principle of responsibility for illness in the allocation of health care.[8]

In order to reach our goal, I will proceed as follows. Firstly, I will try to show that the arguments used as a rule in favor of the application of the principle of responsibility for illness in the allocation of health care are not in fact sustainable. Secondly, even if these arguments were valid, the idea of allocation of health care according to the principle of responsibility for illness would still be unacceptable because, as I intend to demonstrate in Chapter 3, there are a few very strong reasons against it.

2. A CRITICAL REVIEW OF THE ARGUMENTS IN FAVOR OF APPLICATION OF THE PRINCIPLE OF RESPONSIBILITY FOR ILLNESS IN THE ALLOCATION OF HEALTH CARE

According to my research, there are five main arguments in favor of the application of the principle of responsibility for illness in the allocation of health care. I will introduce—and criticize—them below from the least plausible to the most.

1) The application of this principle would contribute to saving some important (public) funds, those spent or 'wasted' as a rule on treating persons accountable for causing their illnesses. Although Malcolm Dean, for instance, credits the British supporters of rationing for this

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[8] Gerald Dworkin, "Taking risks, assessing responsibility," *Hastings Center Report*, 11(1981):5, p. 29-30; Tziporah Kasachkoff, "Drug addiction and responsibility for the health care of drug addicts," *Substance Use & Misuse*, 39(2004):3, p. 489-509.

argument on account of the principle of responsibility for illness,[9] I doubt there is an author, may he be an economist, who could be serious about bringing such a reason in favor of limitation of the right to health care of the persons accountable for causing their illnesses. The idea that persons accountable for causing their illnesses should not be treated only because this would save more or less significant financial resources is, without a doubt, morally unacceptable.

2) The persons accountable for causing their illnesses committed an immoral act and, therefore, deserve (or ought to suffer) punishment for this by referring them to the principle of responsibility for illness in the allocation of health care. Although this statement is often quoted among the arguments supporting the application of this principle,[10] and despite some standpoints coming from its advocates suggesting that this is (at least) one of the reasons why they uphold it, I doubt, once more, that there is an author who would see this argument as a serious reason for the introduction of the principle of responsibility for illness in the allocation of health care. Moral(izing) sentences cannot constitute legitimate reasons for reducing the individual right to medical care even if such sentences are widely popular in our society. The right to health care is not conditioned by the individuals' moral qualities, or their virtues. It is for good reason that most of the supporters of the principle in question explicitly recant such an argument in favor of the principle of responsibility for illness in the allocation of health care (even when the medical services are scarce). In fact, even if moralizing

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[9] Malcolm Dean, "Self-inflicted rationing," *The Lancet*, 341(1993):8859, p. 1525.

[10] Alan Cribb, *Health and the Good Society. Setting Healthcare Ethics in Social Context*, (Oxford: Oxford University Press, 2005), p. 103-104; Stephen Wilkinson, "Smokers' rights to health care: Why the 'restoration argument' is a moralising wolf in a liberal sheep's clothing," *Journal of Applied Philosophy*, 16(1999):3, p. 267, note 8.

judgments were allowed from the moral point of view[11] and accepted as grounds for the limitation of certain individuals' right to health care, this argument would yield on the remark that the persons suffering from 'self-induced' diseases are not ferocious criminals, people who committed abominable acts deliberately and who thus deserve to be punished as severely as is suggested by the principle of responsibility. We must not overlook that if a patient receives low priority in the allocation of some scarce medical services or if, since he cannot cover the costs of the medical services he needs, they are refused to him, the situation can—and it often does—lead to the death of that patient. Neither must we forget that the legitimacy of the death penalty is questionable even in the case of murderers. Not lastly, as some critics of this argument remark, is getting ill not enough punishment already for the persons who assumed a health-threatening lifestyle? Is it not immoral for them to suffer additional punishment by limiting their right to health care?[12]

3) Responsibility for one's lifestyle is a fundamental value, one that deserves and must be asserted and promoted in society. Yet, the application of this principle in the allocation of health care would have precisely this effect. For instance, once people acknowledge the fact that their perilous lifestyle decisions can lead to significant financial losses (due to the fact that they will be forced to cover the costs of the medical services from their own pocket) or even to the dramatic diminishment of their right to benefit from certain scarce medical services, they will be more careful or 'responsible' about making such decisions.

As in the case of the other arguments presented above, this one is not sufficient proof in demonstrating the legitimacy of the principle

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[11] One of the main reasons why these judgments are not allowed from the moral point of view is that they are disrespectful. For an explanation and an excellent analysis of all the vices of moralism, cf. C.A.J. Coady, *What's Wrong with Moralism?* (Malden: Blackwell, 2006).

[12] Einer R. Elhauge, "Allocating health care morally," *California Law Review*, 92(1994), p. 1523.

of responsibility for illness in the allocation of health care. Not any public policy that can help promote individual responsibility in society is sustainable. Besides, like the above-discussed arguments, this one is attributed (for no good reason) to the advocates of the principle of responsibility for illness by some of their critics,[13] rather than formulated and assumed by the latter explicitly.

