TWO CONCEPTS OF DIGNITY.

I am grateful for the invitation to come to the Bioethics Centre at the Chinese University of Hong Kong and for the honour of being asked to give the first Lanson lecture.

PART ONE: TWO VERSIONS OF RESPECT FOR DIGNITY.

It would be hard to find anyone who is against respect for human dignity. Because it is such a platitude it is used as a trump card in ethics, and especially in bioethics. Critical thinking about respect for dignity needs to start by distinguishing two versions. In the first, respect for someone’s dignity is contrasted with not humiliating them. More influential in bioethics is the second version, which includes such things as respect for the dignity of the embryo. Since embryos cannot be humiliated, respect for their dignity must be something different. It is the idea, found in Kant, of showing the respect appropriate to a being’s moral status, or “standing”.

This lecture will first, relatively uncontroversially, develop the idea that not humiliating people should be part of the central core of ethics. Then, I hope more controversially, it will make a case against some of the uses of the “moral status” version of dignity in debates about assisted suicide, embryo research and genetic choices.

Another aim is to use questions about respect for dignity to distinguish two different general approaches to ethics. In one approach, dignity is linked to the idea that respect is due to beings who have an inner life and who have things they care about: beings with whom it is possible to have empathy. The other approach is one that here will be called “abstract” or “legalistic”. I will give reasons for hoping that bioethics will move more towards the empathy-linked approach.
1. RESPECT FOR DIGNITY AS NOT HUMILIATING PEOPLE.

First the relatively uncontroversial version of respect for dignity: the one contrasted with humiliating people.

We are horrified if someone is excluded from a place or an activity because of their ethnicity or their religion, or if someone is ridiculed because of their disability. This version of respect for dignity also rules out stigmatizing people who are gay or who have psychiatric problems.

It also rules out humiliating official acts and policies. These include the early Nazi humiliation of Jews: forcing them to wear a yellow star or to change their names, or excluding them from certain professions. They include the pass laws and other humiliations imposed on Black Africans by the old apartheid regime in South Africa. They include features of British colonialism in places like Africa, including such practices as calling fully adult African servants “boys” and expecting them to call their employers “Master”. They include aspects of the Chinese Cultural Revolution, such as forcing teachers to endure humiliating public denunciations by children, kowtowing on their knees and wearing dunce’s caps, and to make grovelling public “self-criticism”. It rules out the horrendous public floggings still current in Saudi Arabia. It also rules out the blindfolding and other humiliations of Guantanamo.

No elaborate theory is necessary to say why it matters to avoid these various kinds of humiliation matter. Being humiliated is a horrible experience. As Avishai Margalit says in The Decent Society, humiliation is cruelty to its victims. Independent of any further consequences, it is to be avoided for this reason. Of course there may be additional reasons why it is bad. For instance it is a particularly nasty display of inequality.

HUMILIATION AS WEAKENING THE INHIBITION AGAINST ATROCITIES.

Sometimes the further consequences of humiliation can be even worse than the intrinsic cruelty. Atrocities are often preceded by –and facilitated
by humiliating those who will become their victims. During the British Raj in India, General Dyer imposed a humiliating order that, in a street in Amritsar where a British officer had been killed, Indians could not walk but must crawl. This was soon followed by protests in which peaceful Indian crowds were massacred by troops. The effects of humiliation are not confined to the victims. People who humiliate others are themselves changed, sometimes in ways that make atrocities easier to carry out.

In Poland, when the Nazis entered Bialystok they drove Jews out of the town by beating and shooting. They set light to religious Jews’ beards. Jews begging for protection were urinated on. This stripping Jews of their dignity was followed by herding 700 of them into the synagogue, where they were burnt alive. The earlier humiliations helped the perpetrators lose their inhibitions against such an atrocity.

The same result can come by a more indirect route. In the Nazi death camps, victims were stripped of much of their human appearance. Dirty and dressed in rags, they were described by the commandant of Auschwitz: “Look, you can see for yourself. They are not like you and me. They are different. They look different. They do not behave like human beings.”

THE COLD JOKE.

The disinhibiting effects on those who humiliate their victims is found in atrocities round the world. One of the clearest signals of this is the “cold joke”, a particularly strong expression of the desire to humiliate. Torturers working for the Argentinian military dictatorship gave their victims massive electric shocks. They called the shock machine “Susan” and told the prisoners they were to have “a chat with Susan”. This expresses contempt for the victims: “we are so little troubled by what we do to you that we can laugh about it”. It also helps the torturer suppress any sympathy he might have had.

The cold joke is the strongest expression of the perpetrators’ lack of respect by showing amusement at the horrendous things they are doing to people. One news report from Syria had an interview with the mother of a young man killed by so-called “Islamic State”. They had beheaded him. Then they gave his head to his mother. (BBC NEWS 12 September 2016.) This “gift” was a cold joke: we care so little about you or your son
that we can follow up what we have done with this cruel bit of amusement at your expense.

The guards in the Nazi death camps, by removing their victims' dignity, denied them moral standing. The persuaded themselves there was no dignity to respect. Removing this barrier helped make the killings possible. In the Nazi case, some of those directing the atrocities had some awareness of this psychology. Years later Franz Stangl, the Commandant of the death camp at Treblinka, was asked: “Why, if they were going to kill them anyway, what was the point of all the humiliation, why the cruelty?” He replied, “To condition those who actually had to carry out the policies. To make it possible for them to do what they did”.
2. RESPECT FOR DIGNITY AS SHOWING THE RESPECT APPROPRIATE TO SOMEONE’S MORAL STATUS OR “STANDING”.

We have moral rights and claims. These depend on our moral standing: things about us that justify kinds of consideration that do not need to be given to coffee cups or spiders.

