Special Section: Responsibility, Vulnerability, Dignity, and Humanity

Guest Editorial

How to Be Human? Some Answers and New Questions

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This special section of the *Cambridge Quarterly of Healthcare Ethics* examines the delicacies of human nature and human interaction in terms of responsibility, vulnerability, dignity, and humanity. The contributions can be divided into four groups in the order in which they inspect the four title concepts.

Responsibility

The first topic is responsibility. How far does our responsibility for each other extend? What is the meaning of solidarity? Is solidarity a form of justice or an alternative to it? How are healthcare services to be distributed in a just and responsible way in less affluent countries? What theories of morality and justice can be employed to answer these questions?[1]

The matters surrounding solidarity and justice are taken up by Johanna Ahola-Launonen in "Humanity and Social Responsibility". If the revision of healthcare structures needs to be value based and respect individuals as members of communities and citizens of states, it has been suggested that solidarity could be the key value to be observed, and that it would provide a firmer and more humane basis for practical considerations than the liberal notions of justice and rights. Ahola-Launonen questions this solution, and sees it as a form of nostalgia. The solidaristic ideologies evoked are not viable today, or have problems, and justice in the more liberal sense still offers a better starting point for the protection of the wellbeing and integrity of vulnerable populations.

Adalberto de Hoyos, in "Issues on Luck Egalitarianism, Responsibility, and Intercultural Health Care Policies", addresses the fair and efficient distribution of medical and related services in a world where populations age, epidemics abound, and cultural differences make it difficult to provide sensitive care for everyone. The approaches considered are utilitarianism, liberalism, and luck egalitarianism. The author argues that utilitarianism is conceptually unable to deal with situations in which the advanced care of a limited number of people would drain most of the resources available. He also contends that liberalism faces similar resource issues in trying to cope with diseases of epidemic proportions. Luck egalitarianism, or a version of it, is offered as the best solution.

Vulnerability

The second focus of attention is vulnerability. What does it mean? Is it a neglected concept that should be made the focus of global bioethics? How would

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it work in that context? Does vulnerability generate asymmetries between healthcare professional and patients? What should we think about such asymmetries? Are they paternalistic? Are they to be shunned? Or are they to be utilized in medical work? And what if the lack of symmetry works in the opposite direction and makes the healthcare professional, rather than the patient, the vulnerable party?[2]

The questions of definition and international application are taken up by Thiago Cunha and Volnei Garrafa in "Vulnerability: Key Principle for Global Bioethics?" They study the interpretations of the concept in five different geographic and cultural regions, and outline a way forward in its utilization as a global theoretical and practical tool. In the United States, the notion of vulnerability is typically linked with autonomy, in Europe with responsibility, in Latin America with social exclusion, and in Africa possibly with a lack of harmony in social and communal relationships. In Asia, it seems that the notion has no particular indigenous meaning. This diversity prompts Cunha and Garrafa to conclude that vulnerability can only become a key global principle through culturally sensitive dialogue.

The relationship between physicians and those in need of their help is addressed by Vilhjálmur Árnason and Stefan Hjörleifsson in "The Person in a State of Sickness: The Doctor-Patient Relationship Reconsidered". Slightly against current opinion, they suggest that a specific kind of medical paternalism should be seen as acceptable, and indeed as the best way to empower vulnerable patients. Eric J. Cassell's thoughts on information control and meaningful conversation are seen to offer a good conceptualization, and a justification, for this view. Patients should be enabled to reach their own goals and purposes, but as they are in a state of considerable uncertainty in the medical situation, their own immediate ideas can be beneficially challenged, and respectfully edited.

A different look is taken by Karen Wright and Doris Schroeder in "Turning the Tables: The Vulnerability of Nurses Treating Anorexia Nervosa Patients". Instead of focusing on patients, who are standardly seen as the ones in need of protection, Wright and Schroeder direct their attention to healthcare professionals – nurses who are in charge of individuals with eating disorders. They assume a definition that makes a clear risk of harm and an inability to protect oneself against it the essential constituents of vulnerability. Since nurses treating anorexia nervosa patients are at risk of being involved in inauthentic and non-reciprocal relationships with their wards, and have no effective means of avoiding them, their vulnerability is, according to the authors, worthy of further study.

