

IS THERE A DUTY TO RESPECT “HISTORICAL” FAITH? CHRISTIAN PROSELYTISM OF AN OLDER JEWISH WOMAN WITH DEMENTIA

ISRAEL (ISSI) DORON AND CHARLES FOSTER

Associate Professor, Head of the Department of Gerontology, University of Haifa
Fellow of Green Templeton College, University of Oxford; The Ethox Centre and the Faculty of Law, University of Oxford

ABSTRACT

In this article, we present a short case study based on an incident that occurred in Israel several years ago. The incident did not reach the courts but was made public by the family members of the older woman at the center of it. The family argued that the actions taken by one of the parties involved should have been defined as elder abuse, but no criminal charges were ever brought. Yet the issues concern key legal and ethical questions about law, religion, and older persons. More specifically, the incident raises the issue of the moral commitment to one’s past religious beliefs in reference to one’s current choices and preferences once living with dementia. We contend in this article that an Aristotelean account of human dignity would have provided the most satisfactory way to resolve the tensions created by this incident.

KEYWORDS: dementia, human dignity, historical faith, ethics and aging

INTRODUCTION

Many of the world’s populations are aging.¹ More people are living longer. Not only is the number and proportion of older persons rising all over the world, but their impact on human society is becoming much more significant.² With this aging of humans comes a significant increase in the rates of Alzheimer’s disease and other kinds of dementia, especially in the older old.³ Current data sug-

-
- 1 See Peter Auer and Mariàngels Fortuny, *Ageing of the Labour Force in OECD Countries: Economic and Social Consequences*, Employment Paper 2000/2 (Geneva: International Labour Office, 2000), http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_142281.pdf; David E. Bloom and David Canning, “Global Demographic Change: Dimensions and Economic Significance” (paper presented at the Federal Reserve Bank of Kansas City Symposium on Global Demographic Change: Economic Impacts and Policy Challenges, Jackson Hole, August 2004), <http://www.nber.org/papers/w10817.pdf>.
 - 2 See Israel Doron, “Demographic, Social Change and Equality,” in *Equality Law in an Enlarged European Union*, ed. Helen Meenan (Cambridge: Cambridge University Press, 2007), 117–44; Kevin Kinsella and Wan He, *An Aging World: 2008*, U.S. Census Bureau International Population Reports P95/09-1 (Washington, DC: United States Government Printing Office, 2009).
 - 3 See Israel Doron, “The Socio-Demographics of Dementia,” in *Dementia, Law and Ethics*, ed. Charles Foster, Jonathan Herring, and Israel Doron (Oxford: Hart, 2014), 15–24; Cleusa P. Ferri et al., “Global Prevalence of Dementia: A Delphi Consensus Study,” *Lancet* 366 (2006): 2112–17.

gest that 32 percent of persons above the age of 85 report cognitive problems or are diagnosed with Alzheimer’s disease.⁴

This high incidence of dementia in the older population raises new ethical, legal, and social issues around duty of care, medical finances, and legal decision making.⁵ While there have already been attempts to identify some principles and ideas in this new field,⁶ we question the ability of existing paradigms to provide clear and convincing ethical solutions to hard human situations involving older persons with dementia in general, and when intersecting with religious dilemmas specifically.

To illustrate the inadequacy of existing paradigms, we present a short case study based on an incident that occurred in Israel several years ago. The incident did not reach the courts but was made public by the family members of the older woman at the center of it. The family argued that the actions taken by one of the parties involved should have been defined as elder abuse, but no criminal charges were ever brought. Yet the issues concern key legal and ethical questions about law, religion, and older persons. More specifically, the incident raises the issue of the moral commitment to one’s past religious beliefs in reference to one’s current choices and preferences once living with dementia. We contend in this article that an Aristotelean account of human dignity would have provided the most satisfactory way to resolve the tensions created in this incident.

THE CASE

M was born in 1921 in a small city in southern Poland. She was born and raised in an orthodox Jewish family.⁷ The songs sung around the table were Jewish. She celebrated the holidays and lived by the traditions of the Jewish religion and community of her home town. The Second World War brought tragedy and despair as M’s parents, in their attempt to save their daughter, placed her in a Christian convent. She survived the horrors of the Holocaust disguised as a Christian, living a Christian life.

When the war was over, she was reunited with surviving members of her family, and they all eventually found refuge in the newly established state of Israel. M married in Israel and brought up a family of her own, not only within the Jewish state, but also within an orthodox Jewish community.