This idea of recognizing someone’s moral standing resonates with many of us. In the greatest piece of philosophical theorizing about people’s moral standing, Immanuel Kant located its basis in a triangle of properties. These were rationality, autonomy and, what he thought resulted from these, the capacity for morality. They can be bundled together in the phrase “rational moral agency”.

What was the distinctive moral status Kant thought rational moral agency conferred on us? Things that can be bought, land, houses, furniture, cars, computers, clothes, food, are to varying degrees replaceable. So they have no more than instrumental value. Only people, as rational moral agents, are irreplaceable. So they alone are ends in themselves and must never be treated merely as a means to something else.

“Dignity” is the word Kant chooses to express this unique moral status. Kant called the community of rational moral agents a “kingdom of ends”. For him, in the kingdom of ends everything has either a price or a dignity. What has a price can be replaced with something else, as its equivalent; whereas what is elevated above any price, and hence allows of no equivalent, has a dignity… A rational moral agent does not merely have a relative worth, i.e. a price, but an inner worth, i.e. dignity.

There are familiar questions about this account of moral status. Does it apply to all human beings, including those with little or no autonomy? Does it apply to people who are irrational? Does evidence about the capacities of some other species show that they should be included? In everyday life we use each other (bus drivers, doctors, etc.) for our purposes all the time. Where is the boundary between treating them as means and treating them merely as a means? Despite these questions, many of us are drawn to the idea that a person has moral standing and to the idea that we should treat people as ends in themselves and never merely as means.
I cannot help regretting that Kant hijacked the word “dignity” for his ideas about moral standing. In his book *Dignity*, Michael Rosen has given an explanation. He tells us that the German word Kant uses, *Wurde*, means both valuable or deserving (as in deserving of reward) and also dignified. This makes his use of the word understandable. But, if instead he had used some other German phrase without this double meaning, much dubious philosophy might have been avoided.

Obviously, Kant’s ideas about moral standing include a good deal that needs clarifying. Equally obviously, this need not be a reason for wholesale rejection.

There is one question of interpretation to which Kant did give an answer that is startlingly clear. If rational moral agency is its foundation, do people who act immorally still retain moral status, with the rights and claims that follow from it? Kant believed lying was always immoral. He considered the moral standing of a person who tells a potential murderer a lie in order to save someone’s life. He says that the liar “violates the dignity of humanity in his own person” and so becomes “a mere deceptive appearance of a human being” who “has even less worth than a mere thing”. Some of Kant’s ideas about moral standing are deservedly influential. But we should not forget this utterly appalling view that a person lying to save someone’s life forfeits any moral claims on others and becomes less than a mere thing.

In such a case, the liar’s crime is said to be “violating the dignity of humanity”. This is an abstraction, not rooted in any concern for what matters in human terms, neither what matters to the potential murder victim nor to the person who lies to give protection.

This kind of abstraction is still alive in bioethics. It should be given up.
PART TWO: DIGNITY IN BIOETHICS.

There are several debates in bioethics where respect for dignity is given as a reason for resisting some technological development or some proposed policy. Sometimes respect for dignity is cited on both sides of the debate. But the focus here is on a common feature of the uses of the “dignity” objection by those opposing change.

In the United States in 2008, the President’s Council on Bioethics published a book on the topic of *Human Dignity and Bioethics*. The essay on “Defending Human Dignity” was written by Dr. Leon Kass, a scientist and an “old fashioned humanist”, who had been appointed chair of the Council by President Bush. The horrors of Nazism justifiably shape his thinking. If people want to “claim that I am, for reasons of race or ethnicity or disability or dementia, subhuman, or at least not your equal in humanity, and, further, if you mean to justify harming or neglecting me on the basis of that claim, the assertion of universal human dignity exists to get in your way”.

He wrote of the Council’s effort to defend “aspects of human dignity that are at risk in our biotechnological age”. Among many such concerns, Dr. Kass included risks to “the dignity of human being as such, threatened by the prospect of euthanasia and other “technical solutions” for the miseries that often accompany the human condition”. Another risk was to “the dignity of nascent human life, threatened by treating embryonic human beings as mere raw material for exploitation and use in research and commerce”. Another was to “the dignity of human procreation, threatened by cloning-to-produce-children and other projected forms of manufacture”.

The three questions to be considered here are:

Is human dignity violated by allowing assisted suicide?

Should we respect “the dignity of the embryo”?

Is human dignity violated by choosing to have a child with some genes rather than others?
1. DIGNITY AND ASSISTED SUICIDE.

Dignity most often appears as part of the case in support of assisted suicide. “Death with dignity” is something assisted suicide is claimed to allow by saving the person from going through an unwanted period of severe incontinence, drooling, dementia or other massive incapacities that he or she would find humiliating.

In 2002 Diane Pretty’s motor neurone disease left her paralysed below the neck. She was in a wheelchair and had to be fed through a tube. Others had to change her catheter bag or her incontinence pad. It was hard to communicate verbally beyond grunts and moans. Pressure on a keypad by her wrist allowed her to operate an electronic voice, but longer sentences might take her twenty minutes. But her mind was still clear. She did not want to die by choking or suffocation and she said that if she had retained the ability to do so she would have killed herself. She was asked if her life was still not better than being dead. Ten minutes later the electronic voice said, “I am dead”. She wanted a doctor to assist her suicide, something illegal in the United Kingdom. Her palliative care specialist had watched her distress and loss of dignity. He hoped she would have a peaceful, dignified death but could not guarantee it.