4) The majority of public opinion favors the use of this principle by doctors in rationing of scarce medical services. Indeed, more and more studies conducted recently seem to confirm this fact.[14] The public views seem to converge, too, with regard to the idea that persons accountable for causing their illnesses should pay from their own pocket for at least part of the medical services they need.[15]

Still, what these studies really demonstrate, as a rule, is only the fact that the public opinion favors almost unanimously the idea that

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[13] Alexander Brown, "If we value individual responsibility, which policies should we favor?," *Journal of Applied Philosophy*, 22(2005):1, p. 23-44; Bruce N. Waller, "Responsibility and health," *Cambridge Quarterly of Healthcare Ethics*, 34(2005), p. 181-184.

[14] Ann Bowling, "Health care rationing: the public's debate," *British Medical Journal*, 312(1996), p. 670-674; Darren Shickle, "Public preferences for health care: Prioritisation in the United Kingdom," *Bioethics*, 11(1997):3, p. 277-290; Peter Ubel et al., "Allocation of transplantable organs: Do people want to punish patients for causing their illness?," *Liver Transplantation*, 7(2001):7, p. 600-607; Eve Wittenberg et al., "Rationing decisions and individual responsibility for illness: Are all lives equal?," *Medical Decision Making*, 23(2003):3, p. 194-211; G. Schomerus et al., "Alcoholism: Illness beliefs and resource allocation preferences of the public," *Drug & Alcohol Dependence*, 82(2006):3, p. 204-210.

[15] R. Blendon et al., "Bridging the gap between expert and public views on health care reform," *Journal of the American Medical Association*, 269(1993):19, p. 2573-2578; K. Stronks et al., "Who should decide? Qualitative analysis of panel data front public, patients, healthcare professionals, and insurers on priorities in health care," *British Medical Journal*, 315(1997), p. 92-96.

alcoholics or smokers should contribute more to the financing of health care system and/or should have a lower priority in the allocation of scarce medical services (liver transplant, for instance). But it is not very clear whether the public opinion sustains such policies regarding smokers and alcoholics for the reason invoked by the advocates of the principle of responsibility. Quite on the contrary, this view coming from the public does not seem to emerge primarily from the belief that these people are responsible for causing their own diseases, but rather from the shared perception that smoking, alcohol abuse or other health-threatening behaviors are ‘vices’ or socially undesirable acts, which are to be sanctioned or punished through such policies. This was the implication of a particular study which concluded that people who tend to give low priority to alcoholic or smoking patients in the allocation of scarce medical resources often make the same decision even in the case of those patients acknowledged to have become ill from causes other than their lifestyle. Consequently, the authors of this study remark, “people’s attitudes toward transplanting patients with a history of controversial behavior should not be understood merely as resulting from a view that those patients […] do not deserve organs because they are personally responsible for becoming ill. Instead, many people may want to divert resources from patients simply because they engaged in socially undesirable behaviors.”[16] Under the circumstances, the idea that the public opinion sustains the application of the principle of responsibility for illness in the allocation of health care becomes problematic. It is more correct to interpret these empirical results as indicating the fact that the public opinion favors the application of a different (and unacceptable) principle, the principle of moral or social

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[16] Peter Ubel et al., “Social acceptability, personal responsibility, and prognosis in public judgments about organ transplantation,” *Bioethics*, 13(1999):1, p. 68.

value of the patients,[17] and not as a sign of support for the principle of responsibility for illness in the allocation of health care. The fact that the public opinion is not in favor of limiting the right to health care for those people, too, who got ill as a result of deliberate practice of certain professions which, though health-threatening, are useful or necessary to society, endorses the same interpretation as well.

Moreover, this argument is undermined by a well-known problem: is it a position justified solely because it is shared by the majority of the public opinion? Does asking the public opinion represent a legitimate way to try the validity of a view? Certainly not.

5) The principle of responsibility represents a fundamental—if not the ultimate—demand of distributive justice. Its application in the distribution of medical services and the costs thereof could constitute, therefore, the warranty of a truly just, or fair health care system.

This is, indeed, the only argument explicitly advanced by the advocates of the principle of responsibility for illness in the allocation of health care, and the only one constantly invoked in all the apologies for this idea. In addition, it is the only argument which, if correct, constitutes a very strong reason indeed for the application of this principle in the allocation of health care.

The idea that the principle of responsibility represents the basic demand of distributive justice is supported by an entire current of thinking from today's political philosophy, namely, the current that is usually designed (more or less adequately) as 'luck egalitarianism'. It is not by chance that most of the authors promoting the principle of responsibility for illness either are luck egalitarians themselves[18] or authors who invoke works by the latter in support for their own claims.[19]

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[17] A principle according to which the persons of a questionable moral quality or low social value must have low priority in the allocation of scarce medical services.

[18] Roemer 1993, Roemer 1995, Rakowski 2001.

[19] Glannon 1998, Dietrich 2002, Segev 2005, Brudney 2007.