In old age, after losing her husband, M started to develop cognitive impairment that was diagnosed as Alzheimer’s disease. M moved to live in Jerusalem with her older daughter, who took the responsibility of caring for her mother at home. As her physical and cognitive condition deteriorated, M needed much more intensive care, attention, and supervision. M’s daughter sought a caregiver to look after her mother at home. She found B, a mature woman of non-Jewish Polish origin who presented herself as a trained caregiver. At first, M’s daughter was very happy with the

4 Alzheimer’s Association, “2014 Alzheimer’s Disease Facts and Figures,” *Alzheimer’s and Dementia* 10, no. 2 (2014): e47–e92.

5 See Jonathan Herring, “Losing It—Losing What—The Law and Dementia,” *Child and Family Law Quarterly* 21 (2009): 3–29.

6 See Geraldine Boyle, “Social Policy for People with Dementia in England: Promoting Human Rights?,” *Health and Social Care in the Community* 18, no. 5 (2010): 511–19; Hannes Knüppel et al., “Inclusion of Ethical Issues in Dementia Guidelines: A Thematic Text Analysis,” *PLOS Medicine* 10, no. 8 (2013), doi:10.1371/journal.pmed.1001498.

7 While the case we present is based on an actual incident, various facts were changed in order to maintain the parties’ anonymity and to better reflect the ethical dilemma of the case.

arrangement. As M's cognitive condition continued to deteriorate, reaching a point where she did not recognize her daughter, M started to use more and more Polish while communicating with B.

M's daughter initially trusted B and left her alone with M for several hours each day. M seemed happy and relaxed. But after several months, M's daughter started to sense that something was wrong. She could not put her finger on it, but said that she "saw something in my mother's eyes; She had horror in her eyes." One day she returned home early and while hiding behind the door heard, to her astonishment, B is singing Christian songs to M, reading texts from the New Testament, and praising Jesus. The daughter rushed into the room and fired B on the spot. M died three weeks later. It turned out that B was a devout Christian, and she had consistently read and sung Christian songs and texts to M without telling M's daughter. M's daughter filed a criminal complaint against B, contending that she had abused and humiliated M. B's response was that M was happy and smiling at all times: not only did she provide professional care and not cause any harm, but she actually brought happiness to M in M's darkest moments.

Would we define B's behavior as "elder abuse" or as a breach of her ethical duty to M? How should B's behavior be judged ethically? By what criteria? How should decisions, such as the nature of the songs sung to her and texts read to her, be made on behalf of M? And finally, could M's daughter be held liable for elder abuse for exposing her mother to this behavior—assuming she should have known about it?

THE WIDER CONTEXT

M's story is situated within historical and religious contexts that have been explored and studied from many different perspectives. We identify here three particularly important contexts.

First, we know today that the vast majority of Holocaust survivors have experienced traumatic events in their past. The personal stories are so different and diverse, but they are mostly characterized by horror, pain, and loss.⁸

Second, there are studies that suggest that although, unsurprisingly, there is a higher incidence of post-traumatic stress disorder among Holocaust survivors than in the general population,⁹ survivors may also be unusually psychologically resilient.¹⁰ Yet, despite this resilience, several studies have identified common trigger events that evoke Holocaust memories and exacerbate post-traumatic stress symptoms in the survivor population.¹¹ Such events may include unpleasant smells,

8 See Ilana Rosen, *Sister in Sorrow: Life Histories of Female Holocaust Survivors from Hungary* (Detroit: Wayne State University Press, 2008); Brian Schiff et al., "Consistency and Change in the Repeated Narratives of Holocaust Survivors," *Narrative Inquiry* 16, no. 2 (2006): 349–77.

9 See Henry Brodaty et al., "Vulnerability to Post-traumatic Stress Disorder and Psychological Morbidity in Aged Holocaust Survivors," *International Journal of Geriatric Psychiatry* 19, no. 10 (2004): 968–79; Rachel Yehuda et al., "Impact of Cumulative Lifetime Trauma and Recent Stress on Current Post-traumatic Stress Disorder Symptoms in Holocaust Survivors," *American Journal of Psychiatry* 152, no. 12 (1995): 1815–18.

10 See Roberta Greene, "Holocaust Survivors: A Study in Resilience," *Journal of Gerontological Social Work* 37, no. 1 (2002): 3–18; Roberta R. Greene, "Holocaust Survivors: Resilience Revisited," *Journal of Human Behavior in the Social Environment* 20, no. 4 (2010): 411–22; Amit Shrira et al., "Do Holocaust Survivors Show Increased Vulnerability or Resilience to Post-Holocaust Cumulative Adversity?," *Journal of Traumatic Stress* 23, no. 3 (2010): 367–75.