Cases like this are a powerful “dignity” argument for assisted suicide. But, in this debate, respect for dignity as moral status is sometimes cited as a countervailing reason. One version of this case is made by J. David Velleman, in his paper on “A Right of Self-Termination?” in his book Beyond Price, Essays on Birth and Death. He is not against assisted suicide in all cases. He says, “I am neither pro nor con. I’m like, Not so fast.” But he mounts a “dignity” challenge to a central plank of the case in favour of it. He rejects the principle that a person has a right to end his life if it is no longer worth living.

Velleman’s first reason for this is a strong one: life and death decisions can affect others. Suicide can deprive others of a loved or needed parent, spouse, partner or child. This point is a strong one. In different cases, the suicidal person’s interests may or may not trump those of others. But Velleman is surely correct to question the idea that it is always right for the person to put himself or herself first.
Velleman’s other reason for rejecting the “not worth living” justification is my concern here. It is more theoretical. It appeals to dignity in the sense of moral standing.

Velleman accepts that, where a person’s life is not worth living, dying may be best for him: what it would be rational to want for his sake. But, quite apart from the interests of other people, he does not accept that the person’s good is the central issue. It has only conditional value: “What is good for you would not matter if you didn’t matter”. This is less chilling than it sounds. Velleman makes it clear that he believes that every person matters for his or her own sake. But the value of a person (and so of his or her interests) is still conditional: “Every person matters for his own sake, because he embodies an interest-independent value.”

Why cannot the chain of justification end with what is good for people? Why must we go on to some value independent of people’s interests? Consider cases where someone is suffering excruciating pain, or massive impediments of the kind experienced by Diane Pretty. If there is some harmless way of responding to their considered request to help end their distress, why cannot we just act on this? Why should the moral value of the person come into it? To some of us, the considered request and the avoidable extreme distress are all that is needed. Ending it matters without any prior investigation of whether the sufferer “matters”.

This alternative response is rooted in empathy. In one way it could be made to fit Velleman’s formula. He says that a person’s value “inheres in him among other persons. It’s a value that he possesses by virtue of being one of us, and the value of being one of us is not his alone to assess or defend. The value of being a person is therefore something larger than any particular person who embodies it.” The empathy approach could be adapted to this by making the capacity to suffer a criterion of whether someone is “one of us”.

But it seems unlikely that this would be accepted. Velleman wants a more moralistic test. He says that in discussions of assisted suicide, what he misses is “the sense of a value that makes a claim on us—a value that we must live up to.” He accepts that sometimes it may be acceptable for someone to hasten the end of his life. But, “What I deny is that one may end one’s life simply because one isn’t getting enough out of it. One has to consider whether one is doing justice to it.”
This is highly Kantian. It appeals to dignity, understood as respecting the moral status of a person. And it makes the person the only unconditional value, or end in itself, to which such things as his benefit or harm are mere means. “The value of what’s good for a person is only a shadow of the value inhering in a person” and so cannot overshadow it. To give up one’s personhood by dying in order to avoid harm denigrates the value of personhood and so is immoral.

This view brings out sharply the contrast between empathy-linked approaches and the abstract approach. It would of course be wrong to suggest that Velleman and others who take the same view are without empathy towards those seeking assisted suicide. But, for the empathy-linked approach, there would be a strong presumption to give Diane Pretty the release she so much wanted. (“A strong presumption” allows for the possibility of it being over-ridden by harm to others. For instance, if there were good evidence of vulnerable people being pressured into assisted suicide against their real will, this would count against it.)

On the abstract view there is no such presumption. Prior tests have to be passed. Does this person’s decision denigrate the value of personhood? Is Diane Pretty doing justice to her life? The reason for the adjective “abstract” is that the moral principles these tests embody are not rooted in concern for how things are for people. On the empathy-linked view, the central concern is whether we can alleviate how life is treating Diane Pretty, not whether she is somehow short-changing the abstraction called “her life”. If I was in a position similar to hers and asking for assisted suicide I would hope the answer would be “yes”. If the first response was the arrival of some moralist to ask whether I was doing justice to my life, a few undignified obscenities might issue from the speech machine.
We are urged to respect the dignity of the embryo. Central to respecting people’s dignity is not humiliating them. Since embryos cannot be humiliated, it may make more sense to urge respect for their moral status. Though that requires an account of why an embryo has moral status and what it amounts to.

Dr. Leon Kass is rightly concerned to create barriers against “the widespread tendency to treat the foreigner and the enemy, the misfit and the deviant, or the demented and the disabled as less human or less worthy than oneself – and especially as unworthy of basic respect and continued existence”. His ethical outlook is influenced by his work for civil rights in Mississippi. “Our successful battles against slavery, sweatshops, and segregation, although fought in the name of civil rights, were at bottom campaigns for human dignity – for treating human beings as they deserve to be treated, solely because of their humanity.”

Kass opposes treating embryos as “mere raw material for exploitation in research and commerce”. Much medical research on embryos has great potential for human benefit. So it should be justifiable unless there is an over-riding objection to it. One such objection might be that, like Nazi experiments, it goes against treating human beings as their humanity requires. But does it do so?

The targets of the civil rights campaigns were slavery, sweatshops and segregation. All were affronts to the first version of human dignity. They humiliated people. So it is not obvious that appeals to dignity based on the civil rights campaigns carry over to embryos.

An argument is needed to show that embryos have the other kind of dignity: a “moral status” that this research violates. Leon Kass does give an argument. It appeals to equal membership of the human species. “All members of the class Homo sapiens are equally members of that class, and share thereby in whatever standing and dignity adheres to the class as a whole.”

This raises another doubt. The phrase “human beings” (colloquial for “members of the class Homo sapiens”) is widely taken to be equivalent to “people”. If an opinion poll asks “should we respect the dignity of all human beings?” most will take this as being about all people. They will answer “yes” to express rejection of racism and other prejudices. They
will not see themselves as voting against the morning after pill or embryo research. Choosing “Human beings” rather than “people” is effective rhetoric but less helpful to clear thinking.