In the interpretation of the luck egalitarians, the principle of responsibility states that, from the point of view of fairness or distributive justice, a person's right to be compensated by the other members of society for the disadvantages he is facing (or a person's right to be granted a particular social service) depends on the proportion of his responsibility in causing those disadvantages (or the need for that social service). A person legitimately considered (totally or partially) responsible for him suffering from certain disadvantages or for having certain needs—in the sense that they represent consequences of some actions resulting from his own choices or personal decisions—loses (totally or in part) his moral right to receive compensation for those disadvantages or needs.[20] In other words, compensation for disadvantages or alleviation of this person's needs do not represent a demand of distributive justice—although it could constitute, of course, a demand pertaining to other principles or moral, political, or economic values.[21] Only the persons who are not responsible for bringing disadvantages or needs onto themselves have legitimate claims to compensation in the name of social justice. Compensation or alleviation constitutes such a claim. Consequently, as G. A. Cohen explains, "When deciding whether or

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[20] This idea represents the core of what Thomas Scanlon has recently called *forfeiture view* on responsibility, a view by which "a person who could have chosen to avoid a certain outcome, but who knowingly passed up this choice, cannot complain of the result: *volenti non fit iniuria,*" T.M. Scanlon, *What We Owe to Each Other* (Cambridge: Belknap Press, 1998), p. 259; s. also T.M. Scanlon, "The significance of choice," in: Sterling McMurrin (ed.), *The Tanner Lectures on Human Values*, vol. 8 (Salt Lake City: University of Utah Press, 1988), p. 192-195.

[21] For instance, Julian Le Grand explains, although an individual injured in an accident he caused loses, at least in part, according to the principle of responsibility, his right to the medical services he needs, there are reasons other than fairness in favor of the allocation of these services, e.g. compassion or even efficiency (the person in question may be a highly productive member of the community). Cf. Le Grand 1987, p. 261.

not justice (as opposed to charity) requires redistribution, the [luck] egalitarian asks if someone with a disadvantage could have avoided it [...]. If he could have avoided it, he has no claim to compensation, from an egalitarian point of view."[22] For example, if a person "became blind through deliberate and fully informed participation in a dangerous sport that often gives rise to injuries that results in blindness, it becomes questionable whether compensation is owed for the handicap."[23]

In the most frequent expression, which is based on a distinction introduced by Ronald Dworkin, luck egalitarianism is defined as the conception that distributive justice requires compensation for inequalities, disadvantages, or needs resulting from brute bad luck, but not for those coming from option bad luck. By 'brute luck', Dworkin understands just the (bad) luck that does not root in any previous deliberate action, choices or will of the person affected by it, whereas 'option luck' is that which follows a risk assumed deliberately: "Option luck is a matter of how deliberate and calculated gamble turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles."[24] Examples of brute luck could be: someone born defficient in the talent or skills necessary to practice better paid professions, or born with a genetic disease, or severely disabled as a result of a medical error; someone who became ill before he got the chance to make an insurance for that particular disease, and so on. Examples of option luck are

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[22] G.A. Cohen, "On the currency of egalitarian justice," *Ethics*, 99(1989):4, p. 920.

[23] Richard Arneson, "Liberalism, distributive subjectivism, and equal opportunity for welfare," *Philosophy and Public Affairs*, 19(1990):2, p. 187.

[24] Ronald Dworkin, "What is equality? Part 2: Equality of resources," *Philosophy & Public Affairs*, 10(1981):4, p. 293, republished in: Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge: Harvard University Press, 2000), p. 65-119.

someone's financial loss following gambling, injuries or diseases caused by voluntary exposure to the risk of getting them, etc.

The main argument of luck egalitarians in support of the idea that principle of responsibility is a fundamental demand—or even the ultimate demand—of distributive justice is, unsurprisingly, that responsibility for the consequences of one's own actions is the cost, or the 'other side' of one's freedom or autonomy. Individual autonomy and responsibility are inseparable. It is natural, therefore, that only the individual—and not the other members of society as well—be the one to foot the bill (or appropriate the benefits) of his autonomous actions. In other words, individuals cannot demand for compensation from society for the unfortunate consequences of their own decisions, for which they alone are to blame. As Ronald Dworkin thinks, for instance, "people should pay the price of the life they have decided to lead, measured in what others give up in order that they can do so."[25]

The idea that the principle of responsibility is indeed a demand of distributive justice is, however, opposed by very solid counter-arguments. One of the most widely debated of the latter is that the principle grants legitimacy to 'repugnant conclusions' from the moral point of view, an unacceptable aspect for a principle that is desired to constitute an adequate demand of distributive justice. Such a conclusion is, for example, that individuals who got ill or injured (and who do not have a health insurance) as a result of their own carelessness or negligence, and cannot cover the costs of the medical care they need from their own resources, should not be attended to.[26]

This argument roused a huge reaction from the ranks of defenders of luck egalitarianism, bringing forth an entire wave of responses.[27]

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[25] Ronald Dworkin 1981, p. 294.

[26] Elizabeth Anderson, "What is the point of equality?," *Ethics*, 109(1999):2, p. 295-296.

[27] David Sobel, Richard Arneson & Thomas Christian, "What is the point of equality?," *Brown Electronic Article Review Service*, 1999 [http://www.brown.edu/Departments/Philosophy/bears/symp-anderson.html];

The most convincing reply seems to have come from Shlomi Segall. According to him, this conclusion does not affront in fact our sense of justice, but other different values such as, compassion, charity or solidarity. That is, what this argument demonstrates so convincingly is not in fact the idea that the principle of responsibility is not an adequate demand of distributive justice, but only the idea that—unlike what some luck egalitarians seems to believe—justice or fairness are not exclusive values that doctors (or society) must observe in the distribution of medical care (or other social services, or resources).[28]

