

THE RIGHT TO DIGNITY: TOWARDS A BETTER UNDERSTANDING
OF MORALITY IN DEATH

ALEXANDER JIN

*“Tears streamed down my face. I struggled, remembering the rabbi’s caution that the ones we
love most may need
permission to leave us, to die. “I know you may have to leave before I get back. That’s okay.” It
felt nearly impossible
to let him go. My chest was bursting. The pain was crushing.”¹*

What does it mean to die with dignity? The philosopher Susan M. Wolf’s heart wrenching account of her father’s death is a sobering reminder that death presents some of the hardest and most visceral moral questions one can ever pose. This paper explores the ethical dimensions of death and argues that the ways in which many members of the biomedical community and the general populace speak about death, namely through biological terms, is flawed. I will argue that to better understand how a “moral” death is possible, we need to shift conversations surrounding death towards centering one’s right to dignity. Though “dignity” as a concept is fraught with ambiguity and contestation, I will attempt to develop a thorough argument as to why dignity is at the center of a moral agent’s death. Once I have shown the importance of centering dignity in discussions of death, I will briefly sketch what one’s “right to dignity” and what the concurrent obligations for a moral community may look like. I conclude this paper by suggesting that the discourse of one’s right to dignity can have far-reaching impacts on the biomedical community, and

¹ M. Wolf, Susan. “Confronting Physician-Assisted Suicide and Euthanasia: *My Father’s Death*.” *Hasting Centers Report* 38, no. 5 (2008), 25-6.

that centering dignity in bioethical discussions can shed moral light on public policy about abortion, consent in medical research, and medical access.

1 Death with Dignity: A Theoretical Background

What does it mean to die? As it turns out, death is not as easy to define as some might believe. The four major notions of death are as follows:

1. *Traditional*. When someone is no longer breathing and whose heart is no longer beating. Can be “defined as the permanent cessation of breathing and blood flow.”
2. *Whole-Brain*. “The irreversible cessation of all brain functions.” When the brain stem ceases to function and there is no electrical activity in the brain whatsoever.
3. *Higher-Brain*. The loss of higher-brain functions, which entails “the permanent loss of consciousness.” Those in an irreversible coma or a chronic vegetative state would be considered dead under this conception of death.
4. *Personhood*. “Death occurs when an individual ceases to be a person.”²

In current medical practice, the standard of death is a disjunctive use of both ‘traditional’ cardio-pulmonary death and whole-brain death. “Conceptually, death is the cessation of the integrative unity of the various metabolic processes involved in maintaining homeostasis and resisting entropy. The physiological criteria for that to have occurred is the irreversible cessation of all functions of the entire brain (including the brain stem).”³

Mike Collins points out, in his article on “Reevaluating the Dead Donor Rule,” there are two main problems with the whole-brain death criterion (section 1.2 of the Uniform Determination of Death Act).⁴ For one, diagnosing brain death is unreliable. “There are

² Munson, Ronald. *Intervention and Reflection: Basic Issues in Bioethics (Eighth Edition)*. (Wadsworth Publishing, 2007), 684-685.

³ Collins, Mike. “Reevaluating the Dead Donor Rule.” *Journal of Medicine and Philosophy* 35, no. 2 (2010), 156.

⁴ Uniform Determination of Death Act. Approved by the American Medical Association, 19 October 1980. Approved by the American Bar Association, 10 February 1981.
<http://www.uniformlaws.org/shared/docs/determination%20of%20death/udda80.pdf>.

significantly many cases of false positives” as shown by evidence from electroencephalograms (EEGs) as well as “clinically apparent evidence of neurological functioning in the so-called “brain dead” patients.”⁵ Second, the medical profession has effectively been operating contrary to this standard of death for a long time. Collins carefully demonstrates how defenders of brain death unfortunately resort to arguments that collapse due to the fallacies of circular reasoning, *ad hoc*, and *non sequitur*, as they attempt to divert the conversation of brain death into defining “significant” and “insignificant” functions (i.e. arguing for higher-brain death as if it were whole-brain death).⁶ Essentially, physicians make do with makeshift ideas of what constitutes the brain’s “critical functions” and use the cessation of those functions as the standard for brain death, which is not the whole-brain standard as defined by the Uniform Determination of Death Act. Death is not as easy to pin down as one may believe. Due to this misstep in contemporary medicine, Collins asks us to reevaluate what is essential to the Dead Donor Rule – namely, the principles of non-maleficence and respect for patient autonomy – and shift the dialectic to asking the question “under which circumstances would killing be acceptable?”⁷

I interpret this shift in dialectic as a shift that takes us away from biological understandings of death, i.e. traditional/whole-brain/higher-brain death, and towards a sociocultural, moral construction of death, i.e. personhood death. So what does personhood death look like exactly? In order to construct an idea of “personhood” death, we must also construct an idea of what it means to be a “person.” I argue that central to any “person” is

⁵ Collins, 156.

⁶ *Ibid.*, 158-163.