“Human being” can have wider or narrower scope. This claim here is not like the Nazi claim to exclude some people, on grounds of ethnicity or disability, as “subhuman”. The blurred boundary here is about developmental stages. It could be objected that, just as a caterpillar is not yet a butterfly and an egg is not yet a chicken, so an embryo is not yet a “human being”. Kass’s argument depends on whether there is a convincing reply to that objection. One reply is that an embryo has all the genes that a human adult has and so it is a human being. This reply fails. It would make a caterpillar a butterfly and make a fertilised egg a chicken. What the whole approach leaves out is the idea that the concept “human being”, like the concept “person”, has a developmental component.

This argument for the claimed moral status of embryos is weak. But the idea of respecting embryos still strikes a deep chord. A few years ago there were reports of ear-rings made out of human embryos. I found this disgusting and so no doubt did many others. Most people who discuss these matters know we should be cautious about rapidly drawing moral conclusions from a “Yuk” reaction. But such reactions can be a useful early warning signal that there is something to think about.

In some ways the case of respecting embryos is like the case of respecting the dead. A corpse, like an embryo cannot be humiliated. But there are kinds of disrespect for a corpse that would disgust most people. In the Nazi so-called “euthanasia” programme, victims were denied dignity in death. When the ten thousandth corpse was cremated at the killing centre at Hadamar, one of the Nazi staff dressed as a clergyman and gave a gruesome parody of a funeral address:

*That evening… everybody was given a bottle of beer and… we then went down to the cellar. There a naked male corpse with an enlarged head was laid out on a bier. I must emphasize that it was definitely a real corpse and not a cardboard one. The “burner” then placed it on a sort of bier and pushed it into the crematorium. Then M who had dressed up like a clergyman gave a “funeral address”.*

Claude Levi Strauss claimed that respect for the dead is a human universal. Even Neanderthal man buried the dead in roughly prepared
tombs. Levi-Strauss mentions various reasons why peoples studied by anthropologists respect the dead. In return the dead may be hoped to ensure the regularity of the seasons or the fertility of crops or of women. Sometimes cannibalism or sexual intercourse with the corpse is supposed to allow the living to take some of the dead person’s powers. Sometimes the dead are called on to testify on behalf of their descendants. These kinds of respect for the dead (if that is the right phrase for having sex with a corpse or eating it) were rooted in self-interest: deals they do with us in exchange for rest or for powers we take from them.

Now we need different reasons for respecting the dead. There are two more plausible ones. As part of adjusting to losing someone, we may have a deep psychological need to grieve. Another reason, given by Michael Rosen, is that respecting the dead may protect our own attitudes of respect towards the living. Perhaps degrading a corpse could break through a psychological barrier preventing atrocities against the living, in the way eroding the dignity of living people does. The example of Hadamar is not reassuring.

A case, parallel to Rosen’s argument against degrading a corpse, might be made against embryo research, looking for evidence that those engaged in it become less respectful of the life and moral status of others in the society. But there are reasons for scepticism. Medical research using dead bodies, so utterly different from grotesque Nazi “funeral”, has not made doctors casual about living people. And embryo research can reasonably be expected to turn out the same way, however different might be the upshot of mass production of ear-rings from embryos.

We cannot have empathy with embryos, as there is no answer to the question “What is it like to be an embryo?” It is abstract and legalistic to oppose research by appealing to an embryo’s supposed “dignity” based on an arbitrarily stretched definition of “human being”.


3. “DIGNITY” OBJECTIONS TO GENETIC CHOICES, INCLUDING “ENHANCEMENT”.

Most of the dignity objections to making genetic choices about our children also appeal to the idea of dignity as moral status. One of the prominent objectors, Francis Fukuyama, arguing against projects to improve or “enhance” their genes, appeals to the concept of human dignity—that is of the idea that there is something unique about the human race that entitles every member of the species to a higher moral status than the rest of the natural world. The concern is not to put at risk this unique thing that underpins our status.

What is this unique thing? Fukuyama cites a cluster of characteristics: human reason, consciousness (including feelings and emotions) and the capacity for moral choice. He says they are in mutual support. Human reason is pervaded and helped by emotions. Consciousness is shaped by other people and their moral evaluations, by social emotions, memory and reason: none of the key qualities that contribute to human dignity can exist in the absence of the others. He uses this account of human dignity to decide what we should protect from technological change. He concludes that we want to protect the full range of our complex, evolved natures against attempts at self-modification. We do not want to disrupt either the unity or the continuity of human nature, and thereby the human rights that are based on it.

There are problems for this approach. How should we decide which human characteristics are essential to our being human? Do we want to protect “our complex evolved natures” just because they are human characteristics (either universal or very widespread)? Or are we supposed to take “humanity” not as what we are like, but as an ideal?

If we take the first option, we can ignore ideals and simply protect the characteristics humans actually do have. Those characteristics include torturing fellow humans, and killing huge numbers of them in war. We could be better off without these parts of our nature. If, improbably, some genetic intervention could switch off these capacities without further side-effects, it would be strange to say that the gentle peaceful people who resulted were not human. And, even if we did say that, is it clear that to transcend humanity in this way would be wrong?
The more plausible alternative tries to identify the essential characteristics as ones that fit our hopes and ideals for humanity. Is there really some “right” answer that avoids arbitrariness? And Fukuyama’s very Kantian answer (that includes reason and moral choice) may draw the boundaries too narrowly. Does someone too mentally disabled for reasoning and moral choice not qualify for human rights? Fukuyama’s cluster (consciousness, reason and moral choice) is a bit porous at the edges. So perhaps it can be stretched to include almost anything good. But, without stretching, does it leave out imagination, creativity, generosity or a sense of humour?