11 See Keith A. Anderson, Noelle L. Fields, and Lynn A. Dobb, "Understanding the Impact of Early-Life Trauma in Nursing Home Residents," *Journal of Gerontological Social Work* 54, no. 8 (2011): 755–67.

loud voices, waiting in lines for food, the sight of uniforms, and hearing about Jesus and Jewish holidays.¹²

Finally, M’s story occurs in Israel, which was established after the Holocaust, as a safe haven for Jews. Israel’s constitution defines Israel as a Jewish and democratic state, a definition that not only raises significant legal and philosophical difficulties but also creates very difficult real-life issues of implementation.¹³ Not only are Jews the majority of Israel’s population, but Judaism generates the most significant structural characteristics of the state. For example, all Jewish holidays are also state holidays. This Jewish character directly influences the State of Israel’s legal approach to difficult ethical dilemmas. For example, Israel’s Dying Patient Act of 2005 explicitly incorporates values inherited from rabbinic Judaism while purporting to acknowledge modern developments in medicine and technology.¹⁴

CONCEPTUAL ETHICAL APPROACHES

Four lenses are commonly used to examine cases such as this: honoring one’s past identity, honoring one’s new identity, honoring one’s cultural and religious identity, and honoring one’s best interests. In the context of a Jewish person like M, there is a fifth, halacha, Jewish religious law. In the discussion that follows, we analyze the views through each of those lenses and propose an alternative lens that, we think, provides a better view.

The Autonomy-Based Approach: Honoring Past Identity

One way to approach the dilemma represented by M’s case is to rely wholly on respect for the autonomy of the patient. The reasoning would go like this:

- a. While M was a capacitous adult person, there was an ethical obligation to respect her wishes and preferences. It is clear that, while capacitous, M would not have wanted or agreed to be subjected to B’s proselytizing. It would therefore have been unethical to behave as B did.
- b. Once M lost capacity, an ethical duty arose, from the same principle of respect for autonomy, to respect the wishes expressed in the past by her “real” self. This is more easily and uncontroversially done, of course, where there is a valid and applicable advance directive. The legal (although not necessarily the ethical problems) are simpler where the decision-making process is formally delegated to a third party through such mechanisms as power of attorney.
- c. If, as in the case of M, no such legal instruments exist, the basic ethical moral duty is to act in accordance with the known character of the person, so maintaining the coherence of her life’s narrative. This is the process of substituted judgment: it entails making the decision that it is

12 See Paula David and Sandi Pelly, eds., *Caring for Aging Holocaust Survivors: A Practical Manual* (Toronto: Baycrest Centre for Geriatric Care, 2003).

13 See Ruth Gavison, “Jewish and Democratic? A Rejoinder to the ‘Ethnic Democracy’ Debate,” *Israel Studies* 4, no. 1 (1999): 44–72; Michael L. Gross and Vardit Ravitsky, “Israel: Bioethics in a Jewish-Democratic State,” *Cambridge Quarterly of Healthcare Ethics* 12, no. 3 (2003): 247–55.

14 See Carmel Shalev, “End-of-Life Care in Israel—The Dying Patient Law, 2005,” *Israel Law Review* 42, no. 2 (2009): 279–305; Avraham Steinberg and Charles L. Sprung, “The Dying Patient: New Israeli Legislation,” *Intensive Care Medicine* 32, no. 8 (2006): 1234–37.

presumed the patient would make if able to do so, it being also presumed that the patient would make decisions consistent with those that she had made during her capacitous lifetime.

- d. In M's case, it could be reasonably assumed that, if capacitous, she would not tolerate B's explicit displays of Christian commitment.

The "New Identity" Approach: Honoring One's "New Personality"

A second way to approach M's case is to argue that the old M has "died"—killed by her Alzheimer's disease. Out of the ashes has arisen another, entirely new M, with different preferences. Or, in less dramatic words, M's Alzheimer's disease has transformed her personal identity, in similar ways that other life-changing events may change one's personality. It is the new M, the argument would go, who should be respected and honored. If the new M apparently enjoyed—or, while able to express a preference, appeared not to mind, B's religious activities—then it is the new M's preferences that should be respected. M's past (the past of a now nonexistent or transformed person) should not be allowed to affect or dictate the welfare of the new M.¹⁵

The moral obligation to respect the "new" and authentic M is not a mere application of the "autonomy" argument on M's current personality. It stems from a much deeper recognition of the process of "othering" by which "normal" persons classify those who they perceive as "different" (for example, disabled, mentally ill, or old) in a negative way. The "othering" of persons with dementia can very easily lead to their invisibility and loss of personhood.¹⁶ A duty to recognize and respect M's new selfhood is critical for preventing the negative social construction of dementia and its humiliating consequences.