There is yet another crucial argument against the idea that the principle of responsibility is an adequate claim of distributive justice, one to which the luck egalitarians have taken their time to respond. Namely, the principle of responsibility grants legitimacy to other 'repugnant conclusions' which, unlike the above stated, oppose not only moral values such as charity and solidarity, but our very intuition regarding distributive justice. So, a principle leading to such conclusions cannot constitute a legitimate claim of distributive justice. One of these conclusions is, for example, that people who got ill as a result of practicing health-threatening professions of their own deliberate choice (e.g. firemen, miners, and policemen) must pay from their own pocket for the medical care they need, or have low priority in the distribution of scarce medical services when these are requested by people who did not get ill

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Ronald Dworkin, "Sovereign Virtue revisited," *Ethics*, 13(2002):1, p. 113-118; Ronald Dworkin, "Equality, luck and hierarchy," *Philosophy & Public Affairs*, 31(2003):2, p. 190-198; Alexander Brown, "Luck egalitarianism and democratic equality," *Ethical Perspectives*, 12(2005b):3, p. 293-339; Carl Knight, "In defence of luck egalitarianism," *Res Publica*, 11(2005), p. 55-73; Nicholas Barry, "Defending luck egalitarianism," *Journal of Applied Philosophy*, 23(2006):1, p. 89-107; Karen Voight, "The harshness objection: Is luck egalitarianism too harsh on the victims of option luck?" *Ethical Theory and Moral Practice*, 10(2007):4, p. 389-407.

[28] Shlomi Segall, "In solidarity with the imprudent: A defense of luck egalitarianism," *Social Theory and Practice*, 33(2007):2, p. 177-198.

following a health-threatening lifestyle.[29] A similar conclusion is that persons whose earnings are insufficient for a decent living due to their deliberate decision to sacrifice their career in order to raise their children are not entitled to compensation from the other members of society.[30]

The only response at hand for luck egalitarians to counterbalance the idea that the principle of responsibility legitimates such conclusions is that anyone in a health-threatening profession or who puts raising children above a well-paid job is not even partially responsible for his decision. Yet, this response is hardly plausible. Under the circumstances, it seems fair to me to say that, as a matter of fact, not even this last argument for the application of the principle of responsibility for illness in the allocation of health care is acceptable.

3. SHOULD THE PRINCIPLE OF RESPONSIBILITY FOR ILLNESS IN THE ALLOCATION OF HEALTH CARE BE PUT INTO PRACTICE? ARGUMENTS FOR A NEGATIVE ANSWER

If the critical observations from the previous chapter are correct, there already is a serious reason to give a negative answer to this question. The reason is that there is no legitimate argument to support the application of this principle in the allocation of health care. I will attempt to show next that the answer is based also on the fact that we have strong reasons not to apply this principle in the allocation of health care. One of them is that the application of the claims of this principle would lead to discrimination among the patients who come from underpriviledged social categories. Since, unlike the well-off patients, they do not have the necessary resources to cover the costs of the medical services they need for the treatment of 'self-inflicted'

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[29] Anderson 1999, p. 296.

[30] Andrew Mason, "Equality, personal responsibility, and gender socialization," *Proceedings of the Aristotelian Society*, 100(2000), p. 235-239.

illnesses, these people would be practically excluded from the allocation of these services (at least where the principle of responsibility for illness is taken in its first sense).[31] It would be the same, too, if the principle were applied in its second sense, according to which the persons who are not responsible for their illness must have priority over those responsible for causing their own disease in the situation of scarce medical services. This is because most people with health-threatening lifestyles are from underpriviledged social categories. Thus, they would be the most affected victims of this principle.

A solution to this challenge comes from Alvin H. Moss and Mark Siegler, two physicians who advocated the application of the principle of responsibility in the case of liver transplant (to be more precise, in favor of reducing the right of certain alcoholics to candidate for a transplant). Moss and Siegler believe that the principle cannot be applied legitimately in the case of (alcoholic) patients who are poor because these patients cannot be safely considered responsible for their unhealthy lifestyle and, thus, for their ensuing illnesses. For instance, since they do not normally have the (knowledge and financial) resources necessary for the treatment of alcohol addiction, these patients cannot be blamed sensibly for causing their cirrhosis. Only the patients diagnosed with alcoholism and who had the financial resources to pay for treatment that would have prevented them from developing cirrhosis, can be legitimately delayed in their right to liver transplant. Consequently, the two authors argue, far from lapsing into disccrimination against the poor, the application of the principle of responsibility for illness in the allocation of scarce medical resources would actually lead to the diminishment of the right of the well-off to candidate for it.[32]

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[31] Amy Gutmann, "For and against equal access to health care," *Milbank Memorial Fund Quarterly*, 59(1981):4, p. 542-560.

[32] Alvin H. Moss & Mark Siegler (1991), "Should alcoholics compete equally for liver transplantation?," in: Helga Kuhse & Peter Singer (eds.), *Bioethics: An Anthology*, 2nd ed. (Oxford: Blackwell, 2006), p. 421-427.