Another question is whether the status-conferring characteristics in Fukuyama’s cluster are really threatened by every kind of genetic choice. Suppose technology made it possible for parents to make genetic choices that would probably influence their children in the direction of being less vengeful or less aggressive, or being more cheerful or more musical. Should all these choices be banned? Doesn’t the right policy depend on what genetic linkages between characteristics there turn out to be? If, say, making people more cheerful also made them less sensitive to the sufferings of others, we might justifiably pause.

There are many other reasons either for saying “no”, or at least for caution. Some parental genetic choices might reduce the child’s chance of having a good life. And what impact would knowing parents had chosen some of their genes have on the child’s sense of identity or sense of being an autonomous person?

Other reasons for concern might be the possibility of rich people buying their children genetic advantages that poor people could not afford. The idea of genetically reinforced inequalities is not appealing. There is the danger of fruitless and costly conflicts over positional goods. Parents buying possible genetic advantages for theirs over other people’s children might just trigger those other parents to do the same. The costs, not just in money but in medical intervention and in the competitive burden placed on children, might make it better never to start the whole competition. As Fred Hirsch, in his book Social Limits to Growth, wrote of such contests for relative position, “If everyone stands on tiptoe, no-one sees better”.

These reasons to be cautious (at least) about genetic “enhancements” are all empathy-linked. Empathy warns us to take seriously threats to
children’s autonomy or to their having a decent chance of a good life. We can empathise with victims of inequality or of useless and draining struggles for positional goods. How serious these threats are can be investigated empirically. In this they contrast with the abstract claim that human dignity would be eroded by any of these genetic interventions: the belief that we already know that our genetic inheritance should be left exactly as it is.
4. MOVING FROM ABSTRACT LEGALISTIC THINKING TO AN EMPATHY-LINKED VERSION OF MORAL STANDING.

These three accounts of dignity as moral standing are *abstract* in contrast to alternative empathy-linked approaches centred on a person’s life as seen from inside. Calling them “empathy-linked” does not mean that people have moral standing only if we, or some of us, do *in fact* feel empathy for them. If someone has an inner life and there are things they care about, *we could* feel empathy for them even if we do not. This is all that is needed to justify their moral standing. Major moral shifts (the abolition of slavery, moves away from racism or from homophobia, concern for humane treatment of conscious members of other species) have been linked to acceptance of this.

The empathy-linked approach requires interpretation of other people. What will respect his autonomy? What does she most deeply want? What may she freely choose to shape and enlarge what she wants? What will he later be glad of? Most generally, what will enrich or impoverish their lives? This is a plurality of values, not always in harmony with each other. They *can* be squeezed into a single standard ethical formula, perhaps utilitarian or Aristotelian, though the single formula is likely to do less justice to some elements than to others.

This exploration and interpretation of the person comes up when someone asks for assisted suicide. People looking from outside need to explore how far this request is a shallow temporary inclination and how far it comes from deep within the person. The conversations needed for this may often draw the person making the request into self-interpretation and self-exploration.

Abstract legalistic approaches to dignity do not give this central role to exploring the person’s inner world and values. The abstract approach to assisted suicide allows all this to be trumped by some external standard: is the person doing justice to his or her life? For embryos there is no inner world, no values or autonomy to explore. The abstract approach substitutes for all this a set of restrictions based on a stretched definition of “human being”. About genetic choices, it again avoids being empirical. It bases an absolute ban on any genetic possible enhancements, based on abstract claims about what is essential to
humanity. It does not rest on scientific investigation of genetic linkages, or on human interpretation of actual people and what they care about.

Despite the defects of the abstract approach, moral status and the moral claims that follow from it are of real importance. Concern for moral standing does not have to result in empathy being over-ridden by abstractions.

One of the great campaigners inside South Africa against apartheid was the Anglican priest Father Trevor Huddleston. In his book Naught for Your Comfort, he explained his commitment to racial equality. For him, the moral standing of human beings came from his belief that we are all equally made in the image of God. Those of us without religious belief do not share this account of moral standing, but we can applaud the attitude that flowed from it: empathy and concern for all people regardless of ethnicity.

In his obituary of Trevor Huddleston, Archbishop Desmond Tutu described one of his own childhood memories. The society treated an uneducated Black woman such as his mother as a nonentity. I was standing with her on the hostel verandah when this tall white man, in a flowing black cassock, swept past. He doffed his hat to my mother in greeting. I was quite taken aback; a white man raising his hat to a black woman! That gesture left an indelible impression. Perhaps it helped deep down to make me realize we were precious to God and to this white man; perhaps it helped me not to become anti-white, despite the harsh treatment we received at the hands of most white people.

The empathy-linked version of respecting dignity as not humiliating people does have links with the idea of moral status. At the core of much deliberately inflicted humiliation is: “We do not accept that you have a status that requires us to treat you with respect”. This is the message the cold joke underlines. Part of how deliberate humiliation paves the way to atrocities is by eroding the torture-inhibiting and killing-inhibiting respect for the victims’ moral status. The erosion of our shared moral status and the erosion of empathy are closely linked.

The empathy-linked version also extends respect for dignity to actively pre-empting humiliation. A more abstract morality can support this too. But empathy more obviously creates a pressure in this direction.
Avishai Margalit calls a society that does not “officially” humiliate people a “decent” society. A society that officially discriminates against people of some ethnic group, gender, religion, sexual orientation or medical condition is not decent. He calls one that avoids the “unofficial” humiliation of some people or groups by others a “civilised” society. A society where some people shout insults after others, force them to the back of the queue or beat them up is not civilised. To these categories can be added humiliations that are at least partly socially caused but unintentional. These include the humiliations of poverty: Adam Smith mentioned the need to be able to appear in public without shame.