The Family/Community Solution: Honoring One's Cultural and Religious Identity

In many societies, individual identity is expressly seen as subordinate to, grounded on, and assimilated into familial, communal, and religious belonging. Individuals, families, and wider society are seen as interdependent, and there are concomitant reciprocal duties. Notions of the "good life" within such societies are essentially relational: personal fulfillment can be understood and attained only in the context of social relationships. Individuals are seen as quintessentially relational, not atomistic, beings. Historical narrative, cultural values, and the nature and interests of the present and future community are all referents from which individual meaning is shaped.¹⁷

Reciprocal obligations within the family are expressed in the universally acknowledged obligations of parents towards their children and in the decreasingly recognized obligation of children towards their parents articulated in the biblical injunction to honor one's mother and father. These family values and duties are often reflected in the law—for example, in the role sometimes accorded by the law to family members in making decisions on behalf of a family member who has lost capacity.¹⁸ One such example can be seen in the case of *In re Jobes*, in which the New Jersey Supreme Court declared that

15 See John Coggon, "Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?," *Health Care Analysis* 15, no. 3 (2007): 235–55.

16 See Patrick J. Doyle and Robert L. Rubinstein, "Person-Centered Dementia Care and the Cultural Matrix of Othering," *Gerontologist* 54, no. 6 (2014): 952–63.

17 See Jane M. Trau and James J. McCartney, "In the Best Interest of the Patient," *Health Progress* 74 (1993): 50.

18 See Daniel P. Sulmasy and Lois Snyder, "Substituted Interests and Best Judgments: An Integrated Model of Surrogate Decision Making," *Journal of the American Medical Association* 304, no. 17 (2010): 1946–47.

Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient’s approach to life, but also because of their special bonds with him or her. . . . It is . . . they who treat the patient as a person, rather than a symbol of a cause.¹⁹

This legal approach mirrors a more basic ethical duty: one’s duty to family, community and culture. It was clear that M’s family was an important part of her life. She and her family were part of a broader Jewish orthodox community and part of the Israeli nation. The important defining characteristics of M were that she came from a Jewish family, with a Jewish history, within a Jewish state. All this, the argument would go, necessarily meant having care provided in a way consistent with (or at least not inconsistent with) Jewish norms.

“Best-Interests”: A (Notionally) Objective Approach

The “best interests” principle is well known to the law. It has been much criticized but is still widely used.²⁰ According to this principle, when a person cannot make decisions for him- or herself, the decision that should be made on his or her behalf is the one that is in his or her best interest. In theory, there is only one answer to the question “What is in X’s best interests?”²¹ The test is, therefore, notionally objective. In practice, of course, the notionally correct answer is elusive, and it is hard to exclude an element of substituted judgment from the assessment.²²

In Re MM Justice Munby summarized the approach adopted to determine best interests under the English Mental Capacity Act of 2005:

MM’s welfare is the paramount consideration. The focus must be on MM’s best interests and this involves a welfare appraisal in the widest sense, taking into account, where appropriate, a wide range of ethical, social, moral, emotional and welfare considerations. Where, as will often be the case, the various factors engaged pull in opposite directions, the task of ascertaining where the individual’s best interest truly lie will be assisted by preparation of a “balance sheet.” . . . This will enable the judge, at the end of the day, to strike what Thorpe LJ referred to as “a balance between the sum of the certain and possible gains against the sum of the certain and possible losses.”²³

The English courts, at least, have consistently said that “best interests” are wider than medical best interests. The best-interests test is supposed to be a holistic assessment, and accordingly the relational and historical hinterland of the incapacitous patient is, at least potentially, relevant in determining the present best interests. Section 4 of the Mental Capacity Act 2005 is a fair statutory summary of the common law jurisprudence relating to best interests assessments. Section 4(6) provides that the decision maker must consider, so far as is reasonably ascertainable:

19 *In re Jobes*, 529 A.2d 434, 445 (N.J. 1987).

20 See Loretta M. Kopelman, “The Best-Interests Standard as Threshold, Ideal, and Standard of Reasonableness,” *Journal of Medicine and Philosophy* 22, no. 3 (1997): 271–89; Loretta M. Kopelman, “The Best Interests Standard for Incompetent or Incapacitated Persons of all Ages,” *Journal of Law, Medicine and Ethics* 35, no. 1 (2007): 187–96.