However, discrimination against the poor is not the only reason against the application of the principle of responsibility for illness in the allocation of health care, a reason to be counterbalanced by the supporters thereof. Other two reasons of this kind are: 1) that the role of one's lifestyle in causing his disease is not quite clear (the physicians are unable to determine with certainty that a patient got ill as a result of his lifestyle and not because of another factor liable to triggering that disease), and 2) that this principle cannot be applied without violating a fundamental human right, the right to privacy. Even the champions of this principle admit the pertinence of these arguments when it comes to the vast majority of patients suspected of having caused their own diseases (e.g. the smokers who suffer from respiratory diseases or lung cancer, HIV patients, heavily overweight persons with diabetes, etc.) But unlike those who consider these arguments generally valid,[33] the adepts of the principle of responsibility for illness claim that the cirrhotic patients awaiting a liver transplant are a quite different situation. In their case, the doctors can say exactly whether or not the cirrhosis was the result of alcohol abuse: "Alcohol-induced liver damage is a special case, first, because the cause of the illness is clearly identifiable."[34] In addition, doctors can establish whether an alcoholic patient is responsible for inducing his disease without violating his right to privacy: "A second special feature of liver transplantation is

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[33] Haavi E. Morreim, "Lifestyles of the risky and infamous," *Hastings Center Report*, 25(1995):6, p. 5-12; C. E. Atterbury, "Anubis and the Feather of truth: judging transplant candidates who engage in self-damaging behavior," *Journal of Clinical Ethics*, 7(1996):3, p. 268-276; Scott D. Yoder, "Personal responsibility for health: discovery or decision?," *Medical Humanities Report*, 19(1998):3 [http://www.bioethics.msu.edu/mhr/98sp/s98responsibility.htm]; Scott D. Yoder, "Individual responsibility for health: decision, not discovery," *Hastings Center Report*, 32(2002), p. 26-31.

[34] Frank Dietrich, "Causal responsibility and rationing in medicine," *Ethical Theory and Moral Practice*, 5(2002), p. 119.

the easy availability of the relevant information in any given case of liver damage. The symptoms reliably indicate whether it was caused by alcohol abuse or not. Furthermore, the doctors in attendance are usually well-acquainted with a patient's case history. There is no need for troublesome investigations to find out whether the potential recipient of a donor liver is an alcoholic."[35] Under the circumstances, the author of these arguments believes, the application of the principle of responsibility for illness in the allocation of liver transplant is both possible and legitimate.

I find these arguments unconvincing. Firstly, according to specialists, the diagnosis of alcoholic liver disease is far from absolute: "Even liver biopsy, the cornerstone for diagnosis of alcoholic liver disease, is fallible."[36] Besides, "it is impossible to conclude that alcohol use alone causes liver failure in even the heaviest drinking alcoholic patients."[37] Not lastly, alcoholic liver disease can occur even in patients who did not have a history of alcohol abuse.[38] Alcoholic liver disease is not therefore an accurate indicator of alcohol *abuse* in a patient's history. Under the circumstances, it becomes very difficult to understand in what way doctors could know this for sure without resorting to 'troublesome investigations' on his lifestyle and without violating thus his right to privacy. Moreover, as we have seen already, and as the advocates of the principle of responsibility for illness admit themselves, not all alcoholics—but only a part of them—can be blamed reasonably for the fact

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[35] Dietrich 2002, p. 120.

[36] Michael R. Lucey, & Thomas Beresford, "Alcoholic liver disease: to transplant or not to transplant?" *Alcohol and alcoholism*, 27(1992):2, p. 105.

[37] Thomas Beresford, "The limits of philosophy in liver transplantation," *Transplant International*, 14(2001):3, p. 176-177.

[38] Carl Cohen & Martin Benjamin, "Alcoholics and liver transplantation," *Journal of the American Medical Association*, 265(1991), p. 1300; Lucey & Beresford 1992, p. 105; Martin S. Mumenthaler et al., "Gender differences in moderate drinking effects," *Alcohol Research & Health*, 23(1999):1, p. 55-64.

that they have cirrhosis. In other words, many can have solid excuses for their alcohol addiction, or for not having treated it. These excuses, which the opponents of the application of the principle of responsibility for illness in the allocation of health care insist on, include genetic predisposition, the fact that (most of) these choices are made at ages when individuals cannot be legitimately considered responsible for their deeds, the fact that these decisions are influenced by an unfavorable social or family environment, the low social and economic status, inadequate education, reduced ability to analyze and understand the risks of alcohol abuse, cultural background, a period of intense suffering, severe mental disorders, etc.[39] It follows that, in order for a patient

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[39] Amitai Etzioni, "Individual will and social conditions: toward an effective health maintenance policy," *ANNALS of the American Academy of Political and Social Science*, 437(1978):1, p. 62-73; Daniel Wikler, "Persuasion and coercion for health: ethical issues in government efforts to change life-styles," *The Milbank Memorial Fund Quarterly. Health and Society*, 56(1978):3, p. 303-338; Daniel Wikler, "Who should be blamed for being sick?," *Health Education and Behavior* 14(1987), p. 11-25; Charles J. Dougherty, "Bad faith and victim blaming: the limits of health promotion," *Health Care Analysis*, 1(1993): p. 115-116; Henk A. M. J. Ten Have & Michael Loughlin, "Responsibilities and rationalities: should the patient be blamed?," *Health Care Analysis*, 2(1994), p. 119-127; J. W. Lynch et al., "Why do poor people behave poorly? Variation in adult health behaviors and psychosocial characteristics by stages of the socioeconomic lifecourse," *Social Science and Medicine*, 44(1997):6, p. 809-819; Sarah Marchand et al., "Class, health, and justice," *The Milbank Quarterly*, 76(1988):3, p. 449-467; Meredith Minkler, "Personal responsibility for health? A review of the arguments and the evidence at century's end," *Health Education and Behavior*, 26(1999), p. 121-141; Willem Martens, "Do alcoholic liver transplantation candidates merit lower medical priority than non-alcoholic candidates?," *Transplant International*, 14(2001):3, p. 170–175; Mike W. Martin, "Responsibility for health and blaming victims," *Journal of Medical Humanities*, 22(2001):2, p. 95-114; P. Alleman et al., "Transplantation for alcoholic liver disease: the wrong arguments," *Swiss Medical Weekly* 132(2002), p. 296-297; Howard

to lose his right in a legitimate way to a liver transplant, alcohol abuse is not enough reason. Doctors must also be able to prove the fact that the patient can be legitimately made responsible for this (that there is no excuse on his side). This, however, is impossible in the absence of information as accurate and as detailed as possible about the circumstances that affected his decision to drink excessively or made him ignore the possibility of treatment for his disease.[40]

