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The Retarded and The Criteria for the Human

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The author is a professor of theological studies at Notre Dame University. Recently he was on sabbatical leave at The Joseph and Rose Kennedy Institute for the Study of Reproduction and Bioethics where he studied the concept of a "Christian medical ethics." His article evaluates the setting of standards to determine "humaness," particularly in regard to the retarded.

It is often argued that the evaluation of the development and application of new biomedical technology depends on the view one has of man. The degree one thinks man is different from other animals and in what that difference consists seems to be crucial for such issues as the prolongation of life, the limits or uses of behavior modification, and the permissibility of human experimentation. Even though the centrality of our view of man for such decisions seems obvious, how the "distinctively human" is to be understood and used is a matter of controversy. This difficulty may be an indication that there is something morally askew about the general methodological assumption that criteria for the human are required for the work of bioethics to advance. For this assumption makes us forget how inappropriate it is for the preservation of our humanity to justify the exclusion of some men from human care and concern on grounds that they fail to meet such "criteria." The appropriate moral context for raising the question of the "essentially" human should not be an attempt to determine if some men are or are not human, but rather what we must be if we are to preserve and enhance what humanity we have. In other words the question of the criteria of the human should not be raised about others but only about ourselves.

Many raise the question of the "distinctively" human in an attempt to place some limits on what they perceive as the dehumanizing potential of biomedical technology. For example, they argue that we should not try to create "better humans" through positive genetic manipulation, as these procedures violate man's dignity and capacity for self-determination. For example in a recent Chicago Studies (Fall, 1972), William May argues that we should not do what we can do because:

"...man does differ, and differs radically, in kind from other animals and that this difference is rooted in his capacity for conceptual thought."
propositional speech, and self-determination. It is a difference, moreover, implicitly recognized by the majority of contemporary scientists and is affirmed in a very striking way in a comment made by Willard Gaylin, M.D., professor of psychiatry and law at Columbia University, when he wrote: "The human being is the only species capable of systematically altering its "normal" biological system by use of its equally "normal" intellectual capacity."

It is unclear, however, if this kind of appeal to the "distinctively" human is sufficient to place limitations on our technological powers. For example, many justify greater scientific manipulation by appealing to similar conceptions of man as the being open to constant self-modification through our capacity for self-determination.

**Inhumane Treatment**

Both sides of this debate fail to notice that their understanding of the "distinctively" human embodies values that warrant inhumane treatment toward some in our society because they do not comply with such criteria. In their enthusiasm to assert the dignity of man as either enhanced or destroyed by technology, they formulate criteria of the human that appear in our cultural context as an ideology for the strong. For example, such criteria clearly embody our assumption that man's rational and cognitive ability is what makes us human. Yet this belief is the basis for the inhumane treatment and care our society provides for the retarded, as we assume such people are fundamentally other than and foreign to the human community. Our responsibility to them extends to keeping them alive, but humanizing care beyond ensuring their survival is simply not warranted since they lack the essential conditions to claim they are provided for those that are truly human. Such treatment tragically becomes a self-fulfilling prophecy as we dehumanize them through impersonal and institutional cruelty or, in some ways even more destructive, the smothering compassion of pity. Not to be able to think, to talk as we talk, or to do as we do is to forfeit one's right to be treated with respect due to another human.

The presence of the retarded serves as a significant test case for any attempt to determine the "distinctively" human. For sure any criteria of the human that would justify less than human care for the retarded on the ground that they fall outside the purview of our species is morally suspect. The pervasive effects of such a limited sense of the human can be seen not only in the kind of care we provide for many of the retarded in our society but with the stigma we associate with retardation. To describe someone as retarded is not a technical decision based on neutral scientific data and analysis; the criteria that determine retardation have less to do with the "weakness" of the retarded than with the complexity of the demands of our society as well as our tolerance of deviation. In a society already so inhumane, we can ill afford to enshrine our inhumanity in formal criteria that pugnaciously are presented to prevent technology's encroachment on the "essentially" human.

This argument can be made in a less dramatic way by pointing out that the criteria of the distinctively human are not simply a list of empirical characteristics. The notion of the human is a conceptualization that makes meaningful or better intelligible why we associate certain empirical features with being human at all. In other words the evidence for our particular understanding of the human is dependent on prior conceptual and normative commitments that must be justified philosophically and ethically, since it cannot be assumed that the "empirical" conditions we have learned to associate with being man are necessary to the human conceptually and normatively understood. As James Gustafson has said, "A pre-judgment about what is and is not 'truly human' probably lurks in the judgment about what data to use in describing the human." Therefore, to raise the question of the criteria of the human is not first an empirical question, but a conceptual-moral claim about how the nature of man should be understood. We wrongly assume that what our eyes perceive as "normal" is what we should morally understand men to be qua human. The presence of the retarded helps us feel the oddness and the problematic nature of this assumption and its attendant ethical implications.