More recent is the growing awareness of the humiliations of disability, often also partly socially caused. A civilised society is one where disabled people are not exposed to ridicule or contempt. But eliminating these ugly attitudes is not enough. The disability rights movement has moved the focus on to unintended humiliations. “Does he take sugar?” is not a question to ask someone else if he himself is there to be asked. And we have learnt the need for society to make active changes. Now it is a commonplace that buildings without wheelchair access or the traffic lights without sound warnings for blind people can and should be changed.
PART THREE: PSYCHIATRY, HUMILIATION AND MORAL STATUS.

In their late 1970s study on the *Social Origins of Depression*, George W. Brown and Tirril Harris found evidence that severe life events, including psychological trauma, contributed to clinical depression in women. Later, research found the impact was more severe when the trauma included humiliation.

A central cluster of humiliations was important. One was a partner either deciding to separate from them or doing things that provoked the woman to separate. They could be humiliated if their child was delinquent or if someone close committed a crime. Other humiliations came from being physically or verbally attacked, especially by someone close, or if it was in a highly public or upsetting way. Not all humiliation came from other people. Some was “self-administered”: caused by some failure or shameful act of their own.

The way humiliation can contribute to psychiatric disorder raises the question: may its opposite, respect, be important for treatment?

1. MORAL STANDING AND REACHING OUT
   –AVAILABILITY AND LISTENING.

A very crude psychiatry may see treatment simply in terms of curing or containing a disorder and its symptoms. The core of psychiatric respect for moral standing goes beyond this, to seeing that the disorder and the symptoms are only aspects of a person who transcends them. This colours how the person is spoken to and the respect with which he or she is treated. In hospital it means patients each having a room of their own, and the security of knowing they will not be moved without exceptional reason. It means personal contact and friendly support. It means—as far as possible in often under-funded psychiatric services—continuity of care. Jay Griffiths, in *Tristimania*, her diary of manic depression, appreciated the great efforts her psychiatrist made: *He made himself available, reachable… He didn’t shunt me off to the circus*
of serial strangers which so many psychiatric patients experience, and I was grateful for that to the bottom of my heart.

So far, this is familiar. There are many psychiatrists and psychiatric nurses who believe all this and, within sometimes daunting constraints, see the patient as person and act accordingly. But perhaps concern for moral standing should go further. Psychiatry could follow the disability rights movement and be more proactive about features of psychiatric disorder that are taken to be its unavoidable background.

2. STIGMA AND INTERPRETATION.

The degree of stigma still attached even now to psychiatric disorder is a large obstacle to full respect for dignity. Brave people talking publicly about their own psychiatric problems have started to push back the stigma. But equality of respect in this area has a long way to go to catch up with the results gained by feminist and anti-racist campaigns.

Campaigning may not be enough. Part of the stigma is what other people see as the “strangeness” or “weirdness” of psychiatric conditions. Sometimes these conditions find expression in ways that seem to resist intelligibility. The unresponsiveness, the bizarre delusions, the odd or irrelevant comments, the rigid posture or gait, the sudden cackle or the impenetrable face all seem to defy our ordinary ways of interpreting each other’s feelings, thoughts and inner lives.

But those who at times seem impenetrable in this way still have inner lives worth interpreting. And the impression of weirdness is reduced when we start to understand a bit about what is going on inside them.

Many recent advances in understanding psychiatric conditions are at the level of genetics or neuroscience. But, to weaken the stigma of strangeness, accounts in human terms are needed. An account in terms of neurotransmitters, synapses or circuits in the brain may explain some bizarre belief or action. But to undermine stigma we may need to translate this into psychological terms that fit our intuitive human interpretation of people.
3. LISTENING AND INTERPRETATION AS PART OF RESPECT FOR DIGNITY.

We have learnt from the disability rights movement that respect for people with physical disability requires removing the physical barriers that contribute to their problems. To respect the dignity of people with psychiatric problems we need to try to remove the mental barriers that make them seem "weird" or impenetrable. And this involves close attention and sustained attempts at interpretation.

Many psychiatrists already know that such sustained efforts at interpretation can also help treatment. Jay Griffiths made a strong claim for this: *I felt at the time, and still feel now, that my doctor saved my life… So: what did he do right? He listened, deeply. I felt as if he let my words into his mind, so that he could re-hear my words right inside himself and re-listen if necessary… Because he listened to my metaphors, I felt he was willing to walk with me in the landscapes of my mind… In the weirdscape I walked in, he was my lead climber…*

For Jay Griffiths, this listening to her metaphors for her disorder was central. People using metaphors want to be understood: *but in madness this need becomes infinitely more intense. In a manic-depressive episode, metaphors are heavy with meaning and the metaphors must carry an almost unbearable weight. This, I think, is why people are so stubborn about repeating the precise metaphors which tell their truth.* (She mentions some of the metaphors: seeing their disorder as a black sun, the black dog, an abyss, a black hole, or as drowning.) *I was lost and urgently needed to be found, to be located by someone who could… send their soul out to find mine. In terms of our culture, one way of doing this is surprisingly simple: listeners need to hear the metaphors and stay with them. My doctor used my metaphors with almost unaltering precision and I felt safer for it. In all the hours of appointments, there was only one time I remember when he used a completely different metaphor to the one I’d just used, and I couldn’t say anything. It was a broken moment, and I was lost, all over again. But every other time, by using my metaphors, he made me feel located, as if I could hold his hand and follow the way he knew and I’d forgotten, back to safety.*
Jay Griffiths is likely to be right that many people with manic depression need to have their metaphors listened to and explored. She is a poet. Others may put less emphasis on metaphors. For someone whose life centres on being a mother, or being a soldier or a priest, the close attention needed may have to take other forms. Though some of that may include careful listening to distinctively maternal, military or religious metaphors.