Even if doctors were 'well-acquainted' to a patient's drinking history (and so, they were not forced to carry out 'troublesome investigations' into his private life to be sure), it is far from obvious, as the advocates of the principle of responsibility seem to think, that they would do the right thing using this information to lower the patient's priority in meeting his medical needs. On the contrary, there are a few extremely important ethical considerations against this idea. As a matter of fact, a third reason against the application of the principle of responsibility for illness is that it is incompatible with the nature and ethics of the medical profession. As it has been remarked, if doctors were allowed to act in the manner prescribed by the advocates of the principle of responsibility for illness, the immediate consequence would be the breach in the relationship of confidence between doctor and patient,

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M. Leichter, " 'Evil habits' and 'personal choices': Assigning responsibility for health in the 20th century," *The Milbank Quarterly*, 81(2003):4 , p. 603-626; Daniel Wikler (2004), "Personal and social responsibility for health," in: Sudhir Anand, Fabienne Peter & Amartya Sen (eds.), *Public Health, Ethics, and Equity* (Oxford: Oxford University Press, 2004), p. 109-134; Bruce N. Waller, "Responsibility and health," *Cambridge Quarterly of Healthcare Ethics*, 34(2005), p. 181-184.

[40] The fact that it requires the collection of data as accurate and correct as possible about the circumstances that influenced the lifestyle of the persons who got ill as a consequence thereof (and it leads to the violation of their right to privacy) is, in fact, one of the decisive hindrances to the application of the Roemerian calculation formula for the proportion of responsibility (see footnote 3 above), usually overlooked by his critics.

vital for the success of the medical care act. If the patients knew that their doctors could use the relevant information about them in order to establish if they deserve or not high priority in treatment (or should cover, at least in part, the costs of the medical services they need), the patients would lie or be more discreet in giving relevant information on the history of their disease, which would, in turn, jeopardize the accuracy of the diagnosis and treatment generally.[41] This is one of the main reasons why their professional ethics force doctors to play the role of unrestricted advocates for their patients and forbid them to become their 'judges' or use the information about their patients for purposes other than the strict medical practice.[42] One of the basic principles of the doctor-patient relationship is that of beneficence, which engages the doctor into acting solely in the interest of (all) his patients, regardless of the degree of responsibility in some of them in causing their own diseases. In other words, the only criteria the doctor can observe in rationing scarce medical services are medical criteria (urgency, need, and prognosis). The decision of lowering liver transplant priority for an alcoholic is justifiable only based on these criteria.[43] Not by accident, the official guides of medical ethics forbid, as a rule, particularly the application of the principle of responsibility for illness in rationing medical care and sustain the exclusive use of medical criteria.[44] And not by chance, again, many doctors have come up with arguments

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[41] Einer R. Elhauge, "Allocating health care morally," *California Law Review*, 92(1994), p. 1523.

[42] Suzanne Van Der Vathorst, Carlos Alvarez-Dardet, "Doctors as judges: the verdict on responsibility for health," *Journal of Epidemiology and Community Health*, 54(2000), p. 162–164.

[43] Kevin Schwartzmann, "*In vino veritas*? Alcoholics and liver transplantation," *Canadian Medical Association Journal*, 141(1989), p. 1262-1265.

[44] CEJA (Council on Ethical and Judicial Affairs), "Ethical considerations in the allocation of organs and other scarce medical resources among patients," American Medical Association, 1995, p. 8-9 [http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_ka93]; NIHCE (National Institute for

pertaining to the ethics of their profession in order to reject the ideas promoted in the name of the principle of responsibility for illness.[45]

One of the arguments that further justifies the idea that only medical criteria can be used legitimately in rationing scarce medical resources was provided by Robert Goodin.[46] According to him, the application of this principle in the allocation of medical services is simply “out of place” The allocation of medical services is part of those situations when it is morally unacceptable to apply the criterion of responsibility. In such cases, especially in life and death matters, “needs are trumping deserts” when we have to pick a prioritization criterion, and this not just in the sense that needs must always prevail over merits in assessing someone’s right to repair his disadvantage, but also in the sense that merits are simply *cancelled* by needs. Consequently, the principle of responsibility can *never* constitute a legitimate criterion in the allocation of health care, not even “in the last resort,” when the patients’ situations are quasi-equal from the point of view of the medical criteria. In such a case, the only (morally) justified manner of selecting the patient who will have priority in attending to his medical needs is the aleatory selection (such as lottery or flipping the coin).[47]

Health and Clinical Excellence), “Social Value Judgements—Principles for the development of NICE guidance,” 2005, p. 22-23 [http://www.nice.org.uk].