Dignity

The third idea taken up by our authors is dignity. What is it? Where does it come from? Does it mean the same to everyone or are there cultural, social, or political differences? How has it been incorporated in moral views, public debates, and ethical argumentation? How should it be incorporated in these? Can the concept be used only in certain types of doctrines and only by the advocates of those doctrines?[3]

The use of the notion in current bioethical debates is scrutinized by Søren Holm in "Undignified Arguments – A Critique". Holm observes that dignity, in the recent past primarily a part of the vocabulary of religious or conservative

thinkers, has also entered the consequentialist and liberal parlance. Previously, advocates of the latter ideologies tried to show how dignity is an ambiguous and futile idea in bioethics. The proponents of physician assisted suicide, however, refer to dignified and undignified ways of dying, and argue that dignity can be employed in justifying the practice. Holm questions both the earlier and later liberal readings, and contends that while dignity is a meaningful concept, it cannot be used in defense of physician assisted suicide in the way suggested.

A unified concept of dignity would be useful in ethical debates, as pointed out by Sebastian Muders in "Natural Good Theories and the Value of Human Dignity". Such a concept would, among other things, have to be able to distinguish between violations of dignity and other, and presumably lesser, types of wrongdoing. Muders identifies the central role natural good theories have in promoting the value of dignity, and outlines Martha Nussbaum's capability approach and its definition of the notion. The author argues that Nussbaum's model does not make a sufficient qualitative difference between lesser and greater wrongdoings. His own solution is to locate undisputed cases of dignity violations, and to use these as side constraints in examining other alleged violations of dignity.

Humanity

The fourth theme of this special issue is humanity, already touched upon in many contributions delineated above. Is humanity merely a biological category? Or does it have moral meaning? How is it connected with views on personhood, psychological or moral? Could nonhuman persons be our moral equals? Could we be their equals if their intellectual abilities were vastly greater than ours? What about human beings who have limited intellectual abilities? Are they our equals? Who are "we" in those last questions?[4]

The matter of super-intelligent nonhuman persons and other entities is contemplated by David R. Lawrence, César Palacios-González, and John Harris in "Artificial Intelligence – the Shylock Syndrome". From the viewpoint of psychological personhood theories, it would stand to reason that artificially or culturally (as in coming from outer space) super-intelligent entities would recognize our intelligence, however limited it would from their angle be, and consider it a good basis for treating us as moral equals. But according to the authors, this is not straightforward. They might not recognize our intelligence, if theirs was sufficiently different or superior. Or they might not see it as morally relevant. This could make peaceful relations with such beings difficult to accomplish.

Limited intellectual abilities and their relevance to humanity and morality are inspected by Matti Häyry in "Discoursive Humanity as a Transcendental Basis for Cognitive-(Dis)Ability Ethics and Policies". Eva Kittay and Jeff McMahan disagree about the treatment of human beings who are congenitally severely retarded. Kittay states that they have full moral value, and defends this by what she calls a relational theory of human worth. McMahan claims that they have no intrinsic moral value, and backs this up by his theory of psychological personhood and its value. Häyry analyzes their arguments and concludes that neither can reach the conclusions on the basis of the explicated theory alone. They are, in fact, debating the meaning and boundaries of humanity on a much more practical level.

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Notes

1. Some of these topics and their connection to bioethics have recently been examined in Ahola-Launonen J. The evolving idea of social responsibility in bioethics: A welcome trend. *Cambridge Quarterly of Healthcare Ethics* 2015;24: 204–213.
2. A useful discussion on the themes can be found in Schroeder D, Gefenas E. Vulnerability: Too vague or too broad? *Cambridge Quarterly of Healthcare Ethics* 2009;18: 113–121.
3. A negative answer to the last question is given, e.g., in Häyry M. Another look at dignity. *Cambridge Quarterly of Healthcare Ethics* 2004;13: 7–14.
4. The idea of "using humanity as a means" has been analyzed in Häyry M. *Rationality and the Genetic Challenge: Making People Better?* Cambridge: Cambridge University Press, 2010, at 116–122.