**Fletcher**

The significance of this argument can be illustrated by contrasting it with Joseph Fletcher's attempt to provide the biomedical decision maker with a profile of the human in operational terms. (The Hastings Center Report, Nov., 1972). Fletcher's "profile" includes fifteen positive and five negative propositions that are meant to provide necessary and sufficient grounds for attributing the status of human to another. To be man we must be capable of self-awareness, self-control, have a sense of time, futurity and past, be capable of relating to others, show concern for others, be able to communicate, exert control over our existence, be curious, be open to changes, have a proper balance of rationality and feeling, and have a unique identity. Negatively, men are not any of the following: anti-artificial, essentially parents, sexual, worshipers, or a bundle of rights. I am sure each of us will have our special problem with one or more of these criteria especially as some seem to make recommendations about how to be a good or mature man rather that the minimal conditions necessary to be a man. However it is not my purpose to try to evaluate each of these "criteria" separately, as I am interested in trying to make a more general point concerning the vagueness of this list. For Fletcher claims to have developed a list of "operational" criteria that are empirically specifiable, but all the conditions listed have only the vaguest empirical correlates. For example, what "empirical" signs could be given as a necessary warrant to demonstrate that someone had control over himself that would be useful to the doctor? The issue is complicated by Fletcher's failure to distinguish between...
criteria that are necessary and those that are sufficient to determine the human. For example, if a criterion such as having a proper balance between rationality and feeling is a necessary condition for being human, then I suspect some of us are in perpetual peril of losing our status as humans. However, Fletcher does identify minimal intelligence provided by the neo-cortical functions as the necessary empirical condition on which all these other characteristics depend. “In a way,” he says, “this is the cardinal indicator, the one all the others are hinged upon. Before cerebration is in play, or with its end, in the absence of the synthesizing function of the cerebral cortex, the person is nonexistent. Such individuals are objects but not subjects.” (p. 3) Fletcher’s emphasis on this aspect of our physiology rests on his assumption that to be human is to be rational, or in his language, “Homo sapiens, in order to be homo. The ratio, in another turn of speech, is what makes a person of the vita. Mere biological life, before minimal intelligence is achieved or after it is lost irretrievably, is without personal status.” (p. 1) Thus for Fletcher any individual who falls below the I.Q. 40-mark in a Stanford-Binet test is “questionably a person,” and if you score 20 or below you are not a person.

Before raising the more substantive issues about Fletcher’s position, there are some empirical issues that should be considered. It is interesting that Fletcher places such great faith in the Stanford-Binet test since it is extremely unclear what such a test measures (even psychologists are not all sure what intelligence involves or how the Stanford-Binet relates to intelligence). Therefore, even on empirical grounds it is not clear that the one operational criterion Fletcher gives to mark off the human is anything less than arbitrary. More troublesome than this is what empirical features Fletcher would associate with the absence of neo-cortical function, since it could involve anything from the loss of an EEG to the beginnings of senility. Fletcher seems to base his position in this respect on the assumption that activities such as instrumental learning and cognition reside entirely in the neo-cortex, but this has not yet been decisively established. Of course, no one would wish to deny the significance of the neo-cortex for our behavior, yet we should at least be aware that the identification of brain and mind is fraught with philosophical and empirical difficulties. Recent research suggests that we must be careful how we draw the distinction between body and mind since it may be that our spirit and individuality is more dependent on mere biological or bodily processes than we had thought.

Purpose of Criteria

More substantively it can be asked what purpose Fletcher’s criteria are to serve—that is, what conclusions should be drawn from them and what tasks should we try to perform with them? They seem to lend themselves to an interpretation that would exclude many that are now receiving care as human beings. Should we cease trying to obtain better living and learning conditions for the profoundly and moderately retarded? What should be done with the elderly who are no longer able to meet the criteria of being members of the Pepsi-generation? Should we cease developing resources for the care of those whose intelligence is not up to coping with our modern society because they place a drain on our resources while not contributing to the services or artifacts of our civilization?

This “profile” of man does not, I suspect, provide operational criteria any doctor would recognize, but it is rather a statement of the working assumptions about the value of human life that are alive in our culture. The strong stress on the value of intelligence as the necessary condition for all human activity faithfully mirrors the loyalties of our society. Intelligence, however, is not an end in itself, nor is our ability to reason sufficient to make us human if being human has anything to do with being humane. To assert such criteria as necessary to be human separated from the values and community for which they exist is to risk perversions we can scarcely afford in a world that already condemns some children to miserable existence because they cannot exercise “problem-solving” intelligence. We fail to notice that such criteria are really goals through which we manipulate and destroy some for the good of the “normal.” The important moral question is not whether the retarded meet or should meet “criteria of the human” we have established, but whether we do not become inhuman by being concerned with such judgments rather than providing the retarded with respect and care.