[45] M. I. Khalid, “Denying treatment is indefensible,” *British Medical Journal*, 306(1993), p. 1408; Nizam Mamode, “Denying access more costly,” *British Medical Journal*, 306(1993), p. 1408; Matthew Shiu, “Refusing to treat smokers is unethical and a dangerous precedent,” *British Medical Journal*, 306(1993), p. 1048–1049; S. Bhattacharya, “Higher complication rate not confined to smokers,” *British Medical Journal*, 306(1993), p. 1409.

[46] Robert E. Goodin, “Negating positive desert claims,” *Political Theory*, 13(1985):4, p. 586-587.

[47] This moral intuition is shared, in fact, even by one of the defenders of luck egalitarianism, who admits that, “in extending medical treatment, especially emergency treatment, society should be responsibility-blind.” (Segall 2007, p. 195). An argument similar to Goodin’s which also sustains this

So, a fourth reason why the principle of responsibility for illness should not be applied in the allocation of health care is that its application would not observe the demands of morality. However, this idea is not sustained only by Goodin's argument. I consider here the fact that the persons with heath-threatening lifestyles (e.g. smokers or alcoholics) have a bigger contribution to the financing of health care system than persons with healthy lifestyles. The so-called 'sin taxes', for instance, recently introduced in Romania too, represent an important and quite popular method of supplementing the funds for these services.[48] So, the idea that it is fair that these people should have low priority in the allocation of medical care is impossible to justify. Are they not entitled to equal medical care by (at least) this additional contribution, even in the event that they are 'personally responsible' for their diseases (without being asked to pay for this care from their own pocket, as Roemer says)? If only because of this supplementary contribution, they are entitled to attendance to their medical needs that is equal to that for non-smoking and non-drinking patients, even when the medical resources or services are scarce. It is true that, probably in order to prevent this sort of criticism, the adepts of the principle of responsibility for illness favor its application only in the case of absolute scarce medical services.[49] But, as has been remarked, the individuals with health-threatening lifestyles

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conclusion is that medical services represent, due to their decisive importance in ensuring a 'normal functioning' of the individuals, a 'special' category of goods which must not be allocated according to the claims of the principle of responsibility. Cf. Eli Feiring, "Lifestyle, responsibility and justice," *Journal of Medical Ethics*, 34(2008), p. 34-35.

[48] In Romania, according to Minister Eugen Nicolaescu's statements, the 'sin taxes' contributed €170 mill. in 2006 and €350 mill. in 2007 (acc. to N.G., "Românii vicioşi salvează bugetul sănătății / Romanian Vices Save Health Budget," *Ziarul Online*, July 25, 2006 [http://www.ziarulcn.com/article/aid/37340/romanii-viciosi-salveaza-bugetul-sanatatii].

[49] The absolute scarce medical services are those services the availability thereof does not depend primarily on the amount of money allocated for pro-

have a major contribution to the availability of these services as well. More exactly, many organ donors are people who died in accidents caused by alcohol intoxication or by the fact that they assumed other major risks to their health.[50] Under the circumstances, even the idea of limiting only these patients' right to candidate for allocation of absolute scarce medical services is indefensible.

Perhaps the strongest reason against the application of the principle of responsibility for illness in the allocation of health care is that it would be inevitably discriminatory. This principle legitimates the limitation of the right to medical care of several categories of patients other than those usually considered by the advocates of the principle (alcoholics and/or smokers sometimes). These categories include, for instance, the persons who got ill or injured as a result of practicing professions that threaten their health (including doctors who work in an environment with a high degree risk of contamination), as a result of 'workaholism', excessive exercise, trying to save someone's life (e.g. in a fire), and so on. But none of us would consider as justified the idea of limitation of the right to health care in the case of these categories of patients. As a matter of fact, the adepts of this principle do not sustain such an idea either, although they should, for the sake of consistency in their argumentation. The fact that they do not shows that another frequent accusation against them may be reasonable. They are accused of actually not supporting the principle of responsibility for illness, but

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viding them, but on the availability of non-financial resources (e.g. transplant organs).

[50] Tarek I. Hassainen et al., "Does the presence of a measurable blood alcohol level in a potential organ donor affect the outcome of liver transplantation?," *Alcoholism*: *Clinical and Experimental Research*, 15(1991):2, p. 300-303; Harry Bonet et al, "Liver transplantation for alcoholic liver disease: Survival of patients transplanted with alcoholic hepatitis plus cirrhosis as compared with those with cirrhosis alone," *Alcoholism*: *Clinical and Experimental Research*, 17(1993):5, p. 1102.

really nurturing a masked affinity for the principle of moral or social value of patients. In other words, the true reason why they advocate the limitation of the right to medical services of alcoholics (and/or smokers) whose illness was caused by their lifestyle is the fact that their lifestyle is 'vicious' and/or without social value.[51] But such moral(izing) sentences or judgments on the social desirability of certain types of behavior cannot constitute legitimate reasons for the limitation of someone's right to health care.