21 See Philip Alston, ed., *The Best Interests of the Child: Reconciling Culture and Human Rights* (Broadbridge: Clarendon Press, 1994).

22 See Thomas G. Gutheil and Paul S. Appelbaum, “Substituted Judgment: Best Interests in Disguise,” *Hastings Center Report* 13, no. 3 (1983): 8–11.

23 *In re MM (An Adult)* [2007] EWHC 2689 (Fam), para. 99.

- (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- (c) the other factors that he would be likely to consider if he were able to do so.²⁴

The effect of this subsection in M's case is, we think, obvious. Section 4(7) would require soundings to be taken about M's best interests from, inter alia, the family. It provides that the decision maker

must take into account, if it is practicable and appropriate to consult them, the views of—

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
 - (b) anyone engaged in caring for the person or interested in his welfare,
 - (c) any donee of a lasting power of attorney granted by the person, and
 - (d) any deputy appointed for the person by the court,
- as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).²⁵

It was practicable and appropriate to consult, inter alia, M's daughter, and it is plain what the daughter's response to proposed Christian evangelization would have been had she been consulted. Had the question of the appropriateness of B's conduct been assessed in England or in any other jurisdiction applying a best interests determination, it is likely, subject to one very important caveat, that it would have been decided that that conduct was not in M's best interests.

The caveat relates to an issue we have considered already: the question of identity. *Whose* best interests should be considered? The old M, steeped in Jewish tradition? Or the new M, who might like Christian songs, or indeed enjoy or benefit from anything done by B? The courts, in all jurisdictions of which we are aware, have found ways of avoiding the metaphysically problematic issue of personality-transforming disease in comparable contexts. As long as the "best interests" test survives, the problem cannot be sidestepped forever. In the context of M's case, and for present purposes, it is enough to note the existence and magnitude of the problem.

The Religious Jewish Perspective

Finally, it should be noted that Orthodox Judaism itself has a view of M's case. Filial responsibility and the duty to care for one's older parents are central moral and religious obligations in Judaism.²⁶ This familial duty of care is anchored in the fifth commandment: "Honor your father and your mother, so that your days may be long in the land that the Lord your God is giving you."²⁷ The fifth commandment has been interpreted through the years, in both Jewish law and other religions, to include a duty to provide care and support to aging parents.²⁸ Judaism recognizes that sometimes

24 Mental Capacity Act, 2005, c. 9, <http://www.legislation.gov.uk/ukpga/2005/9/section/4>.

25 Ibid.

26 See Seymour Moskowitz, "Adult Children and Indigent Parents: Intergenerational Responsibilities in International Perspective," *Marquette Law Review* 86 (2002): 401–45.

27 Exodus 20:12 (New Revised Standard Version).

28 See Amy Zietlow and Naomi Cahn, "The Honor Commandment: Law, Religion and the Challenge of Elder Care" *Journal of Law and Religion* 30, no. 2 (2015): 229–59; Charlotte K. Goldberg, "The Normative Influence of the Fifth Commandment on Filial Responsibility," *Marquette Elder Law Advisor*, no. 10 (2009): 221–44.

it is practicable and justifiable to delegate the performance of this duty to another—for instance by financing or arranging paid care by others, or even by placing the parent in a nursing home.²⁹

It is easy to state the broad biblical principle: it is harder to summarize the complex Jewish law relating to the provision of care by non-Jewish migrant workers. Jewish religious law³⁰ is notoriously pragmatic. This pragmatism is evident in the halacha relevant to the facts of our case. Over recent years in Israel many non-Jews have started to work (and often live) in Jewish houses. This has produced a rich crop of halachic rulings as to what is permitted and not permitted in this new social context. How, for instance, are the kashrut rules (about what can be eaten) to be interpreted when a non-Jew is involved in preparing the food? To what social and labor rights are non-Jewish care workers entitled when providing care to Jews? In the halachic scheme, these issues are considered on a case-by-case basis, and different rabbis may give different—and sometimes contradictory—rulings.

In principle, under halacha, personal care can be provided to older persons by non-Jewish care workers. However, it is clear that a Jewish environment must be maintained and the older Orthodox Jewish patient remains bound by halachic rules. Rabbinical authorities in Israel have ruled, for instance, that the food given to a Jewish patient by the non-Jewish caregiver must be *kosher*; that the caregiver cannot cook or eat using the same utensils as the Jewish person; that a non-Jewish caregiver can sit at the same table as the rest of the older person’s family; and that the caregiver should be thanked for her or his good work.