⁷ *Ibid.*, 170.

their dignity. Moreover, a shift must also occur in how we think and talk about rights. Common appeals to one's "right to life" and, relatedly, one's "right to die" will no longer suffice. What is required to facilitate the dialectic shift advocated by Collins is the application of a philosophically rich understanding of one's right to dignity.

2. Arguments for the Right to Dignity

J.D. Velleman gives some insights into the importance of dignity and what a right to dignity might look like in his article "A Right to Self-Termination?". In this article, Velleman articulates two arguments typically advanced by proponents of a right to die: 1) a person has the right to make their life shorter, which includes opting to die, in order to make it better, and 2) we generally defer to the individual in decisions about their good. Velleman accepts 2) but rejects 1) on the grounds that "value requires a potential valuer but not a potential beneficiary."⁸ That is to say that when we respect a person, we respect a person's value as a person, and not the benefits they may accrue as a person. The value of a person, therefore, is not simply an interest or option that they can claim – it is simply there. "Kant's term for this value is 'dignity', and he attributed dignity to all persons in virtue of their rational nature. What morality requires of us, according to Kant, is that we respect the dignity of persons."⁹ He continues:

[T]he dignity of a person isn't something that he can accept or decline, since it isn't a value for him; it's a value in him, which he can only violate or respect. Nor can it be weight against what is good or bad for the person. As I have argued, value for a person stands to value in the person roughly as the value of means stands to that of the end: in each case, the former merits concern only on the basis of concern for the latter. [...] The value of means to an end cannot overshadow or be overshadowed by

⁸ Velleman, J. David. "A Right of Self-Termination?" *Ethics* 109, no. 3 (1999), 609.

⁹ *Ibid.*, 611.

the value of the end, because it already is only a shadow of that value, in the sense of being dependent upon it.¹⁰

Of course, this argument for respecting a person's dignity does not only operate for others, it also extends to having a respect for oneself as a dignified moral agent. It follows that, in considering one's own death, the value of one's dignity is not something that can simply be weighed (and, indeed, perhaps it should not be "weight" at all) against the benefits one can accrue for oneself. Rather, the principle consideration for any moral agent knocking on death's door is their *dignity*.

Respecting the dignity of persons requires us to value one's standing as a moral agent in a community of moral agents. This, I believe, is what is at the heart of Collins' recommendation for physicians to refocus their commitment to non-maleficence and respect for patient autonomy. An opponent may assert that adherence to this moral imperative asks too much of us and would prolong the pain and suffering of terminally ill patients who wish to die but cannot out of a respect for dignity. But respecting one's dignity does not necessitate that one must continue to live no matter how much they hate their life, since "respect for an object of dignity can sometimes require its destruction."¹¹ There are levels of pain, after all, that can undermine a person's dignity by eroding their rational capacity as a human—at which point, respecting their right to dignity may entail facilitating "death with dignity."

Respecting the demands of morality and the dignity of both others and ourselves will serve us well in death. Reframing the discussion around the moral capacities of a terminally ill patient will allow us to explore more medical options while, as Collins

¹⁰ Ibid., 613.

¹¹ Ibid., 617.

suggested, reasserting our respect for non-maleficence and patient autonomy. At what point does a person in a vegetative state cease to be a person and when should we “pull the plug”? What do you really mean when you say you do not wish to be “hooked up to those machines,” and how exactly should we respect Ulysses contracts given people frequently underestimate quality of life with a debilitating condition? Under what conditions should medical professionals be ethically allowed to perform euthanasia? These are questions that cannot be solved with appeals to biological death—only appeals to personhood death and questions of dignity can begin to address some of these concerns. In addition, appeals to one’s “right to death” and/or one’s “right to life” are useless when we cannot even determine where life and death begins. Indeed, I would argue that proponents of such rights are really basing their arguments off of under-theorized ideas of dignity. What they really care about, and what all of us as members of a moral community should care about, is what it means to be a human and what constitutes a dignified life as a human.

3 The Right to Dignity and the Right to Self-Termination

Now that we have established dignity as the primary consideration in examining the death of a moral agent, we must ask what our obligations are, as a community of moral agents, if we are to respect a collective right to dignity as it pertains to death. The following list is by no means meant to be exhaustive, nor is it meant to be definitive (for moral problems *must* be up for contestation), but I hope it may serve as a decent point of departure moving forward. For one, as Collins elaborates, it seems clear that both the legislative and the medical community has a duty to reevaluate their current standards of death, move the needle towards talking more about personhood death, and properly inform dying patients

about the uncertainties surrounding death. Second, we need to talk more about, and act upon, how medical professionals can assist in helping individuals exercise their right to dignity through death. Physicians would probably say that the intentional “destruction” of a human is an ethically hazardous territory they avoid at all costs. But the fact of the matter is physicians are already doing this, for, at the very least, “surgeons are already killing their patients by removing organs from brain dead but living patients.”¹² The medical community must come to terms with the unreliability of biological conceptions of death and join the rest of the community with engaging in the larger human project of constructing what human dignity looks like.