4. AIMING TO HELP THE PERSON TAKE CONTROL OF COPING WITH THE ILLNESS.

Part of respecting the person with a psychiatric disorder is not seeing them as confined to the passive role of being treated. It is a matter of helping them –to the extent to which it is possible- to contribute to the cure or management of their own psychiatric problem. In the most optimistic case, it is to enable them to take control of coping with it.

Simon Champ has described how his own changing attitudes towards his schizophrenia played a role in reclaiming himself. At first he identified with his symptoms. Then his identification became more positive and more aggressive: “Hi, I’m Simon and I’m schizophrenic”. Then he started to take a larger view: I was recovering my personhood and saw the illness as influencing rather than defining me. He reacted against the passivity of “suffering” from it. Becoming angry about the stigma it had and about how society had treated him, he had renewed hope for his own life.

His sense of identity had been linked to ideas about having a job and about masculinity. His view changed. His sense of worth could come from other things than paid work. And he came to see that real men do indeed cry. He says that understanding his illness has involved deep communication with himself: that has given me the most precious thread… that has linked my evolving sense of self, a thread of self-reclamation, a thread of movement toward a whole and integrated sense of self, away from the early fragmentation and confusion I felt as I first experienced schizophrenia.
He reflects on how he reclaimed himself. *You do not simply patch up the self you were before developing schizophrenia… you have to actually recreate a concept of who you are that integrates the experience of schizophrenia.* He says there is a continuity with the original self. He now has peace of mind: *as if I've come home to myself, a self changed, a self I last felt at 17 and yet now I'm 40. All those years… separate me from the teenager I was but somewhere inside I'm complete again, as I used to be then.*

Of course many people with psychiatric conditions may not get there. They may not have Simon Champ’s exceptional powers of self-awareness and self-reflection. Their thinking may be less articulate. Sometimes people are so invaded by illness that they are relatively powerless. (Although not talking about her here, I will borrow Jay Griffith’s own vivid metaphor: *In depression, I feel I have been taken over and have lost myself entirely. Instead, a rude incumbent has slumped into my life, leaving half-eaten sarnies under the sofa and stale smells in every room.*) It may take a long period of medication and/or therapy to expel or even tame the rude incumbent enough to help the person come anywhere near being able to take even partial control. Even so, ideals only rarely attainable should not be abandoned. And for medical professionals to respect dignity through alert and imaginative interpretation is one way of practising in the light of this ideal.

**FOOTNOTE: HOPES FOR THE BIOETHICS CENTRE.**

I hope the theme of this lecture has some relevance to medical ethics as taught and practiced in a Bioethics Centre.

Obviously there must be collaboration between people coming from the many medical disciplines and those who come from the discipline of philosophical thinking about ethics. This will sometimes call on efforts of imagination and mutual learning.

For much of my adult life, I taught philosophy, often ethics, at Oxford. This was not to medical students, but to those whose course combined philosophy with politics and economics, or with psychology, classics, mathematics, physics, languages, etc. In tutorials I would try to elicit and challenge their beliefs about ethics, often using familiar but unrealistic
thought experiments: would you divert a trolley that is going to kill five people on to another track where it will kill only one person? I was impressed by how they would often quickly bounce back highly intelligent responses, and how good they were at meeting my objections.

Later I moved to teach medical ethics at King’s College London. The class contained people of all adult ages. (Almost all my Oxford undergraduates were aged between 18 and 23.) The class at King’s contained lawyers and others, but what was striking was the range of medical disciplines represented: General Practitioners, nurses, psychiatrists, surgeons, midwives, anaesthetists, researchers, medical administrators and others.

I soon found that my abstract dilemmas about assisted suicide, etc. were inadequate. “No, no. It isn’t like that at all. Take this case we had last month…” Soon I realised that I was learning at least as much as the class. One time I offered what I hoped was a more realistic case. A woman who was a General Practitioner responded: If she said that, my first question would be “Have you told your Mum?” I had moved a long way. (Oxford undergraduates don’t have Mums. They all sprang into the world at the age of 17, already rational.)

The stereotypes philosophers and doctors have about each other have a degree of truth. Philosophers tend to think doctors decide ethical issues by intuition or by professional guidelines laid down by others, and do not subject either to enough critical thinking. Doctors think philosophers are obsessed with abstract principles, only put to the test by quite unreal thought experiments that never engage with the complex human realities seen in medical practice.

These stereotypes are of course not universally true. But in general there needs to be more convergence between thought and experience. Immanuel Kant, writing about our knowledge of the physical world, said thinking without experience is empty and experience without thought is blind. Doctors do need to think critically about fundamental values. And philosophers do need to draw on medical and other human experience. In general, philosophers should be much more engaged with better interpretation of people: their needs, and values: what they (we) are like. This too is ethics.

This published version of the lecture has been considerably improved by Alastair Campbell’s valuable response when it was delivered.
Introduction

Fortunately, to be a commentator on a lecture does not entail that one disagrees with it! I heartily endorse a great deal of what Jonathan has argued for in this lecture; and I cannot think of a more timely moment to speak up for respect for human dignity in an absolute opposition to humiliation, when in the USA and in the UK political leaders have used public humiliation of minority groups as a way of gaining power, and such denial of basic human rights has seemingly become acceptable to large section of the population.