There are many other halachic rulings relevant to caregivers. Taken as a whole the rulings make it quite clear that non-Jewish caregivers are not bound by halachic rules, but that arrangements should be made for them to provide care in a way that allows the older person to observe all the halachic rules. The Jewish person should, according to these rulings, continue to observe the halachic rulings despite her debility. Where halacha permits a relaxation of the usual halachic rulings because of the debility (for example by eating or drinking on Yom Kippur), that itself is a halachic dispensation—an example of halacha, not a deviation from it.³¹

Applying these principles to our case, it is quite clear that under the halacha, B’s explicitly Christian actions would be wholly unacceptable to an Orthodox Jew, and that a caregiver should not be allowed by a child to expose a dependent parent to a non-Jewish environment.

BEYOND INDIVIDUALISM, FAMILIALISM, AND RELIGIOSITY: THE NEED FOR A HOLISTIC APPROACH

We think that the existing ways of analyzing the problem are plainly inadequate. Good law and good ethics assume good anthropology and good biology. The existing approaches generate wrong results because their anthropological and biological premises are wrong.³² In M’s case,

29 See Moshe Lieber, *The Fifth Commandment: Honoring Parents—Laws, Insights, Stories and Ideas* (New York: Mesorah Publications, 1998).

30 Our use of the term “Jewish law” in this article should not be confused with either “Israeli law” or “Jewish ethics.” “Israeli law” refers to the laws of the State of Israel. Sometimes those laws reflect Jewish traditions or halachic rules, but they are the outcome of a secular and democratic process. “Jewish ethics” does not refer strictly to the halacha or the Orthodox rulings but rather to the broader philosophical and ethical grounds of a Jewish religion and tradition.

31 Abraham S. Abraham, *The Older Patient—A Halakbic Perspective on Nursing Issues* [in Hebrew] (Jerusalem: Reuven Mass Publications, 1989).

32 See Charles C. Foster and Jonathan Herring, *Altruism, Welfare and the Law* (New York: Springer, 2015).

on the one hand, the “past-autonomy” approach respects the view of an entity who, as a result of the disease, has ceased to exist. On the other hand, the “new personality” approach fails to recognize adequately that, however transformed by their disease the patient may be, she came from somewhere, is a creature of the past as well as of her current disease, and is entangled in a mesh of relationships which should not be ignored—even if the patient herself is not aware of the extent or nature of her entanglement.

Moreover, we have never met the iconic “autonomous” man, the protection of whose interests sometimes seems to be the sole concern of modern bioethics. We doubt that he exists: nobody who falls within the bell curve of psychological normality holds self-determination to be the sole ethical lodestone. To base an entire scheme of ethics on the presumed interests of a nonexistent being is likely to cause problems.

But if we are wrong, and the quintessential autonomous person does exist, surely his or her interests should not be allowed to determine the content of our ethics. If she does exist, her egocentrism should not be encouraged in her, let alone be allowed to dictate the ethical agenda for us all. Self-determination, quite apart from resting on a nonexistent foundation, sometimes, and obviously, produces ethically monstrous results. But even if it did not, it would still be open to the objection that life is not, and accordingly ethics should not be, so simple.

It is therefore increasingly recognized that the straightforward—and wholly abstract—autonomous man, beloved of John Stuart Mill and Julian Savulescu, is not qualified to be the sole draftsman of our ethical thoughts.³³ He is being edged out by relational autonomy, which recognizes that the way that we express our autonomy is necessarily (and should necessarily) be conditioned by the demands of our relationships.³⁴

Relational autonomy is a very welcome development, but it is insufficiently radical to deal with cases, like that of our Holocaust survivor, where identity is called into question. There it is necessary to take a further step. Who is M? She *is* the nexus of relationships in which she exists and in which she has existed. The boundaries of her identity are not as hard as pictured in the traditional atomistic picture of the autonomists. The boundaries are porous. These notions are captured by the idea of *human dignity*. They are not, we think, captured by anything else.

Ideas of human dignity have been understandably criticized as amorphous.³⁵ But that does not mean that they are inevitably, incurably, so.³⁶ Any concept sufficiently holistic to be able adequately to address the complexity of human existence is likely to attract fire from philosophical reductionists who prefer to peer through a narrow lens.³⁷ We contend that ‘holistic’ is a compliment, not an insult. One of us (Foster) has argued that it is possible to demonstrate exegetically that the two aspects of dignity commonly identified in the literature—dignity as empowerment versus

33 See Charles C. Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (London: Bloomsbury Publishing, 2009).

34 See John Christman, “Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves,” *Philosophical Studies* 117, no. 1 (2004): 143–64; Catriona Mackenzie, “Relational Autonomy, Normative Authority and Perfectionism,” *Journal of Social Philosophy* 39, no. 4 (2008): 512–33.