Our society’s high value of rationality tends to make us forget that our ability to think cannot be separated from our nature as social beings. As G. H. Mead taught, we would never be able to distinguish the “me” and the “not me,” the bedrock of awareness and reason, if we were not graced with the presence of the other. This descriptive point provides the basis for the more substantive ethical claim that our capacity to reason rightly is a correlative of our ability to regard others with respect. The use of the criterion of intelligence to warrant the exclusion of those that appeal and think differently from us is to cut off the moral basis of our ability to be rational at all. Put in more traditional terminology, our rational ability is not the prior principle of our moral activity for we are able to reason because we are fundamentally social beings. To emphasize our rational ability separated from its social-moral context is to intellectualize arbitrarily the power of cognition and language.

Being Human

To be a man is to be able to perceive and respond to other men with recognition of care. It is unclear to me what empirical criteria are correlative of this understanding of man since the forms of re-
sporne are rich and varied. That we need to develop some empirical rules of thumb to check our arbitrariness in some of the hard cases occasioned by our increased technological skill is not in question. As Eric Cassell suggests, “The function of morality in medicine is no longer simply to protect the weak and the sick from indifference or venality, but to protect them also from mercy grown overwhelming by technological advance.” However, the development of such rules of thumb must be developed with the kind of exactness that such cases entail, rather than with the generality that opens them to the perversion of justifying our uncaring of those who do not fit our current standards of “fully human.”

In this respect, I think a strong cautionary note needs to be interjected about developing criteria of the human that will somehow relieve us of the hard choices that we are confronting in modern medicine. For criteria that are sufficient for all the kinds of cases we confront will be so vague that their concrete implications will be ambiguous at best. Even if you try to make such criteria more operational for the doctor by tying them to empirical characteristics, it is by no means clear that the moral questions involved in many of these cases will be any more resolvable. For even though such criteria may help you decide that this life is not “fully human,” the question of whether care should be given still remains. I suspect that we are human exactly to the extent we can reach out and provide care for those who have no “right” to it but more concretely, as important as criteria are to inform decisions, we cannot make them do all the work of ethical judgment and argument for all cases, since no question is going to relieve or should make less troublesome the burden of deciding to operate to save the life of a severely retarded child. To try to substitute “impersonal criteria” for what should be the moral agony of such decisions is already to sacrifice more of our humanity than we can stand.

Finally, I think we should feel the oddness of trying to determine this or that as the criteria that makes us human. The complexity of being human is an immensely complex pattern to be ever reduced to something like “criteria.” Too quick appeals to the mystique of being human can be but excuses for cloudy and sloppy thinking that attempts to evade some of the hard issues we are confronting, but they may also be profound responses to the human sense that ultimately we are not our own creators. To be a man is to be open to the call of what we are not, and there is therefore no chance that our humanity will be enhanced by excluding from our ranks those who do not understand as we. We must therefore approach the attempt to develop criteria of the human with the humility that recognizes that we would be less than human if we did not recognize that there are limits to what can be brought under our control.

Definition and Criteria of Clinical Death

Robert F. Rizzo, Ph.D. and Joseph M. Yonder

Synopsis

Using the 1968 Journal of the American Medical Association article on brain death by the Ad Hoc Committee of the Harvard Medical School and the 1972 JAMA report by the Task Force on Death and Dying of the Institute of Medicine, Ethics and the Life Sciences on a re-examination of brain death as a clinical death as it relates to care of the terminal patient.

Clinical Death

With technical progress in the care of the sick and dying comes a number of problems and a need to reexamine traditional presuppositions, concepts and procedures. Advances in chemical and mechanical means for sustaining life have raised questions concerning the clinical definition of death and the tests for determining when clinical death has occurred. Though these questions have important relevance to a wide range of legal as well as personal and medical matters, they have immediate bearing on the role of the physician in his relationship of trust and service to the patient and community and on the quality care of the terminal patient. These are our major concerns in reexamining the definition and criteria of clinical death.

Medical technology has challenged the moral and medical criteria for determining death. Technical advances in health care have led some to put emphasis on “brain death” rather than on heart and respiratory cessation as the criteria for diagnosing clinical death. The strain of moving from heart and respiratory cessation to brain death reveals the inadequacy of present medical and moral guidelines in the face of an increasingly sophisticated technology. Deeply woven in the culture of our society, there emerges the central question of the controversy. Are we really interested in the quality care of the patient and particularly the terminal patient?

In the care of the dying, a redefinition of clinical death and its criteria would mean that doctors would withdraw extraordinary measures for sustaining life much soon-