So what I have to say will be less a critique and more a critical development of some of Jonathan’s arguments. In doing this I shall also try to relate his account to some of the bioethical issues here in Asia. I shall raise three issues: 1) Does empathy have enough normative power to support dignity? 2) How does dignity at the end of life relate to social solidarity? 3) In psychiatry how to overcome effectively the alienation experienced by people with mental illness?

1 - Empathy and Normative Power

It has often been observed that the concept of human dignity is very closely allied to the defence of fundamental human rights, indeed, the key documents spelling these out have this as a starting point. But this means that our account of dignity has to have normative force, that is, it has to enshrine duties correlative to the asserted rights. Does empathy have this force, especially
when (in Asia as in many other parts of the world) these rights are often under threat? It will be well known to this audience that there have been attempts to discredit ‘human rights talk’ as a cultural imposition from the West, which fails to respect ‘Asian values’. But interestingly, if empathy is rephrased as benevolence or care towards all one’s fellow humans, then it chimes well with Confucian accounts of dignity, and thus more generally with Asian values. Here is how one Confucian scholar who works in the City University of Hong Kong puts it:

The Confucian ethical account identifies the capacity to care and respect for others as the defining characteristics of our humanity. The giving and receiving of care are ongoing affirmations of our shared basic dignity and common humanity. Human dignity requires care and that is why care is a moral good. Human dignity should therefore be the moral framework for guiding and constraining care, in the contexts of both public and family care, especially during old age and extreme dependency.

I think the difficulty with requiring *empathy* as opposed to benevolence or caring as the essential way of respecting dignity, is that one may not always be capable of achieving empathy - of (as Jonathan himself puts it) ‘being centred on a person’s life as seen from the inside.’ This can be very hard to achieve in many cases, and so may be too high a moral requirement. So here we have the old Kantian problem - if we want dignity to have *normative* force, then ‘ought implies can’. We may not always be able to empathise, but we can care. I shall return to this in my third point about respecting the dignity of the mentally ill.

2 - The End of Life and Social Solidarity
Jonathan writes very movingly about the powerful case for assisted suicide arising from tragic situations like that of Diane Pretty, and he faults David Velleman for requiring that we see our lives as of value in themselves and so not to be given up too easily. To be fair to Velleman, he does not necessarily oppose suicide, but merely asks that we stop a while and consider what this entails. Does it treat the value of each human life too lightly? It does sound heartless to ask such a question when we read of how Diane Pretty suffered, but that does not mean the question is not worth asking. I think Jonathan dismisses too easily the concern that legislating for assisted suicide can pose a real threat to many vulnerable people, whose lives are equally valuable. This is especially important in the Asian cultural context for two reasons. This firstly has to do with the strong sense of family duty, which in Singapore is even ensconced in law! Because filial piety is so important, even legally required, children feel obliged to an extreme degree to care for their parents at the end of life – but the obverse of this is that parents can feel themselves a terrible burden on their families, not least in a financial way. So there is a real danger that legislation permitting assisted suicide would lead to a sense of obligation on the elderly to take their leave before they are really ready to do so, for the family’s sake. The second concern (though this does not apply so much in either Hong Kong or Singapore) is that many countries in our region have totally inadequate health coverage and a virtual absence of effective terminal care. The Economist recently carried out a survey of the ‘quality of dying’ in 80 countries. Singapore and Hong Kong came out quite well (12th and 22nd respectively), but Indonesia was at rank 53, Mainland China at 71st and the Philippines at 78th. So
again, in this South East Asian context, legalising assisted suicide may be precisely the wrong solution, the least caring, benevolent or empathetic, since it would mask the need for adequate palliative and terminal care.

3 - Alienation, Empathy and Mental Illness

This, I believe, is the area in which Jonathan’s plea for empathy-linked dignity is at its most powerful and effective. He writes very effectively about the alienation, stigmatization and humiliation that the mentally ill suffer, and this is sadly true in many cultures including here in Asia, where having a mentally ill member of the family can often be seen as a loss of face, and the practice of covert medication and concealing the illness appears to be pretty widespread. It is significant, is it not, that one of the old terms for a psychiatrist was an ‘alienist’? Jonathan’s plea for both empathy and an imaginative entry into this ‘alien’ world is surely right, and here I’d like to add another literary reference to the ones he offers: I Never Promised You a Rose Garden, by Hannah Green.

But I find his concluding statements revealing, since they suggest that what he is offering is not a moral requirement but a moral aspiration. Speaking of the struggle that mentally ill persons so often experience in trying to take charge of their own recovery, in order to reclaim themselves, he accepts that this is an ideal towards which we should strive:

‘…just as perfect justice is a regulative ideal for fallible human judges, the aim of helping psychologically troubled persons to stand up and walk away by themselves is one regulative ideal for mental health professionals.’
Sure, I agree this is an ideal – it chimes in with some work I have done on the ‘virtuous patient’, meaning someone who is able to fulfil his or her own potential despite the demeaning effects of illness and disability. BUT don’t we want more than aspiration if we speak of a duty to respect the dignity of the mentally ill? Here is where I want Jonathan to be tougher. Empathy is an aspiration but caring adequately is a duty! So why is psychiatry so underfunded, why do we tolerate that? And why is the kind of care Jonathan wants so rarely provided to most patients? Why instead do we have physical and pharmacological containment, ECT, and the use of massively expensive drugs that can result in the chemical elimination of the kind of recovery of self he advocates? (Shades of *One Flew over the Cuckoo’s Nest*³⁴)

So, in conclusion, I agree wholeheartedly with the main points made in this lecture – my only concern is that these values need to be implemented in a genuine move toward a more humane society.

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⁴ Kesey, K. *One Flew over the Cuckoo’s Nest*. Signet Books, 1964. (Subsequently made into a film, starring Jack Nicholson.)