35 See John Harris, “Cloning and Human Dignity,” *Cambridge Quarterly of Healthcare Ethics* 7, no. 2 (1998): 163–67; Ruth Macklin, “Dignity Is a Useless Concept: It Means No More Than Respect for Persons or Their Autonomy,” *British Medical Journal* 327 (December 2003): 20–27.

36 See Charles Foster, “Putting Dignity to Work,” *Lancet* 379, no. 9831 (2012): 2044–45; Christopher McCrudden, “Human Dignity and Judicial Interpretation of Human Rights,” *European Journal of International Law* 19, no. 4 (2008): 655–724.

37 See Aharon Barak, *Human Dignity: A Constitutional Value and a Constitutional Right* (Cambridge: Cambridge University Press, 2015).

dignity as constraint; or attribute-dignity and status-dignity—are really two sides of the same coin, rather than, as commonly contended, an indication that dignity ideas are hopelessly internally inconsistent.³⁸ Although there is no space in this article for the argument, if it is correct, it frees dignity from the most influential stigma that it bears.

Dignity, in this account, is given an essentially Aristotelean meaning: it is objective human thriving. An intervention will be dignity-enhancing if it increases the thriving of the subject. Yet who is the subject? Dignity, importantly, is “Janus-faced,” as Mountfield and Singh put it: if X is subjected to a humiliating ritual by Y, Y’s dignity is likely to be affected more than X’s.³⁹

Is the language of thriving useful in real-world bioethical contexts? If it can be said that an insensate patient (say, in a persistent vegetative state), or, even, a dead patient, has dignity interests that are properly described in the language of thriving, then it will not be hard to show that M has dignity interests, too, thus justifying the use of a dignity analysis in her case. Take, then, the hardest of cases: a dead patient. Suppose that medical students use the ear of a dead patient as an ashtray. Suppose that we agree that is wrong. We note in passing that it is impossible (or at least unsatisfactory) to characterize the wrongness in terms of an affront to autonomy or to any other (or any combination) of Beauchamp and Childress’s four principles,⁴⁰ and that in order to criticize the medical students it is necessary to resort to the language of dignity.⁴¹

Does it make any sense to say that the dignity interests of the patient (articulated in terms of *thriving*) are violated by the medical students? We think that it does, and that there are at least five ways in which it can be put. First, part of the patient’s human *being* survives. She lives on in the minds of others, and for that surviving element to continue to thrive, her body needs to be respected. Second, her wishes survive. No doubt she would have wished her ear to be spared such abuse, and for her persisting wishes to flourish, the abuse must be avoided. Third, if the possibility of such abuse had occurred to her while she was still alive, her peace of mind—and hence her flourishing—would have been affected. Accordingly an assurance, embodied in an ethical or legal code, that this abuse could not occur, would enhance flourishing. Fourth, and relatedly, the prohibition of such abuse would declare and enshrine a societal respect for persons which would be generally conducive to human thriving. And fifth, the medical students are behaving in a way that diminishes their own flourishing: it callouses them. Note that all or most of these reasons rely on a quintessentially relational picture of the patient.

Assuming this analysis to be right, what does it entail for M? Who was M, in her cognitively compromised condition? She was, first of all, a live person. It is of the essence of a person that they have a history. Even in arguments about the personhood of the embryo and fetus, the history of the embryo or fetus, in terms of its genetic origins, is regarded as foundational. How much more so must decades of embodied human life be relevant to the question of M’s identity, and what it is legitimate to do to her? Throughout the whole of her life she had been part of a nexus of relationships—as we all always are. For most of her life that nexus had been distinctively Jewish. That meant that it was distinctively not Christian.

Most would consider that, all things considered, and assuming that the core mode of being is good or not bad, consistency is a hallmark of a good, thriving life. People who change their

38 See Charles C. Foster, *Human Dignity in Bioethics and Law* (Oxford: Hart, 2012).

39 See Brenda Hale, “Dignity,” *Journal of Social Welfare and Family Law* 31, no. 2 (2009): 101–8.

40 Beauchamp and Childress’s four principles—respect to autonomy, beneficence, non-maleficence, and justice—form one of the most widely used ethical frameworks in bioethics. See Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford: Oxford University Press, 2001).