This leads me to the third, and perhaps, most important obligation resulting from observing a collective right to dignity: we, as a community of moral agents, must continually engage in the moral project of respecting dignity and constructing conceptions of human dignity. “Though it may not be the whole story, surely Kant was onto something important when he claimed that human dignity rests on the capacity for moral agency within a community of those who respect the demands of morality.”¹³ Perhaps that is what Wolf’s rabbi meant when they suggested our loved ones “may need permission to leave us.” Perhaps what they need is the permission to exercise their right to dignity and forfeit their standing in the moral community all together.

I suspect critics will have two main lines of objection to the claims I have made thus far in this paper. One argument against shifting away from biological notions of death is that there *can* be a purely biological way of determining whether or not someone is dead. The objectors argument, I take it, would likely go: “sure, some of the standards we have had

¹² Collins, 172.

¹³ Hardwig, John. “Is There a Duty to Die?” *The Hastings Center Report*, no. 2 (1997), 40.

so far may have been faulty but that does not mean we need to get rid of the standard all together. Your argument comes to the wrong conclusion—what we really need are better biological standards of death. After all, what can we trust at the end of the day if not science?” I do not doubt death is a biological phenomenon, and I am even willing to concede that we may one day find the perfect biological way of testing death. Yet even if we were to find the panacea of biologically determining what death is, we can never take away the tricky moral questions surrounding death. As Collins reminds us, “we cannot simply *legislate* whether someone is dead or not.”¹⁴ What we can do as a group is decide upon what are morally permissible actions for medical patients close to death. What we can do is decide upon what are morally permissible actions for physicians with terminally ill patients. What we can do is talk about how best to respect the dignity of terminally ill patients, considered as moral agents, and discuss what dignity truly means.

Another critic might say that “human dignity” as a concept is fraught with too many ambiguities for us to come to any sort of consensus, which is in no way helpful to medical professionals who make life-or-death decisions every day. To this I say: exactly. Defining dignity is hard! Being a part of “a community of those who respect the demands of morality” is hard! Simply being human is hard! But that does not mean we should not try our best at doing any of these things. In effect, current medical practices are already deciding what a dignified life/death looks like by, typically, attempting to sustain life at all costs. “However, it is not clear that respecting the sanctity of life requires continuing it at all costs, and if it does not, then one must show how there is any *moral* difference between

¹⁴ Collins, 173.

allowing inevitable death to occur and causing inevitable death to occur for the sake of furthering other persons' living and well-being."¹⁵

What I am suggesting is that medical practice fundamentally involves serious ethical questions that must be addressed. These questions, even if they are not explicitly addressed, will always be "answered" in some way or another by ongoing medical practice. Though questions about personhood, dignity, and death may be thorny, they are questions that need to be tackled head-on. The only thing we can hope for is that we may come up with some moral understandings for what answers to these questions may look like—and I believe shifting death discourse to talking about dignity and one's right to dignity is a step in the right direction.

Finally, I would like to suggest that emphasizing dignity and developing a more robust discourse of one's right to dignity can have profound impacts on bioethical issues such as abortion, consent in medical research, and medical access. In abortion, common appeals to a fetus' right to life may be better framed in terms of one's right to dignity and who gets to claim such a right. Moreover, talking about one' right to dignity would likely give us a stronger understanding of how to respect potential-mothers' bodily autonomy in considering abortion, and give us a better view of what ethical abortion counseling may look like.¹⁶ Relatedly, framing discussions around one's right to dignity is likely to further our appreciation for healthy and ethical informed consent in medical research. Finally, instead of fighting for a "right to healthcare," which some have argued to be

¹⁵ Ibid., 172.

¹⁶ Woodcock, Scott. "Abortion Counseling and the Informed Consent Dilemma." *Bioethics* 25, no. 9 (2011): 494-503.

counterproductive,¹⁷ advocates for more universal access to basic health care may find it better to argue in the name of a right to dignity, rather than a right to healthcare per se. A thorough development of how a discourse for one's right to dignity may impact a plethora of bioethical matters is beyond the scope of this paper, and more research needs to be done on this matter.

4 Conclusion

This paper has argued for a shift in the way the biomedical community, and the moral community as a whole, talks about death. I have argued that questions of dignity are at the heart of a moral agent's death and that we need to shift discourse away from biological constructions of death and towards personhood death. Similarly, we must move away from talking about one's right to life/death and towards one's right to dignity. Beyond death, centering dignity in bioethical conversations may also profoundly impact other issues such as abortion, research consent, and medical access. As Susan M. Wolf's account of her father's death reminds us, meeting the demands of morality and acting in the name of dignity, particularly in death, may be hard but it may change us for the better: "Staying, keeping vigil, fighting to secure a comfortable death, stroking his hair, standing guard as death approached was my *duty*. It was the final ripening of my love. We both changed, even closer at the end."¹⁸

¹⁷ Reidy, David A. "A Right to Health Care? Participatory Politics, Progressive Policy, and the price of loose language." *Theoretical Medicine and Bioethics* 37 (2016): 323-342.

¹⁸ M. Wolf, 26. Emphasis added.

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