Finally, a last reason against the application of this principle in the allocation of medical services is that it contradicts the demands of the principle of equality of opportunities for the individuals in society. Equality of opportunity is one of the basic principles for the idea of a human right to health care. Or, in the absence of equal access to medical services and of equal treatment of medical needs, individuals cannot benefit from equal opportunity to pursuit their life plans. In fact, as Yvonne Denier remarks, "fair equality of opportunity is a *forward-looking* concept. It provides the moral basis for a fallback framework

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[51] Steven Schenker, Henry S. Perkins & Michael F. Sorell, "Should patients with end-stage alcoholic liver disease have a new liver?," *Hepatology*, 11(1990):2, p. 314–319; Carl Cohen & Martin Benjamin, "Alcoholics and liver transplantation," *Journal of the American Medical Association*, 265(1991), p. 1299-1301; Arthur L. Caplan, "Ethics of casting the first stone: personal responsibility, rationing, and transplants," *Alcoholism: Clinical and Experimental Research*, 18(1994):2, p. 219-221; Arnold J. Verster, "Caring for unhealthy lifestyles," *Canadian Medical Association Journal*, 151(1994):5, p. 509; Haavi E. Morreim, "Lifestyles of the risky and infamous," *Hastings Center Report*, 25(1995):6, p. 5-12; Peter Ubel, "Transplantation in alcoholics: separating prognosis and responsibility from social biases," *Liver Transplantation and Surgery*, 3(1997):3, p. 343-346; Stephen Wilkinson, "Smokers' rights to health care: Why the 'restoration argument' is a moralising wolf in a liberal sheep's clothing," *Journal of Applied Philosophy*, 16(1999):3, p. 255-269; Tziporah Kasachkoff, "Drug addiction and responsibility for the health care of drug addicts," *Substance Use & Misuse*, 39(2004):3, p. 489-509.

that contributes to all persons' receiving a fair chance in life. Because of this, it would be unfair to cut off fair equality of opportunity in the future because of past behavior. Although it sounds paradoxical, holding people responsible for their ends means that in assuming the presence of fair institutions, we are acting as if they can exercise their underlying moral power to *form* but also to *revise* their conceptions of the good and valuable."[52]

4. CONCLUSION

If the critical observations and the arguments presented in this study are correct, the idea of the application of the principle of responsibility for illness in the allocation of health care is unacceptable. The use of this principle is not acceptable, either, in what concerns the allocation of scarce medical services or in the situation when none of the medical criteria (urgency, need, and prognosis) can help a doctor to establish which patient must have priority in attending to his medical needs. Not only are the usual arguments for the application of this principle unsustainable, but also a few other extremely powerful reasons go against this idea. If these latter reasons are indeed valid, then the idea of the application of the principle of responsibility for illness in the allocation of health care should be rejected even by those who still believe, despite the critical observations presented here, that at least some of the arguments in favor of it are sound (e.g. the argument that the principle of responsibility is a legitimate demand of distributive justice).

However, while rejecting this idea, I have not rejected the one that, as the adepts of the principle of responsibility for illness say, it is correct to give low priority in the allocation of scarce medical services to

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[52] Yvonne Denier, "On personal responsibility and the human right to healthcare," *Cambridge Quarterly of Healthcare Ethics*, 14(2005), p. 232 (the author's emphasis).

persons with health-threatening lifestyles (e.g. alcoholics or smokers). The reason is that we can endorse such an idea with an argument other than that these patients (or some of them) are personally responsible for their diseases. It refers to the fact that the chances these patients have to benefit from the allocation of scarce medical services are much slimmer than in the case of the people with healthy lifestyles.[53] However, I am not qualified to analyze the validity of this argument. I will not finish, though, before I make it clear that even this argument was rejected by the authors who are in the position to do so.[54]

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[53] C. E. Atterbury, "The alcoholic in the lifeboat: Should drinkers be candidates for liver transplantation?," *Journal of Clinical Gastroenterology*, 8(1986):1, p. 1-4; M. J. Underwood & J. S. Bailey, "Should smokers be offered coronary bypass surgery?," *British Medical Journal*, 306(1993), p. 1047-1048.

[54] David A. Van Thiel et al., "Liver transplantation for alcoholic liver disease: A consideration of reasons for and against," *Alcoholism: Clinical and Experimental Research*, 13(1989):2, p. 181-184; Thomas Beresford, "Alcoholics and liver transplantation. Facts, biases, and the future," *Addiction*, 89(1994), p. 1043-1048; F. Kee et al., "Expanding access to coronary artery bypass surgery: who stands to gain?," *British Heart Journal*, 73(1995), p. 129-133; Robert G. Batey, "The case for liver transplantation in end-stage alcoholic liver disease," *Drug & Alcohol Review*, 15(1996):2, p. 183-188; G. P. Pageaux et al., "Alcoholic cirrhosis is a good indication for liver transplantation, even for cases of recidivism," *Gut,* 45(1999), p. 421-426; T. Cowling et al., "Comparing quality of life following liver transplantation for Laennec's versus non-Laennec's patients," *Clinical Transplantation*, 14(2000), p. 115–120; M. R. Roberts et al., "Survival after liver transplantation in the United States: a disease-specific analysis of the UNOS database," *Liver Transplantation*, 10(2004):7, p. 886–897.

Index of concepts

Index of names

We come across an era of strong and even more unusual individual claims, while the solution to often conflicting demands becomes increasingly elusive and parochial. One of the most intriguing philosophical questions is how to link human responsibility to those consequences of action which no one can fully foresee but, nevertheless, which no one can afford to neglect. Many biotechnological challenges are of this nature. This book is meant to give some insights in the mutual justification which ought to regulate the space between autonomy and responsibility by taking up a stance on some dilemmatic issues in the medical field.

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