41 See Charles Foster, “Dignity and the Use of Body Parts,” *Journal of Medical Ethics* (2012): 44–47.

minds are frowned on as “lacking integrity.” The word “integrity” is telling. We tend to assume that an internally consistent life—each of whose parts fits seamlessly with the other—is a better life than its converse. Assuming, then, that M had no understanding of the Christian proselytizing to which B subjected her, the proselytizing would still seem to be contrary to M’s dignity because it was plunging her into an environment alien to the one in which she had lived: it was forcing her into living in circumstances inconsistent with those in which she had lived.

In fact, however, there were signs in this case that M was distressed by B’s preaching. Given the empirical evidence about Holocaust survivors’ sensibilities, this is hardly surprising. It makes the case based on breach of thriving or dignity much easier to argue. M was then akin to a patient in locked-in syndrome, forced to listen to psychologically uncomfortable white noise yet unable to do anything about it.

Whether or not M was aware of the proselytizing, it was an affront to the network of relationships of which she consisted. Most in that network would have been outraged. Their peace of mind would be profoundly affected. A violation of M was a violation of them. The fact that M was apparently in no position to object to what B was doing makes B’s action all the more dignity denying: it was abuse of a position of trust (and thus contrary to B’s dignity); it was exploitation of the vulnerability of M (and thus contrary to the dignity both of M and B); and (insofar as M was capable of forming wishes of her own), a violation of M’s autonomy (and autonomy, if it is medically possible, will always be an important component of dignity).

Of course there are countervailing thriving interests too, notably those of B herself, who no doubt thought, inspired by Jesus’s Great Commission at the end of Matthew’s Gospel, that she had an obligation to preach what she perceived as the “good news” to M. No doubt she would have felt uncomfortable if she had not acted in obedience to that evangelistic imperative. Perhaps she felt that her own eternal destiny was at stake. Her dignity would be affronted by a prohibition on evangelism.

This illustrates well how dignity analyses must work. There are always many stakeholders to any transaction—all of whose dignity interests will be affected by the proposed transaction. One should decide whether the transaction is ethically acceptable by conducting a Bayesian-type analysis of the dignity interests of all stakeholders (who will always include everyone in the world, for no one is wholly unaffected by anything that happens to another human), weighting the interests by reference to criteria such as proximity to the core action in the transaction. Patients’ interests and perpetrators’ interests will always weigh heavily: the ripple gets flatter the further it is away from the epicenter. A Benthamite quasi-utilitarian calculus is used, by which the (weighted) interests are added up. A positive dignity score (indicating that the net amount of dignity in the world is increased by the proposed transaction) would indicate that the transaction should go ahead.⁴²

This discussion has concerned the ethics of B’s conduct, not its legality. But we must record our view that it is ludicrous to suggest, as was done by M’s daughter, that B should be criminally liable. This view is itself a consequence of our analysis. However, under Israel’s criminal law, one needs to prove not only “abuse” but also “cruelty” in order to establish a criminal offense. Therefore, under the facts of this case, any conclusion about culpability is unlikely to be sufficiently clear as to justify a criminal sanction. B’s own dignity interests were plainly in play here: so clearly in play, we think, as to amount to a defense to a criminal allegation especially once “cruelty” is part of the legal threshold.

42 See Charles Foster, “Dignity and the Ownership and Use of Body Parts,” *Cambridge Quarterly of Healthcare Ethics* 23, no. 4 (2014): 417–30.

What about a disciplinary sanction? There we are more agnostic. Much would depend on factual nuances: what did B know about M’s background, the mores of Jewish tradition, and the sensibility of the family? Did M really show signs of distress? If so, was B aware of those signs? Should she have been? Many regulatory codes demand cultural and religious sensitivity. Whether there has been a breach of such a rule, and, if so, what sanction should follow, are always fact-sensitive questions and are beyond the scope of this article.

SUMMARY

In our view, and according to our understanding of the concept of human dignity, B was wrong to expose M to Christian influences. The wrongness cannot be adequately described except by invoking the concept of human dignity—much maligned in the literature,⁴³ but, we suggest, indispensable. An account of dignity, based on an Aristotelean conception of human thriving, captures all the criteria relevant in analyzing the ethics of the caregiver’s actions.

43 See, e.g., Ruth Macklin, “Dignity Is a Useless Concept,” *British Medical Journal* 327, no. 7429 (2003): 1419–20; Mirko Bagaric and James Allan, “The Vacuous Concept of Dignity,” *Journal of Human Rights* 5, no. 2 (2006): 257–70; John Harris, “Cloning and Human Dignity” *Cambridge Quarterly of Healthcare Ethics* 7, no. 2 (1998): 163–67; Peter Singer, *Applied Ethics* (Oxford: Oxford University Press, 1986), 228.